Regulatory Bulletin

Regulation of restrictive practices and the role of the Senior Practitioner, Restrictive Practices

RB 2023-22

Approved providers have specific responsibilities under the *Aged Care Act 1997* (the Aged Care Act) and the Principles relating to the use of any restrictive practice in residential aged care and short-term restorative care in a residential care setting.

Amendments to the Principles came into effect on 1 December 2022, which provide greater clarity about who can provide informed consent for the use of a restrictive practice where a consumer lacks capacity to give that consent.

The amendments:

- provide clarity for the meaning of 'restrictive practices substitute-decision maker';
- include responsibilities for providers regarding restrictive practices nominees;
- introduce a consent hierarchy, which must be used when there has been no restrictive practices substitute decision-maker appointed under state and territory laws; and
- include immunity provisions against criminal or civil liability under state and territory laws when relying on informed consent under Commonwealth laws.

The amendments do not affect informed consent already given by an individual or body authorised to consent to the use of a restrictive practice under the relevant state or territory where the use has already occurred. The arrangements are interim measures primarily intended to address situations where there are no persons or bodies that can be appropriately authorised under state or territory laws.

The Aged Care Quality and Safety Commission (the Commission) continues to monitor providers' use of restrictive practices through complaints handling processes, responding to reportable incident notifications made under the Serious Incident Response Scheme (SIRS), and as part of quality assessment and monitoring activities, including accreditation. During these processes, Commission officers seek evidence of the actions taken by providers to minimise the use of restrictive practices, and where a restrictive practice is used, to ensure that it is in accordance with legislative requirements. This evidence is gathered through observation, reviewing records of care, interviews with consumers and their representatives, and enquiries of management, staff, health professionals and others at the service.

This Regulatory Bulletin outlines the requirements that must be met before and during the use of any restrictive practice and the resources available to support providers to meet these requirements. It outlines how the Commission will monitor compliance and manage any identified non-compliance with these requirements, as well as a provider's performance against the Quality Standards.

The Regulatory Bulletin provides general guidance only and is not prescriptive. Providers should review the legislation, including the amendments to the Principles introduced under the *Quality of Care Amendment (Restrictive Practices) Principles 2022*, and consider each decision relating to restrictive practices on its particular facts and circumstances. Examples given in the Bulletin are not provided to emphasise importance, and all provisions are given an equal weighting when being assessed.

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Information in this bulletin applies to:

All residential aged care services and flexible care services through which short-term restorative care is provided in a residential care setting.

Attachment: N/A

Notes

This Regulatory Bulletin includes:

- revised legislative requirements for use of restrictive practices, including definitions of types of restrictive practices and consent provisions for the use of restrictive care
- introduction of a Restrictive Practices Compliance Notice and potential for civil penalties
- reference to requirement to develop Behaviour Support Plans for consumers
- reference to the role of the Senior Practitioner, Restrictive Practices
- reference to risk-based monitoring of providers' performance against the *Quality of Care Principles 2014* (the Principles) and the Aged Care Quality Standards (Quality Standards)
- links to the restrictive practices and consent resources available on the Commission website.

To be reviewed: 24 October 2024

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In this Bulletin:

- **Approved health practitioner** means a medical practitioner, nurse practitioner or registered nurse.
- **Behaviour Support Plan** refers to a plan for a consumer, made in accordance with the Principles, that sets out information regarding any changed behaviours (also known as 'behaviours of concern') for that consumer, including all alternative strategies which have been tried prior to the use of any restrictive practice for that consumer. The Principles set out the responsibilities of the provider relating to Behaviour Support Plans, including assessments and documentation which should be prepared and included.
- **Care and services plan** refers to the care and services plan required by the Quality Standards.
- **Informed consent** means the consumer, or a restrictive practices substitute decision-maker, has been provided with all relevant information regarding a practice, including the use of any restrictive practice, in order to make a decision about its use, has agreed to its use and this consent is documented.
- **Medical Treatment Authority** for a consumer, means an individual or body that, under the law of the state or territory in which the consumer is provided with aged care, has been appointed in writing as an individual or body that can give informed consent to the provision of medical treatment to the consumer if the consumer lacks capacity to give that consent.
- **The Principles** refers to the *Quality of Care Principles 2014*.
- **Provider** means both approved provider of residential aged care services and approved provider of flexible care services through which short-term restorative care is provided in a residential setting.
- **Restrictive practices** mean any practice or intervention that has the effect of restricting the rights or freedom of movement of the consumer.
- **Restrictive practices nominee** means an individual or a group of individuals nominated by the consumer who can give informed consent to the use of the restrictive practice in relation to the consumer if the consumer lacks capacity to give that consent, has agreed in writing, and has capacity to give that consent.

