

Restrictive practices scenarios

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Australian Government
Aged Care Quality and Safety Commission

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Restrictive practices mean any practice or intervention that has the effect of restricting the rights or freedom of movement of a consumer receiving aged care and services. Restrictive practices refer to practices, interventions, medications or chemical substances that are used or employed to restrict a consumer's free movement, restrict access to their environment, and/or influence their behaviour.

The Quality of Care Principles 2014 define five types of restrictive practices: chemical restraint, environmental restraint, mechanical restraint, physical restraint and seclusion. These align with those listed in National Disability Insurance Scheme legislation.

Providers need to be familiar with the descriptions of each of these restrictive practices as they apply in aged care and the legislative obligations which support their appropriate use.

Aged Care Legislation

Providers should be mindful of their obligations under the *Quality of Care Principles 2014* (the Principles) and pay careful attention to the legislative requirements underpinning the use of restrictive practices when applying those obligations to real-life situations.

From 1 July 2021, approved providers have updated and specific responsibilities under the *Aged Care Act 1997* 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. The legal requirements on approved providers about the use of restrictive practices under the Aged Care Act are set out in the Principles and include obligations to ensure that restrictive practices are only used in response to appropriate clinical assessment and (for chemical restraint) prescribing by health professionals.

Section 15E of the Principles outlines the practices or interventions that are restrictive practices, and 15F, 15FA, 15FB and 15FC of the Principles covers the requirements for use of any restrictive practice.

Sections 15HA through to 15HG outline the responsibilities and matters to be set out in behaviour support plans, which **from 1 September 2021**, are required to be in place for all consumers who have changed behaviours, who may require the use of restrictive practices or for consumers for whom restrictive practices are used or implemented.

State and Territory Laws

It is important to note that State and Territory (S and T) laws continue to apply to the use of restrictive practices. When a person lacks capacity to make medical decisions for themselves, States and Territories have differing legislation relating to who can legally give substitute consent and in which specific situations. It is important that prescribers and other health professionals performing a role in relation to restrictive practices are aware of the legislation specific to their own jurisdiction.

Table 1, at the end of this document, outlines relevant State and Territory legislation and individual referral agencies which may assist with substitute decision making on a consumer's behalf, if they lack the capacity to do so themselves or do not have a substitute decision maker.

Capacity Australia, a not-for-profit charity which promotes autonomy in decision making, has resources which may also assist with consent and substitute decision making.

DBMAS and SBRT

The scenarios regularly include the use of behaviour support specialists. These may include, but are not limited to, representatives of the Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Teams (SBRT).

DBMAS is a support service, operated by Dementia Support Australia, for people with dementia, and operates across a wide range of settings.

SBRT are Commonwealth Government funded, mobile clinical experts who help aged care providers care for people with severe behavioural and psychological symptoms of dementia in residential aged care settings and multipurpose services.

Serious Incident Response Scheme

The Serious Incident Response Scheme (SIRS) is an initiative to help prevent and reduce incidents of abuse and neglect in residential aged care services subsidised by the Australian Government. The Commission website has guidance and information on SIRS.

Provider should be familiar with the SIRS information, including understanding what constitutes a Priority 1 and Priority 2 reportable incident.

The scenarios

The scenarios have been designed to inform and educate providers and their staff and reflect common questions the Commission receives regarding use of restrictive practices in aged care.

The scenarios have been prepared to assist providers to understand and apply new legislative requirements which are designed to reduce and prevent the inappropriate use of restrictive practices and affirm the centrality of person-centred aged care. The legislative changes reflect the expectations of the Australian community that older persons are treated as individuals, with dignity and respect. The changes reinforce the rights of aged care consumers, in making decisions about their own care, to have their wishes respected and to live with dignity and autonomy.

In each of the scenarios, a capitalised reference or key is used to indicate the restrictive practice being used or applied. In each case, this key appears next to the name of the fictitious consumer featured in the scenario and will help readers to identify scenarios of particular type or interest.