- **Restrictive practices substitute decision-maker** in the first instance is a person or body that, under the law of the state or territory in which the consumer is receiving aged care, can give informed consent to the restrictive practice (or to the prescription of medication in the case of a chemical restraint). To support providers in some jurisdictions where there is no explicit legal avenue to appoint a restrictive practices substitute decision-maker or an application has been made for an appointment under the law of the state or territory but there is a significant delay in deciding the application, a consent hierarchy must be applied to identify a restrictive practices substitute decision-maker.

Refer to the Commission's glossary for definitions of key terms.

Key points

- The Commission's focus continues to be on ensuring that risks to consumers' safety, health and wellbeing through the use of restrictive practices are minimised, and consumers are treated with dignity and respect.
- Restrictive practices must only be used as a last resort, in the least restrictive form and for the shortest time possible.
- The Principles require providers to satisfy a number of conditions before and during the use of any restrictive practice. These include (but are not limited to):
  - Restrictive practices must only be used where the provider has documented changed behaviours (or behaviours of concern) for the consumer,
  - where these changed behaviours have been assessed by an approved health practitioner who has day to day knowledge of the consumer,
  - to the extent possible, best practice alternative strategies have been considered or used prior to the use of any restrictive practice, and
  - consent to the use of any restrictive practice if required.
- The provider is required to document the alternatives to restrictive practices that have been considered and used, and why they have not been successful. Alternative strategies must reflect best practice and take into account the consumer's past experience, background, preferences and matters that might be meaningful or of interest to them.
- The provider is required to have a clinical governance framework in place that has:
  (a) someone responsible for the governance of restrictive practices
  (b) processes in place to identify and minimise the use of restrictive practices
  (c) processes to ensure compliance with the Principles for behaviour support planning and restrictive practices.
- The Commission expects that where a restrictive practice is used, such a framework will ensure that informed consent for the restrictive practice has been obtained from the consumer or their restrictive practices substitute decision-maker.
- Where any restrictive practices are used, the consumer must be monitored. This can include monitoring for signs of distress

or harm, side effects and adverse events, changes in mood or behaviour, changes in wellbeing, as well as independent functions or ability to undertake activities of daily living.

- The necessity for the use of the restrictive practice must be regularly monitored, reviewed and documented. The effectiveness of the use of the restrictive practice, as well as the effect of changes in the use of the restrictive practice must be monitored.
- Providers are required to have a Behaviour Support Plan in place for every consumer who exhibits changed behaviours (or behaviours of concern), or who has restrictive practices considered, applied, or used as part of their care. The Behaviour Support Plan forms part of the care and services plan and does not replace it.
- The Commission may issue a Restrictive Practices Compliance Notice where there is information to suggest a provider is not, or may not be, complying with its responsibilities on the use of restrictive practice. The Commission's existing regulatory powers to respond to non-compliance also continue to apply and are detailed in the Commission's Compliance and Enforcement Policy.
- Providers should familiarise themselves with the amended requirements in the Aged Care Act and Principles.

Aged Care Act 1997

Providers have responsibilities under section 54-1(1)(f) of the Aged Care Act to ensure a restrictive practice is only used in the circumstances set out in the Principles.

Quality of Care Principles 2014

Part 4A of the Principles:

- provides that certain practices or interventions are restrictive practices
- sets out circumstances for the use of restrictive practices
- outlines requirements for the provision of informed consent for the use of restrictive practices
- specifies other responsibilities of providers relating to restrictive practices.

The Principles state that any form of restrictive practice cannot be used unless a number of specific conditions are met.

If any restrictive practice is used, the Principles require providers to document certain specified information in the consumer's Behaviour Support Plan and monitor the consumer for signs of distress and harm. The Principles outline the requirements of the Behaviour Support Plan, and include information on assessments, monitoring, review, evaluation and provision of informed consent.

From 1 December 2022, the Principles provide greater clarity regarding who can provide informed consent for the use of a restrictive practice where a consumer lacks capacity to give that consent. The amendments set out a hierarchy of consent, which must be applied when a mechanism under state and territory laws to appoint a restrictive practices substitute decision-maker is not available, or a substitute decision-maker has not yet been appointed. This includes when there is a significant delay in the state or territory deciding an application for the appointment of a restrictive practices substitute decision-maker.

Aged Care Quality Standards

Obligations lie across all **Quality Standards** regarding restrictive practices. Standard 8 requires providers who deliver clinical care to have a clinical governance framework in place that includes minimising the use of restrictive practices and organisational wide governance systems for regulatory compliance, that includes compliance with the Principles on minimising the use of restrictive practices.