The scenarios have been marked as:

- C** – Chemical restraint
- E** – Environmental restraint
- M** – Mechanical restraint
- P** – Physical restraint
- S** – Seclusion

Some scenarios have been created which outline use of a practice which does not meet the definition of a restrictive practice. These have been included to support providers understand that everyone's situation is different and should be considered with those individual circumstances in mind. Such scenarios are marked using "**Not x**" – for example, where a scenario initially could be about a chemical restraint but further information indicates that the medication use is not a restrictive practice, it will be marked **Not C**.

Of note – all scenarios are fictitious and do not represent actual consumers of Commonwealth funded aged care in Australia.

Ronald, 67 year old male (Not C)

Ronald has a background of chronic schizophrenia, managed by his GP and with regular reviews by his long-standing psychiatrist. His medication is risperidone. He is happy in the residential aged care service and says he enjoys the staff interactions and social opportunities provided. Ronald understands why he is on the medication, and his doctors have assessed that he is able to give his own consent.

This IS NOT chemical restraint. The medication is to treat a diagnosed mental condition (schizophrenia) and Ronald is consenting.

Maria, 78 year old female (E, C)

Maria was diagnosed with dementia four years ago and is taking donepezil (Aricept). She recently transitioned to a secure residential service due to wandering from her home at night, becoming lost and becoming aggressive with family members. Maria was very agitated and upset when she arrived at the service. There are keypads on the doors and Maria does not know the access code. She has repeatedly tried to follow staff and visitors out the doors. Staff are very vigilant about preventing her from leaving as there is a risk that she will get lost or wander to nearby busy roads and the river.

This IS environmental restraint. The locked environment is preventing Maria from going where she wants to. This requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

Because Maria is distressed and constantly exit-seeking, the aged care staff request the assistance of available behaviour support resources and assistance from the family, to reassure her and give staff strategies to help her settle in. This is used to inform development of her behaviour support plan. Maria's GP is also asked to help, assesses her and suggests that a low dose of risperidone in the short-term might help with the behaviour and distress. Maria's husband (who is her authorised representative) discusses this and gives his informed consent. The staff need to be satisfied that this consent has been provided and must document its provision. Maria is calmer. She is monitored for side effects such as drowsiness and there is a clear plan to document her behaviour and to review the need for the risperidone in the following weeks as she settles in.

This IS chemical restraint. Although Maria has a diagnosis of dementia, the risperidone is prescribed to manage her behaviour/s associated with dementia, it is not a drug to treat dementia itself. The donepezil she is taking is a drug to treat dementia, the risperidone is not; rather, it is being used to manage associated behaviour. The use of risperidone requires assessment, documentation and consent according to the Principles (including the consideration of alternative responses, and obtaining of informed consent from Maria's husband, as her authorised representative) and the relevant state and territory legislation.

Geoffrey, 92 year old male (Not E)

Geoffrey has been in his residential service for many years with vascular dementia. He was placed in a locked service against his will by a guardian with the appropriate authority, due to extreme risks living at home that he was unable to understand. When Geoffrey was expressing his wish to leave and, importantly, had the ability to leave, the locked service did constitute environmental restraint.

However, Geoffrey's health has gradually declined, and his dementia is now advanced. Geoffrey is now bed-bound, doubly incontinent, eating and drinking little and does not talk. He is no longer capable of wishing to leave or trying to leave and is dependent on staff for all care and comfort. While Geoffrey no longer requires a locked service, as his care needs have changed and is approaching the end of his life, there is no practical alternative, and the service considers it would be inhumane and contrary to his best interests to move him given he is approaching the end of his life, and his guardian has consented for Geoffrey to remain at the service. He is in a familiar environment with staff who know his individual care needs and preferences, and he is no longer on any medications.

This IS NOT environmental restraint.

Geoffrey's overall health status, and not his environment, restricts his free movement. Nothing else is interfering with his freedom of movement. His position would be the same whether or not he is in a locked service.