Other specific requirements are found in the following Quality Standards:

- Standard 1: consumer dignity and choice, whereby the consumer is supported to take risks to live the best life they can
- Standard 2: ongoing assessment and planning with consumers
- Standard 3: personal care and clinical care which is best practice and responsive to consumers' changing needs
- Standard 5: a service environment that is safe and comfortable and promotes the consumer's independence, function and enjoyment
- Standard 7: human resources, specifically in relation to staff training and understanding of provider processes regarding restrictive practices.

Restrictive practices

Practices or interventions that are restrictive practices:

Chemical restraint is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a consumer's behaviour, but does not include the use of medication prescribed for:

- the treatment of, or to enable the treatment of, the consumer for:
  - a diagnosed mental disorder; or
  - a physical illness; or
  - a physical condition; or
- end of life care for the consumer.

Examples of chemical restraint are administration of any medication, including prescribed, pro re nata (prn or as required) and over the counter medication, to a consumer, which influences their behaviour.

Environmental restraint is a practice or intervention that restricts, or that involves restricting, a consumer's free access to all parts of the consumer's environment, including items and activities, for the primary purpose of influencing a consumer's behaviour.

Examples of environmental restraint are restricting a consumer's access to an outside space, removing or restricting access to an activity, or limiting or removing access to a wanted or needed item, such as a walking frame, by putting it out of reach.

Mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a consumer's movement for the primary purpose of influencing the consumer's behaviour. It does not include the use of a device for therapeutic or non-behavioural purposes in relation to the consumer.

Examples of mechanical restraint include use of a lap belt or princess chair, bed rails, low beds or use of clothing which limits movement and is unable to be removed by the consumer.

Physical restraint is a practice or intervention that;

- is, or that involves, the use of physical force to prevent, restrict or subdue movement of a consumer's body, or part of a consumer's body, for the primary purpose of influencing the consumer's behaviour; but
- does not include the use of a hands-on technique in a reflexive way to guide or redirect the consumer away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the consumer.

Examples of physical restraint are physically holding a consumer in a specific position to enable personal care issues such as showering to be attended to, pinning a consumer down, or physically moving a consumer to stop them moving into a specified area where they may wish to go.

Seclusion is a practice or intervention that is, or that involves, the solitary confinement of a consumer in a room or a physical space at any hour of the day or night where:

- voluntary exit is prevented or not facilitated; or
- it is implied that voluntary exit is not permitted

for the primary purpose of influencing a consumer's behaviour.

Examples of seclusion are placing a consumer alone in a space or room from which they cannot exit, including in a space by themselves where their access to a call bell or walker is limited, or imposing a 'time out'.

Seclusion significantly affects a consumer's dignity and rights and should only be used after all other forms of behaviour management or appropriate alternative restrictive practices have been exhausted.

Seclusion is an extreme form of restrictive practice and should never be used as a punishment.

A practice that may be considered a restrictive practice for one consumer may not be considered a restrictive practice for another. Devices in place for safety purposes or to prevent harm, even if consented to by the consumer, may still be considered a restrictive practice under the Principles, if they meet the Principles definitions of a restrictive practice.

The use of the practice or intervention still requires the same process of assessment, consent, monitoring and evaluation as would be in place for use of any other restrictive practice.

Requirements for the use of any restrictive practice

The Principles outline certain requirements that apply to the use of any restrictive practice in relation to a consumer:

(a) the restrictive practice is used only:

  (i) as a last resort to prevent harm to the consumer or other persons and

  (ii) after consideration of the likely impact of the use of the restrictive practice on the consumer

(b) to the extent possible, best practice alternative strategies have been used before the restrictive practice is used

(c) the alternative strategies that have been considered or used have been documented

(d) the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the care recipient or other persons

(e) the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the care recipient or other persons

(f) informed consent to the use of the restrictive practice has been given by:

  (i) the care recipient or

  (ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker;

(g) the use of the restrictive practice complies with any relevant provisions of the care and services plan for the care recipient or Behaviour Support Plan

(h) the use of the restrictive practice complies with the Aged Care Quality Standards set out in Schedule 2;

  (i) the use of the restrictive practice is consistent with the Charter of Aged Care Rights set out in Schedule 1 to the User Rights Principles 2014

  (ii) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

These are the requirements that providers **must** have regard to prior to and during the use of any form of restrictive practices.

Assessments prior to the use of restrictive practices

An approved health practitioner, who has day-to-day knowledge of the consumer, must have assessed and documented that there is a risk of harm to either the consumer or another person, and that the use of a restrictive practice is necessary. The restrictive practice and its use must be in accordance with the requirements of the Principles.

In the case of chemical restraint, the assessor and prescriber of the associated medication must be a medical practitioner or nurse practitioner. As this person will in many circumstances not be an employee or representative of the provider, the provider must have assured themselves that the assessment and giving of consent has taken place and documented in accordance with the requirements of the Principles. The provider must also ensure that the assessment and decision to use the chemical restraint, the changed behaviours and reasons that necessitated the use of the restrictive practice, and the information provided to the assessor, are recorded in the care and services plan.

If chemical restraint is used, the provider is responsible for ensuring the prescribing medical practitioner or nurse practitioner is regularly given information about the effect and use of the restrictive practice. The purpose of this information is to ensure that the prescriber understands whether the chemical restraint is effective, still required, or that its use needs to be reassessed.

Use of restrictive practices in an emergency

The Principles enable the temporary use of restrictive practices in the event of an emergency without having regard to some of the requirements listed above, including the requirement to have informed consent from the consumer or their substitute decision-maker. The exemption from some requirements as outlined in the Principles is intended to ensure that a provider can appropriately and rapidly respond to an emergency to ensure the protection of a consumer or other persons from immediate harm.

As soon as practicable after the use of the restrictive practice in an emergency, the provider must inform the consumer's restrictive practices substitute decision-maker about the use of the restrictive practice, and this must be documented. Once the emergency is over, the provider should revert to the usual policies and procedures regarding the application or use of any restrictive practice for the consumer. This includes reduction or removal of the restrictive practice, assessment, consideration and use of alternative strategies, and

subsequent update and review of the consumer's **Behaviour Support Plan** and **care and services plan**.

The Commission expects that in many circumstances the emergency use of restrictive practices will be treated by the provider as an incident, and the provider will seek to identify ways they can better support the consumer and reduce risks of the same or similar incidents occurring in the future.

Any use of a restrictive practice that is not consistent with the consumer's documented needs as described in their care and services plan is a reportable incident under SIRS. This includes where the restrictive practice is used in an emergency situation.

An emergency is a serious or dangerous situation that is unanticipated or unforeseen which requires immediate action. Situations where restrictive practices are required in residential aged care in the event of an emergency should therefore be rare.

It is expected that providers will be actively engaged in a consumer's day to day care and support needs, including behaviour support planning, and that this understanding and engagement will reduce the occurrence of emergencies.

Providers should be conscious of alternative strategies relevant to each individual to avoid the need for emergency use of restrictive practices. This includes actively responding to the needs of their consumers in order to avoid the deterioration of health, to respond to their needs and to avoid distress and escalation of changed behaviours, to a point where emergency use of restrictive practices may be required.

In monitoring compliance with provider responsibilities relating to the use of restrictive practices, the Commission will be reviewing care and services plans and Behaviour Support Plans where emergency use of restrictive practices has been applied. This review will include considering the consumer's care needs in the lead up to the emergency, whether the emergency could have been anticipated given past history of behaviour, whether distress was detected and responded to and what action was taken to deal with the situation prior to it becoming an emergency.

If emergencies are occurring for extended periods of time or are occurring regularly for one or more consumers in a provider's care, this may indicate that a provider is not meeting their responsibilities under the Aged Care Act and Principles and the Commission would monitor or investigate these circumstances.

Where there is evidence that insufficient action has been taken by a provider to avoid emergency use of restrictive practices for a consumer, the Commission may take further proportionate regulatory actions where it is deemed appropriate to address any non-compliance.

Responsibilities while restrictive practices are being used

If a restrictive practice is used, a consumer must be regularly monitored for signs of distress or harm, side effects and adverse events, changes in wellbeing, as well as independent functions or ability to undertake activities of daily living.

The necessity and effectiveness of the restrictive practice must be considered on an ongoing basis, and in accordance with the overarching requirements, and its use ceased or altered if the practice is no longer required or is ineffective or causing harm.

Providers must consider (to the extent they are able to) whether environmental changes can be made that would reduce or remove the need for the use of a restrictive practice.

Behaviour Support Plans

Providers are required to have a Behaviour Support Plan in place for every consumer who experiences changed behaviours (or behaviour of concern) or has restrictive practices used as part of their care, unless in an emergency as outlined above.

Providers are expected to have Behaviour Support Plans included in the care and services plan for the consumer. The plan must outline a consumer's behaviour support needs and the use of restrictive practices (if the consumer requires or may require them).

This includes requirements that providers have documented evidence that best practice alternative strategies have been considered or used relevant to the individual consumer concerned, prior to the use of the restrictive practice as a last resort, have documented evidence of consent for use of the restrictive practice, and evidence of ongoing monitoring and evaluation for its continued use.