Donald, 88 year old male (E)

Geoffrey's room-mate, Donald has mild dementia and is wheelchair dependent. He likes to go into the courtyard and sit in the sun and would like to go out of the service for a change of scenery and to do some shopping. The staff often do not have time to facilitate this and this is upsetting him. Donald has a behaviour support plan documenting that he has no particular behaviours of concern but that he does get upset when he cannot leave. The behaviour support plan also documents why he cannot access the courtyard and community independently.

Donald IS being environmentally restrained; the locked environment, as well as his impaired mobility, are interfering with his free movement to do what he wants to do.

Anne, 84 year old female (C)

Anne has dementia and has lived in a residential service for a few years. She has begun to wander around a lot more and has been getting into other people's beds. She calls out frequently and is awake for many hours at night. The nursing staff ask the GP to provide something to help her sleep. The GP suggests some management strategies and a referral to a behaviour advisory service. The GP prescribes both regular diazepam (Valium) and risperidone PRN (as required) in case she is having a particularly bad night.

BOTH of these drugs ARE being used as chemical restraint, even though in the case of risperidone it is PRN and not regular. The use of risperidone constitutes a chemical restraint because it is being used for the primary purpose of influencing Anne's behaviour to stop her wandering. Both drugs require assessment, documentation and consent according to the Principles and the relevant state and territory legislation, including a behaviour support plan.

Christine, 96 year old female (Not C)

Christine, who lives in a residential service, is deaf and has trouble communicating but is not cognitively impaired. She asked her GP for something to help her nausea that is limiting her appetite and her enjoyment of food. She does not want any investigations. The GP looks for causes of the nausea, outlines the options and the potential side-effects and they decide to try prochlorperazine (Stemetil) and assess for effectiveness and side-effects such as drowsiness.

This IS NOT chemical restraint.

The medication is technically categorised as a psychotropic, and it may have side effects such as drowsiness that require monitoring. It is not being used to influence her behaviour; rather, it is being used as an anti-nausea agent. The indication should be reflected on the medication chart.

Charles, 68 year old male (E)

Charles is an indigenous man with chronic renal disease, diabetes and he is blind. He does not have any cognitive impairment. He is in a secure residential service which is the only one available near his community and family. He wants to access the community at times and is assisted on outings by staff. At other times he goes out with family members. He cannot see to use the numbered keypad to unlock the door and cannot leave without assistance, but he is able to ask. He does not wish to move to an open (unlocked) residential service that has been offered to him as in his view this will be more restrictive as he will be away from his community, his family will be much less able to take him out, and he will not be on his country. Charles has been assessed by his GP and this is documented appropriately. He has considered alternatives and is able to provide his own informed consent. Additionally, the provider regularly monitors Charles for signs of distress or harm. The provider also reviewed the necessity of the restraint and determined there was no practical alternative.

This IS environmental restraint as the provider is restricting Charles' free movement in a locked environment; Charles is not able to leave without assistance. However, the provider is compliant with its responsibilities under the Principles and the relevant S & T legislation because alternatives to environmental restraints have been explored and discussed by Charles' GP with him as part of the process of seeking and obtaining informed consent, including discussion of review arrangements.

Pam, 82 year old female (M)

Pam has dementia and has come into the residential service after a bad fall at home which resulted in a hip fracture and a long hospital admission with complications. She is frail, very weak and unsteady, and has been advised to use a frame to walk. Pam forgets about the frame and whenever she wants to go to the bathroom, she gets up impulsively and tries to rush there unaided. She has had two near-miss falls in the service. The staff decide to sit her in a recliner chair to prevent her walking unaided and falling. The chair is very comfortable, but she is unable to get out of it without assistance.

This IS mechanical restraint as Pam is being prevented from moving freely, even though the motivation is safety. It requires assessment, documentation and informed consent according to the Principles and the relevant state and territory legislation.

When Pam was noted to be incontinent in the recliner, the staff implemented a regime of regular toileting which was successful in eliminating incontinence and reduced the impulsive rushing behaviour. Additional measures were introduced to prevent her getting bored and lonely in the recliner, including opportunities to walk with the frame while supervised.

As Pam recovers, the appropriateness of the recliner is regularly reviewed, and she is gradually moved back to a different seating arrangement and assisted to walk again with her walking frame.