Behaviour Support Plans must set out information about the consumer that helps the provider to understand the consumer's background and changed behaviours, including but not limited to:

- any assessments which have been carried out regarding those behaviours;
- known triggers which may precede those behaviours;
- alternative strategies which are known to be successful, or unsuccessful, in managing those behaviours; and
- any restrictive practices which are used or applied once alternative strategies have been tried.

Consent for use of any type of restraint is required and should be documented in the consumer's care and services plan. **From 1 December 2022**, the Principles clarify the consent arrangements for the use of restrictive practices by a restrictive practices substitute decision-maker.

Providers are encouraged to make use of the range of resources available on the Commission's website regarding behaviour support planning.

Consent

Chemical restraint

For the use of a chemical restraint the prescriber of the medication (i.e. the older persons GP or treating specialist) is responsible for seeking and obtaining informed consent from the consumer or their restrictive practices substitute decision-maker. The provider is responsible for having clinical governance arrangements in place to ensure that consent has been obtained and documented, and that this is consistent with state, territory, or Commonwealth laws.

Informed consent

Informed consent means that the consumer (or their nominated substitute decision-maker) has been provided with information relevant to the individual consumer and their current circumstances and has had the opportunity to review and ask questions about the use of any restrictive practice, and subsequently has made a decision to have a restrictive practice used or applied as part of their care or not.

A consumer's capacity to provide informed consent should be presumed in the first instance. In the event of the consumer lacking capacity to provide informed consent regarding use of restrictive practices, the restrictive practices substitute decision-maker can provide this consent.

The Commission has released resources to help providers understand their responsibilities around consent, including:

- Frequently asked questions about consent
- Consent for medication in aged care

Further resources are available on the Commission website.

Restrictive practices substitute decision-maker

From 1 December 2022, the Principles provide a new meaning of 'restrictive practices substitute decision-maker'. In the first instance, a restrictive practices substitute decision-maker is an individual or body appointed under state or territory law in which the consumer is provided with aged care, to give informed consent to the use of restrictive practices for a consumer who lacks capacity to provide the consent for themselves.

Consent hierarchy

From 1 December 2022, the Principles include a consent hierarchy. The consent hierarchy must be used when there is no individual or body appointed for a restrictive practice under the law of a state or territory **and**; there is no clear mechanism for appointing such an individual **or** body or an application has been made for an appointment under the law of the state or territory but there is a significant delay in deciding the application.

The hierarchy is to be applied sequentially, meaning providers must start at the top of the hierarchy and can only move down to the next tier of person if the higher tier of person doesn't apply. (For example, only if the consumer does not have a partner they are in a close and continuing relationship with could the provider approach a relative or friend). Once a restrictive practices substitute decision-maker satisfies the requirement under their tier of the consent hierarchy, the informed consent of that individual must be sought. If the substitute decision-maker cannot be contacted, does not have the capacity or refuses to give informed consent, a provider will then be restricted from identifying a person on a lower tier of the hierarchy to seek informed consent. In this event, restrictive practices cannot be used for the individual consumer.

The following consent hierarchy applies when identifying who the restrictive practices substitute decision-maker is:

1. Restrictive practices nominee (see definition on page 3 and section below)
2. A partner:

   (a) with whom the consumer has a close and continuing relationship,

(b) who has agreed in writing, and

(c) who has capacity to give consent.

3. A relative or friend:

(a) who was an unpaid carer for the consumer immediately before the consumer entered aged care,

(b) who has a personal interest in the consumer's welfare on an unpaid basis,

(c) with whom the consumer has a close and continuing relationship,

(d) who has agreed in writing, and

(e) who has capacity to give consent.

4. A relative or friend:

(a) who has a personal interest in the consumer's welfare on an unpaid basis,

(b) with whom the consumer has a close and continuing relationship,

(c) who has agreed in writing, and

(d) who has capacity to give consent.

5. Medical treatment authority (see definition on page 4).

Where there is more than one relative or friend, then the eldest of those individuals (highest age) is the restrictive practices substitute decision-maker.

The consent hierarchy does not override state and territory laws where there are **clear** mechanisms for an individual or body to be appointed as a person who can give consent to the use of a restrictive practice on behalf of another person, or if a person has already been appointed as a substitute decision-maker under those laws.

Providers are reminded that decisions regarding informed consent, including where the consent hierarchy for restrictive practices has been used, must be documented in the consumer's care plan, and that consent for restrictive practices use must be reviewed and documented on an ongoing basis as part of care planning for each consumer.

Applying the consent hierarchy when an application has been made under state or territory law

The hierarchy can be used when an application has been made for an appointment under state or territory law, but there is a significant delay in deciding the application. This recognises the time it may take for state or territory bodies to hear and decide applications, while providing safeguarded pathways for providers to obtain appropriate informed consent to the use of a restrictive practice in the interim. It also ensures restrictive practices may be used where necessary to promote the health, safety and wellbeing of consumers.

Consideration of whether a delay is 'significant' will depend on the individual circumstances for each consumer and will be considered on a case-by-case basis. This is not solely dependent on the time taken to make the decision and the following should be considered when determining whether a significant delay is occurring:

- The relevant circumstances of the consumer.
- The impact and consequences of the timing of the decision on the consumer.
- Whether the impacts and consequences are reversible.
- Whether the state or territory tribunal is able to make emergency decisions.

It is open to providers to seek their own independent advice, including legal advice, as specific cases arise in relation to whether the delays may be considered significant and affect the consent hierarchy.

Restrictive practices nominees

From 1 December 2022 a consumer can nominate an individual or a group of individuals (up to 3 people) who can give informed consent to the use of a restrictive practice in relation to the consumer if they lack capacity to give that consent. At the time of making the nomination, the consumer must have the capacity to make decisions associated with the nomination. The nominee/s must accept the nomination in writing and have the capacity to make decisions about the use of restrictive practices on the consumer's behalf.

There are also additional responsibilities for providers regarding nominations of restrictive practices nominees. Providers must take reasonable steps to ensure:

- a consumer is not subject to **coercion or duress** in making, varying or revoking a nomination for a restrictive practices nominee
- a restrictive practices nominee (whether as an individual or as a member of a group) is not subject to coercion or duress in agreeing, or withdrawing agreement, to be a nominee.

Consideration of what constitutes 'reasonable steps' will depend on the individual circumstances for each consumer and will be considered on a case-by-case basis. Providers are responsible for demonstrating the logical and reasonable steps taken to identify and respond to coercion and duress in the nomination process. The provider should not rely on a nomination if they have not taken reasonable steps to ensure coercion or duress has not occurred.

A consumer with capacity may make, vary or revoke their nomination in all instances and the making, varying or revocation of the nomination must be made in writing. The role of the nominee in decision-making is effective only when an appropriate assessment indicates the consumer is no longer capable of making that decision.

Providers must also:

- assist consumers to notify the restrictive practices nominee, provide the nominee with a copy of the nomination and seek the nominee's agreement; and
- keep a record of a consumer's restrictive practices nominee, whether the nominee has agreed and whether the nominee has withdrawn that agreement.

Immunity provisions

From 1 December 2022, the Aged Care Act includes an immunity provision so that providers and other relevant individuals such as staff members, volunteers and medical practitioners, are not subject to criminal or civil liability under state and territory laws for relying on consent provided by a person authorised to give that consent under the Commonwealth laws.

The immunity provision will only be available where all of the legal requirements around who may consent to the use of a restrictive practice are strictly followed. If the use of the restrictive practice is not used in accordance with the requirements under Part 4A of the Principles, the immunity will not apply.

Enforcement

The Commission has a range of regulatory powers to respond when a provider is not complying with its responsibilities. This includes a power specific to the use of restrictive practices in addition to existing enforceable regulatory actions. The Commission may take one or more regulatory actions where it is deemed appropriate and proportionate in order to address the non-compliance.

Restrictive Practices Compliance Notice

The Commission may issue a **Restrictive Practices Compliance Notice** where there is information to suggest a provider is not, or may not be, complying with its responsibilities for the use of restrictive practices as detailed in the Principles. This notice specifies actions the provider must take within a reasonable period to address the identified or potential non-compliance.

For more information on the Commission's approach to compliance and enforcement, including use of its regulatory powers, refer to the Compliance and Enforcement Policy.

Supporting providers in minimising use of restrictive practices

The Commission continues to focus on supporting providers with advice regarding appropriate use of restrictive practices and minimising their use.

The Commission has guidance available to assist providers regarding minimising use of restrictive practices. This includes information on:

- behaviour support and care planning
- informed consent and decision making
- dementia care
- clinical governance
- medication safety

Guidance Resources are available on the Commission website.

Senior Practitioner, Behaviour Support

In response to the independent review of legislative provisions governing the use of restraint in residential aged care Final Report December 2020, and as part of the Government's response to the findings of the Royal Commission into Aged Care Quality and Safety, the Commission has established a role of Senior Practitioner, Behaviour Support.

The **Senior Practitioner, Behaviour Support** leads education in the sector, including for aged care providers, prescribers and other critical partners to support providers in understanding their regulatory obligations regarding use of restrictive practices, and to support positive behaviour practices as alternatives to restrictive practices.

The **Senior Practitioner, Behaviour Support** provides expert advice and supports the Commission in responding to complaints about the provision of aged care services, notifications received under the Serious Incident Response Scheme, monitoring and assessment of providers' performance, and managing non-compliance relating to providers' responsibilities on the use of restrictive practices, behaviour support and the Quality Standards.