George, 79 year old male (Not C, Not E)

George is normally able to come and go freely from his residential service by tapping a set of numbers into the keypad at the door. One day he is very confused, incontinent and behaving inappropriately, abusing other consumers and refusing to eat, get out of his wet clothes or to shower. Staff consider the options of securing him in a chair with a lap-sash; or calling the GP for a phone order of risperidone to settle him down and to prevent him from harming himself or others.

BOTH of these options, if implemented, WOULD BE restrictive practices.

However, the staff realise that a sudden change in behaviour like this represents a clinical deterioration and there may be a serious underlying medical condition causing it. George may have delirium and the cause should be investigated. The decision is made to transfer him to hospital and his family are notified. George developed pneumonia, is successfully treated and returns to the service. George is back to his old self and does not require any restrictive practices.

Staff recognised that their initial thinking that George needed some form of restraint wasn't well-informed, and that they should have considered an underlying medical condition or cause as part of the observed sudden onset behaviour changes. Staff review the restrictive practices procedure and note that additional input, such as screening for delirium, could be added to promote best practice. At a staff education workshop, George's case is discussed and it is decided that a de-identified version of this scenario would be used as a staff training tool on restrictive practices.

Merle, 79 year old female (E,M)

Merle is in a secure (locked) residential service. She has very poor vision and hearing and is unable to use the keypad unassisted. She is very concerned about her bed mobility as she has recently fallen out of bed while trying to get up. She is frightened to roll over in bed in case she is too close to the edge. She would like to have the bed rails up at night to prevent her falling out and give her confidence to move in bed, and she has consented to their use. This consent is documented in her care plan. She also finds that rails help her move in the bed by giving her something to grab on to. If she wants the rails down, she is able to use the call buzzer to seek staff assistance.

The care worker is concerned that the use of bed rails represents mechanical restraint. Staff regularly monitor Merle for signs of distress or harm. The necessity of the restraint was reviewed in the context of Merle's wishes and determined that there was no practical alternative. Merle was fully informed about the potential risks that bedrails can pose in relation to injury and mobility, and both this and her informed consent has been documented.

The secure service and the use of bed rails ARE BOTH restrictive practices, as they are restricting Merle's free movement and require a behaviour support plan. However, if assessment, documentation and consent is provided according to the Principles and the relevant state and territory legislation, including ongoing monitoring, evaluation and support, then the provider is compliant with their responsibilities.

Wally, 88 year old male (C,M)

Wally has dementia, is being cared for in a residential service, and has started to get up by himself and try to get to the bathroom at night. He has recently commenced on quetiapine at night to try to prevent him waking and becoming agitated. Since administering this medication, the care staff have observed him staggering in the wrong direction, looking very unsteady and confused. They wonder if putting the bed rails up will prevent Wally from getting up and putting himself at risk.

On the first night that the bed rails are used, Wally is found with his leg caught, very distressed, trying to get over the rail. Now very concerned, staff reassess the situation and realise that the quetiapine has made Wally more unsafe at night, as he is more drowsy, confused and unsteady. The rails also have increased the risk of harm from injury or falling while trying to climb over them.

The staff realise that **this management IS BOTH chemical restraint and mechanical restraint**, and it is not working well for Wally. They cease both measures immediately. They look for causes of Wally's night time agitation and find that he is having difficulty emptying his bladder. This is raised with Wally's GP and the staff also provide regular assisted toilet opportunities through the night with a bottle. They move Wally's bed so that staff can see him easily if he wants to get up. This behaviour management strategy works well for Wally and he is more settled overall. The strategy is documented in Wally's behaviour support plan.

Marion, 66 year old female (M)

Marion has a lifelong intellectual disability and has begun to demonstrate some behaviours of concern in her residential service. She constantly picks and scratches at her skin and at times makes herself bleed. Her torso has scars, abrasions and shallow ulcers which bleed as she picks at them. The care staff dress Marion in 'all-in-one' leotard-type underwear, overalls and outer clothes which zip at the back. Marion can no longer reach areas of her body, and her self-injuring improves. She cannot toilet herself anymore and needs either pads or assistance to toilet. She often tries to toilet herself and is distressed because she cannot undress herself.

This IS mechanical restraint as clothing is used to restrict Marion's free movement (access to her own skin and toileting), even if the movement (scratching etc.) is doing her harm. It requires assessment, documentation and consent according to the Principles and the relevant state and territory legislation.

As the scratching is new, medical attention is sought. Marion is diagnosed with atypical scabies, the correct treatment rapidly resolves the skin problem, and the restrictive practice is no longer used.

Evan, 74 year old male (Not C)

Evan has severe osteoarthritis and mild dementia. He is normally quiet and likes to sit in the sun and smoke. He has had a long-term habit of drinking beer and whiskey in the evening. He reluctantly moves into a residential service as he can no longer manage living alone. On the day after he arrives, Evan is angry, shouting and confused. He has a tremor. He is convinced that someone has stolen his wallet and believes he is in his own home with intruders. He demands some alcohol.

The GP assesses Evan and recognises that his acute (sudden) confused state is likely due to alcohol withdrawal and prescribes diazepam (Valium) with the intention of gradually reducing the dose or transferring Evan to hospital if he doesn't settle easily. Evan does well, and in two weeks is no longer on any Valium. He has settled into the service and enjoys the company. He has negotiated access to alcohol with dinner.

This IS NOT chemical restraint, as diazepam is a recognised treatment for alcohol withdrawal.

Hazel, 84 year old female

Hazel has disabling Parkinson's Disease. When she moves into a residential service, she calls out at night for attention and when staff arrive, she doesn't seem to have anything wrong. Some of the other consumers are complaining about the noise. Hazel sleeps a lot during the day and is not wanting to wake for meals. She is losing weight. The staff request that the GP prescribe risperidone at night for Hazel.

The GP does not want to use this chemical restraint without exploring other measures, and also recognises that it is medically complex as antipsychotics such as risperidone are relatively contraindicated with Parkinson's Disease. The GP refers Hazel to a behavioural advisory service for specialist assessment. Hazel's family are consulted and tell the staff that Hazel loves TV and gets frightened when alone. The TV is left on overnight when she is awake, and her bed is moved so she can see staff. Hazel's dinner is kept in the fridge then heated and given to her when she is awake, and she is given other snacks overnight to compensate for her missing some meals during the day. No restrictive practices are needed as Hazel's care needs have been understood through behaviour management strategies which are then documented.

Viv, 86 year old female (C)

Viv is admitted to the residential service from hospital. She has moderate dementia but is cheerful and settled. She has never had any behaviours of concern. Viv's daughters ask to check the medications she is being given to be sure they are correct. They notice that she is prescribed risperidone PRN (to be given when necessary). This is not something Viv normally takes, and they question it. They are told that it is routine for consumers to be prescribed this by their GPs 'just in case'. They look up the uses and side effects. They are concerned as they do not think it is needed and do not want Viv to have it. They have a meeting to express their concerns. They have not given consent for this and understand that informed consent is required even for PRN medications. The care manager confirms that this is the case and reassures the family that the residential care staff will work with the GP to ensure that risperidone will not be given unless there has been clear assessment, communication, discussion and consent. The manager identifies that there may be other consumers who have been prescribed psychotropic medication 'just in case' who also need to have this arrangement reviewed. These reviews are undertaken in consultation with each consumer's GP and substitute decision maker, and this particular process is discontinued.

This prescribing of risperidone, including in a PRN setting, IS chemical restraint.

At the time PRN medication is prescribed, a consumer must be assessed by the prescriber as requiring chemical restraint from time to time in the foreseeable future in clearly specified circumstances. It is not acceptable to have a prescription made out 'just in case' it is needed. It requires assessment, documentation and consent according to the Principles and the relevant state and territory legislation. In this case Viv's daughters withhold their consent and risperidone cannot be given.