The **Senior Practitioner, Behaviour Support** also ensures that the views of individual consumers and their representatives continue to be given appropriate weight in assessing providers' compliance with their legislative obligations to minimise the use of restrictive practices.

Frequently asked questions

1. Do the changes to consent from 1 December 2022 mean that a provider needs to review all existing restrictive practice consent arrangements?

Providers should ensure that policies, procedures, and practices regarding receiving of consent comply with relevant state and territory laws. Providers must document consent for the use of restrictive practices, including when the consent hierarchy has been used, on the consumer's Behaviour Support Plan.

Consent arrangements for restrictive practices existing prior to 1 December 2022 will require review and renewal, and this review and compliance with the changes should be reflected in the Behaviour Support Plan. When further consent is required, providers should have regard to the arrangements that apply from 1 December 2022.

2. Can the consent hierarchy be relied upon for other areas of aged care?

No, the consent hierarchy is specific to restrictive practices. State and territory legislative arrangements relating to consumers who lack capacity continue without change.

3. Can consent for the use of restrictive practices be withdrawn?

A consumer with capacity or a restrictive practices substitute decision-maker can withdraw their consent for the use of restrictive practices at any stage. They can also vary any consent provided.

4. Do the *Quality of Care Principles 2014* requirements regarding restrictive practices apply to home care settings?

The legislative requirements contained in the Principles regarding restrictive practices apply to residential care and flexible care in the form of short-term restorative care provided in a residential care setting. They do not currently apply to home care settings.

Home services are still required to meet the requirements of the Aged Care Quality Standards, more specifically in:

- Standard 1 - treating consumers with dignity and respect
- Standard 2 - ongoing assessment and planning with consumers including behaviour assessment and planning
- Standard 3 - delivering care and services which are safe and responsive to consumers' changing needs including minimising restrictive practices and best practice behaviour support
- Standard 5 - providing an environment which encourages free movement
- Standard 7 – Human resources, specifically in relation to staff training and understanding processes regarding srestrictive practices and best practice behaviour support
- Standard 8 – Organisational governance including effective organisation wide governance systems in place including a clinical governance framework which minimises the use of restraint.

Under the SIRS, there is a responsibility for all providers to notify the Commission of reportable incidents related to inappropriate use of restrictive practices. For further information, refer to the SIRS guidance on the Commission's website.

5. How will the Commission monitor compliance with provider responsibilities in relation to the use of restrictive practices?

The Commission is committed to addressing the inappropriate use of restrictive practices and ensuring that consumers receive appropriate behaviour support, including the use of alternative strategies prior to the use of any restrictive practice.

The Commission will monitor and investigate provider compliance with the restrictive practices requirements to ensure the safety, health, wellbeing, and quality of life of consumers through multiple avenues. Information about potential non-compliance may be received through complaints, SIRS notifications, concerns raised regarding the Code of Conduct for Aged Care, assessments of providers against the Quality Standards and data collected as part of the Quality Indicator Program (QIP).

Restrictive practices obligations lie across **all Quality Standards**. Where a provider is found non-compliant against the Quality Standards regarding use or application of restrictive practices for consumers, usual regulatory processes will apply.

Where monitoring or investigation indicates poor procedures or systemic failures of the provider regarding restrictive practices use, the Commission may take further action which may lead to compliance action under the Principles. A Restrictive Practices Compliance Notice may be issued in addition to other compliance notices relating to that or other compliance action against the provider.

6. How does the Commission monitor risks related to use of restrictive practices?

The Commission uses its regulatory intelligence (including regular reporting from providers) to profile risks relating to the inappropriate use of restrictive practices. This includes issues raised in complaints, reporting under SIRS as well as the QIP.

The QIP requires providers of residential aged care to submit information quarterly about the percentage of consumers who are physically restrained in each of their services and the percentage of consumers who received antipsychotic medications. Under the QIP, physical restraint includes environmental, physical and mechanical restraint, as well as seclusion. More information about how to collect data as part of the QIP can be found in the QIP Manual 3.0 Part A, available on the Department's website.

The Commission uses risk profiling to undertake risk-based targeting in the assessment and monitoring of providers' compliance with the Principles and Quality Standards.

The Commission also uses its risk profiling to advise the sector on its performance, and in developing guidance and education for providers, consumers and their representatives in the use of restrictive practices.

7. Does a Serious Incident Response Scheme (SIRS) notification need to be made each time the restrictive practice is used?

The inappropriate use of restrictive practices is a reportable incident and the provider will need to ensure they are meeting their reporting responsibilities under SIRS on a case-by-case basis. A SIRS notification is not required when the provider has met all of its responsibilities relating to the use restrictive practices.