Ken, 74 year old male (C)

Ken has dementia which was diagnosed three years ago and has been in residential aged care for eighteen months. He has increasingly shown disinhibition and sexualised behaviours. He makes frequent inappropriate sexual remarks to the female staff and is exposing himself to female visitors. The staff ask for medication to be prescribed for Ken to reduce the offending behaviours. The GP prescribes cyproterone (Androcur) as an anti-androgen medication to reduce testosterone and sexual desire. When Ken's family find out a few months later they are upset with this approach and wish to know why Ken's rights have not been respected and why Ken and the family were not consulted.

The Nurse Manager speaks to the family about the medication and the rationale. It is explained that the GP has the role of obtaining informed consent, but the residential service will not administer medication if they are aware that consent has not been legally obtained, especially when the consumer and their family are objecting. The family and Ken all refuse to give consent and are mindful of Ken's ability to experience pleasure and the potential serious side effects of the drug.

A meeting is set up with the GP. Prior to the meeting the GP becomes aware that Androcur administration is considered chemical restraint. The GP apologises to Ken for not obtaining his informed consent and an agreement is reached to engage a behaviour support specialist and to provide Ken with privacy when required. Medication is stopped and his behaviour is monitored and documented. DBMAS is contacted to assist with behaviour management and other supports. While Ken is not being chemically restrained, a behaviour support plan is developed to manage and monitor his behaviour and wellbeing, and to prevent distressing behaviour as far as possible.

Anti-androgen medication to affect behaviour IS chemical restraint. It requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

Despina, 79 year old female (P)

Despina has dementia and lives in a local residential service. Despina often refuses personal care including after episodes of faecal incontinence. This has resulted in complaints from her family and other consumers about her hygiene. In order to provide care, staff have started to hold her arms to prevent her hitting out while another staff member washes and changes her. Despina resists this and finds it distressing

This IS physical restraint. When the care manager becomes aware of this practice, she educates staff about restrictive practices and, with the consent of Despina's family, refers Despina to a behaviour advisory service. Initially bowel management strategies are put in place to minimise the faecal incontinence. It is suggested that staff ensure the bathroom is warm and comfortable. Only female staff shower Despina and they check the water temperature is ideal before commencing. While getting ready they speak quietly to Despina about topics of interest to her. They reassure her and explain each step of the process as it occurs. With Despina more relaxed and comfortable with staff, she is more accepting of care provided and is not restrained. These measures are documented in Despina's behaviour support plan as they prevent behaviours and distress and avoid the use of any restrictive practice.

Sandra, 88 year old female (Not P)

Sandra is new to the residential service and is not yet familiar with the layout of her surroundings. At meal times staff invite Sandra to the dining room. Noticing Sandra is unsure of where to go and heads off in the wrong direction, the carer gently places her hand on Sandra's back to redirect her. Sandra does not object to the touch and is happy to walk in the direction the staff member indicates, and offers her arm to be held and guided. The staff member explains the route to Sandra as they walk.

This IS NOT physical restraint. Sandra is being assisted to where she wants to go and is not being prevented from walking where she wishes to go.

Arjun, 82 year old male (E,S)

Before retiring, Arjun spent 40 years working as a night security guard. He continues to wake at 2 a.m. Arjun has dementia and often wanders at night disturbing other consumers in the residential service. Staff propose locking the door to his room at night, containing Arjun's wandering to his room and ensuite.

This IS environmental restraint and seclusion.

It requires assessment, documentation and consent according to the Principles and the relevant state and territory legislation. When the idea is discussed with Arjun's wife she objects, raising safety concerns, and is worried about his distress at not being able to open his door and the impact on his rights. She describes what Arjun did at home when he woke at night, and how he liked to quietly watch TV with a cup of tea and magazines. He would then nap most of the morning. These strategies were documented in the behaviour support plan to implement for Arjun. Review of the strategies indicated that Arjun was much more settled overall and even though his door remained unlocked, his wandering had ceased.

Yasmin, 76 year old female (Not E, Not S)

Yasmin lives in a local residential service. She feels vulnerable on her own and has trouble sleeping, fearing people will enter her room. Yasmin asks staff if a lock can be fitted to her room, so she can lock it when she is inside. The benefits and risks of this are discussed with Yasmin, so that she can make an informed decision, and strategies to minimise risks agreed. This includes the door unlocking when the handle is turned from the inside and Yasmin and staff having keys to the room. A process for staff checking on Yasmin when she is in her room is agreed, with staff always knocking and identifying themselves before entering.

This IS NOT environmental restraint or seclusion. Yasmin is able to enter and exit her room at will and has control over her environment.

Billy, 93 year old male (S)

Billy has hearing, vision and mobility impairment and is no longer able to walk without help. He often asks to be returned to his room in the residential service after short periods in communal areas, and then a short time later asks to be taken back out again. Staff, frustrated with helping Billy backwards and forwards, have begun to ignore his calls to come out when he is in his room.

This IS Seclusion. While Billy is not locked in his room, he is alone and unable to leave by himself, he has limited perception of his surroundings and staff are not enabling him to go where he wants to. Assessment, documentation and consent are required according to the Principles and the relevant S & T legislation.

Billy complains that staff often do not respond to his calls and he is spending long periods of time in his room, alone. Billy explains that he is bored and lonely in his room, however doesn't enjoy and can't join in the activities in the common room. The lifestyle officer works with Billy to identify activities and areas he would like to spend time in away from his room and these are implemented and reviewed as part of his behaviour support plan.

Sam, 89 year old male (S)

Sam has dementia and is unable to mobilise independently in his residential service. He often calls out loudly. When staff attend they are unable to identify what he wants. Other consumers complain about the noise. Staff move Sam to a second common room at the far end of the hallway. They turn on the TV and leave him alone. Sam's shouting can't disturb the other consumers when he is in this room.

This IS seclusion as while Sam is not locked in an area, he has been confined alone in an area that he is unable to leave.

When this is pointed out, and staff also realise how frightened and lonely Sam is, they ensure he is accompanied by a staff or family member who chats, explores activities with him and takes him outside. Sam's behaviour has settled and he no longer calls out.

Abdul, 91 year old male (Not P)

Abdul has low blood pressure and sometimes gets dizzy if he stands too quickly. Abdul has finished his meal and stands to leave the table in the dining room at his residential service. A nearby staff member notices Abdul looks unsteady and gently holds him by the arm to steady him and lower him back to his seat. When Abdul has recovered, he stands more slowly and walks away from the table.

This IS NOT physical restraint. Staff have gently assisted Abdul. He has not been prevented from taking the actions he wishes to take.

Janette, aged 78 years (E,S)

Janette loves socialising with other consumers in her residential service and often likes to chat late into the evening. When trying to settle people in their beds for the night, staff become frustrated when Janette and her friends won't finish their conversations. Staff tell Janette that if she does not come to her own room now and remain there until morning, she will not be permitted to go on the outing tomorrow. Fearful of the consequences of staying with her friends, Janette goes to her room.

This IS environmental restraint and seclusion.

Janette is made to be alone in her room when she chose to be with her friends. She feels unable to leave because of the instruction to stay and threat of consequences if she doesn't. While she is not prevented from leaving her room by a barrier, she feels unable to leave as she is afraid of displeasing the staff and missing out on a pleasurable outing she is looking forward to. The threat of not being able to attend an outing is punishment.

Janette's daughter finds out when she phones and hears Janette in tears. She complains to management. Staff receive training on restrictive practices and that it is not acceptable to threaten or punish consumers. This is inappropriate use of restrictive practice and notifiable under the Serious Incident Response Scheme.

Arthur, 71 year old male (P)

Arthur resides in a secure residential service as he has a history of wandering. Arthur likes to spend most of his day gardening in the enclosed courtyard which he can freely access. He is usually happy to come in for meals. One day Arthur unexpectedly becomes more agitated. When staff ask him to come in for lunch Arthur responds aggressively, pushing the staff member towards another consumer and throwing his gardening tools. These movements make Arthur unsteady on his feet. Staff try talking calmly and slowly moving other people away. This appears to increase Arthur's agitation and he attempts to strike another consumer. Staff are concerned that Arthur may harm himself or others. They consider this to be an emergency, and a staff member holds Arthur from behind until other consumers are moved inside.