The Commission will assess each SIRS notification and will request additional information from the provider as required. While a provider is not required to continue to report a specific instance of inappropriate use of restrictive practices once reported to SIRS, the provider will be required to work with the Commission to ensure good practice and compliance with restrictive practices (see point 8 below).

Refer to the Commission's SIRS Provider Resources' regarding Inappropriate use of Restrictive Practices for further information.

8. What happens if the Commission receives a Serious Incident Report or complaint that a provider has not used restrictive practices in accordance with the requirements?

Part of the Commission's role is to receive and manage complaints about the delivery of aged care, and reports about certain types of serious incidents. Following receipt of a complaint or SIRS notification, the Commission usually gathers information so that it can assess the matter and decide on the appropriate response. Depending on the

circumstances, the Commission may engage with the provider so that the provider can understand and resolve a matter including undertaking their own further investigation. The Commission may also initiate its own investigations into the provider's compliance.

The Commission considers the full range of provider responsibilities when managing complaints and serious incident reports. The effective management of consumer's behaviour, effective incident management, appropriate consultation and consent, the handling of emergency situations and appropriate use of restrictive practices are all matters the Commission frequently considers.

If, as a consequence of responding to a complaint or reportable incident, the Commission determines that a provider may not be meeting their responsibilities under the Principles and Quality Standards, this may lead to further regulatory action, including compliance activity.

The Senior Practitioner, Behaviour Support will oversee Commission regulatory activity relating to the use of restrictive practices. It is critical that consumers, their families and representatives have the ability to raise concerns with a provider about the way distress and behaviour is being addressed and how restrictive practices are being used, and that where they are being used inappropriately, this is seen and responded to by providers as a reportable incident.

9. What are a provider's obligations regarding obtaining informed consent before using chemical restraint?

In summary, the prescriber of medication for the purpose of chemical restraint is responsible for seeking and obtaining informed consent from the consumer or their restrictive practices substitute decision-maker. The provider is responsible for having clinical governance arrangements in place to ensure that consent has been obtained and documented, and that this is consistent with state, territory or Commonwealth laws.

If a medical practitioner or nurse practitioner prescribes medication, including psychotropics, for the purpose of chemical restraint, they are responsible for seeking and obtaining informed consent. In doing so, the practitioner must be aware of their ethical and legal obligations, including under relevant state, territory or Commonwealth laws. The provider must be satisfied that the practitioner obtained consent to the prescribing of the medication being used as chemical restraint.

With respect to provider responsibilities, in the Quality Standards, Standard 3 - Personal care and clinical care, Standard 5 – Organisation's service environment and Standard 8 - Organisational governance include requirements for providers to:

- have effective organisation wide governance systems in place including a clinical governance framework which minimises the use of restraint; and
- have effective organisation wide governance systems for regulatory compliance.

These governance systems help ensure that clinical care provided in the service is safe, of good quality and accords with relevant legal requirements. This includes ensuring that consent has been obtained, and that this is consistent with the relevant state or territory laws.

Under the Principles, the provider must inform the consumer or their representative about the use of the chemical restraint in an emergency. The service must provide this information before commencing the chemical restraint if it is practicable to do so, or immediately after. This communication should be done in a way that the consumer or their representative can understand, include an explanation on the reasons for use, the risks that were being addressed, benefits of and alternatives to the restrictive practice, and they should be given the opportunity to discuss their concerns and expectations.

If the consumer or their representative has concerns about the medication, they should be referred to the medical or nurse practitioner who prescribed the medication, and if ongoing use is anticipated then the informed consent process should commence with the prescriber.

Further information is available in the Commission's Consent for medication in aged care – fact sheet.

10. Is the Psychotropic Medications self-assessment tool mandatory as part of an assessment?

The Self-Assessment Tool for Recording Consumers Receiving Psychotropic Medications (psychotropic medications self-assessment tool) provides details of the type of information that the Commission will seek to review when undertaking assessments of aged care services against the Quality Standards, and as part of that, monitor how services are effectively overseeing the use of chemical restraints.

Use of the psychotropic medications self-assessment tool is not mandatory. Providers are encouraged to use it to understand their service and consumers and support continuous improvement processes in relation to how they use and minimise the use of chemical restraint, and manage risks of psychotropics generally

Providers may also or instead use other tools that give them the required information and may adapt the tool to their purposes.

The Self-Assessment Tool for Recording Consumers Receiving Psychotropic Medications, with accompanying guidance, can be found on the Commission website at www.agedcarequality.gov.au/minimising-restrictive-practices/provider-resources.

Need to know more?

If you have any questions, contact the Commission by email on: info@agedcarequality.gov.au.

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