This IS physical restraint. As soon as it is safe to do so, staff release their hold on Arthur. Recognising that the sudden change in Arthur's behaviour may indicate clinical deterioration, the GP is called. Arthur's family is informed of the incident as soon as possible, including that physical restraint was used. Arthur has a fever and a brief viral illness which is treated appropriately, and soon returns to his usual routine.

Table 1. State and territory legislation, and relevant organisations for referral for substitute decision making.

| State | Legislation | Relevant organisations |
|-------|--|--|
| ACT | <ul style="list-style-type: none"> • <i>Guardianship and Management of Property Act 1991</i> • <i>Medical Treatment (Health Directions) Act 2006</i> • <i>Public Trustee and Guardian Act 1985 (ACT)</i> • <i>Power of Attorney Act 2006 (ACT)</i> | <ul style="list-style-type: none"> • Public Trustee and Guardian (ACT) • ACT Civil and Administrative Tribunal (ACAT) • Public Advocate – ACT Human Rights Commission |
| NSW | <ul style="list-style-type: none"> • <i>Guardianship Act 1987</i> • <i>Guardianship Regulations 2016</i> • <i>Powers of Attorney Act 2003 No 53</i> | <ul style="list-style-type: none"> • Public Guardian (NSW) • NSW Civil and Administrative Tribunal • NSW Trustee and Guardian |
| NT | <ul style="list-style-type: none"> • <i>Adult Guardianship Act 2016</i> • <i>Guardianship of Adults Regulations 2016</i> • <i>Northern Territory Civil and Administrative Tribunal Act 2014</i> • <i>Advance Personal Planning Act 2013 (NT) (the Act)</i> | <ul style="list-style-type: none"> • Northern Territory Civil and Administrative Tribunal • Office of the Public Guardian (NT) |
| QLD | <ul style="list-style-type: none"> • <i>Guardianship and Administration Act 2000</i> • <i>Public Guardian Act 2014</i> • <i>Human Rights Act 2019</i> • <i>Powers of Attorney Act 1998</i> | <ul style="list-style-type: none"> • Office of the Public Guardian (QLD) • Public Advocate (QLD) • Queensland Civil and Administrative Tribunal |
| SA | <ul style="list-style-type: none"> • <i>Consent to Medical Treatment and Palliative Care Act 1995</i> • <i>Consent to Medical Treatment and Palliative Care Regulations 2014</i> • <i>Advanced Care Directives Act 2013</i> • <i>Guardianship and Administration Act 1993</i> • <i>Guardianship and Administration Regulations 2015</i> | <ul style="list-style-type: none"> • Office of the Public Advocate • South Australian Civil and Administrative Tribunal |
| TAS | <ul style="list-style-type: none"> • <i>Guardianship and Administration Act 1995</i> • <i>Guardianship and Administration Regulations 2017</i> • <i>Guardianship and Administration (Corresponding Law) Notice 2014</i> • <i>Guardianship and Administration (Corresponding Law) Notice 2011</i> | <ul style="list-style-type: none"> • Office of the Public Guardian (TAS) • Guardianship and Administration Board |
| VIC | <ul style="list-style-type: none"> • <i>Guardianship and Administration Act 2019</i> • <i>Guardianship and Administration Board (Application) Regulations 1994</i> • <i>Medical Treatment Planning and Decisions Act 2016</i> | <ul style="list-style-type: none"> • Office of the Public Advocate (VIC) • Victorian Civil and Administrative Tribunal |
| WA | <ul style="list-style-type: none"> • <i>Guardianship and Administration Act 1990 (WA)</i> • <i>Guardianship and Administration Regulations 2005</i> | <ul style="list-style-type: none"> • State Administrative Tribunal • Office of the Public Advocate (WA) |



The Aged Care Quality and Safety Commission acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.



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