Australian Government
Department of Health and Aged Care

Consent for Restrictive Practices: Case studies

under the Commonwealth hierarchy[1] which commenced on 1 December 2022. This document should be read in conjunction with our other resources on consent for restrictive practices.

Case Study 1: Nomination by the care recipient

Max is a care recipient living in an aged care facility. He has dementia and his Medical Practitioner has assessed that he no longer has capacity to make decisions about his care and treatment due to his level of cognitive impairment. When Max did have capacity, he nominated his family members to act as an 'individual nominee' and 'group nominees' to make decisions about the use of a restrictive practice in the event he lost capacity to consent to a decision.

The approved provider tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Max assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As there is no RPSDM appointed under the state/territory law and no explicit legal avenue in the state/territory in which Max resides to appoint a RPSDM, the approved provider can rely on the Commonwealth hierarchy.

Max has nominated an 'individual nominee' and a 'group nominee'. The approved provider can rely on item one of the Commonwealth hierarchy. Max nominated his wife Mary as an individual nominee and his three adult children, Greg, Tanya and Bruce, as members of a nominee group. When making the nomination, Max clarified that Mary would have precedence as the primary nominee followed by the nominee group. Max advised it is only if Mary loses capacity that the nominee group could make decisions about the use of a restrictive practice in relation to him and all members of the nominee group must consent, or the restrictive practice cannot be used.

When the approved provider reaches out to seek informed consent from Mary, the approved provider is not satisfied that Mary has the required capacity to act as the RPSDM. The approved provider must then seek consent from all three members of the nominee group and confirm they have capacity. All three members must consent to the use of restrictive practice to allow the restrictive practice to be used.

[1]The Commonwealth hierarchy is set out in the table in 5B(2) of the Quality of Care Principles 2014.

Case Study 2: Delay in appointment under state/territory law

Beatrice is receiving short-term restorative care in a residential aged care facility and no longer has capacity to make decisions about her care. Beatrice has a partner and children.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Beatrice assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

There is no RPSDM appointed for Beatrice under the state/territory law where she lives but there is an explicit legal avenue in the state/territory law to appoint a RPSDM. In this circumstance Beatrice's approved provider cannot rely on the Commonwealth hierarchy.

An application is made to the relevant tribunal to have a RPSDM appointed for Beatrice. Due to a backlog of cases, the tribunal issues a hearing date which is five months away, two months longer than its standard timeframe. The approved provider considers this is a significant delay and so can use the Commonwealth hierarchy until a RPSDM is appointed by the tribunal.

Beatrice does not have an individual or group nominee in place so the approved provider can move to item two in the Commonwealth hierarchy. Beatrice's partner has a close continuing relationship with Beatrice and has full capacity. The approved provider seeks consent from the partner as the RPSDM until the tribunal formally appoints a RPSDM. Beatrice's partner agrees in writing to act as the RPSDM.

The approved provider gives the RPSDM all necessary information regarding the proposed restrictive practice including its purpose and associated risks, frequency and duration of use, alternative strategies to be used and details around the monitoring and review. The RPSDM considered the information provided and decided to consent to the use of the restrictive practice for the specified period of time.

Following the tribunal's appointment of a RPSDM, the approved provider can no longer rely on Beatrice's partner's consent. The approved provider must now seek consent from the RPSDM appointed under state/territory law, which may or may not still be Beatrice's partner.

Case Study 3: Care recipient with a friend who cared for them prior to entering care

Lloyd has recently entered a residential aged care facility and has been assessed as no longer having capacity to make major decisions about his care. Lloyd's wife passed away two years ago, he has a daughter, and a neighbour who was his carer on an unpaid basis prior to Lloyd entering the residential aged care facility. The neighbour received a Carer Allowance to care for Lloyd but was not employed as his carer.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Lloyd assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As there is no RPSDM appointed under the state/territory law and no explicit legal avenue in the state/territory law to appoint a RPSDM where Lloyd lives, the approved provider can rely on the Commonwealth hierarchy.

Lloyd does not have an individual or group nominee therefore the approved provider can move to the second item in the Commonwealth hierarchy. As Lloyd does not have a partner the approved provider can move to the third item in the Commonwealth hierarchy. Lloyd has a relative and a friend both with a personal interest in Lloyd's wellbeing, who could both be considered an appropriate RPSDM. However, because the neighbour was an unpaid carer before he entered care, the neighbour meets the criteria of the third item in the Commonwealth hierarchy and is eligible to be the RPSDM over the relative.

The neighbour has capacity and agrees in writing to be the RPSDM. The approved provider can then seek the neighbour's informed consent for the use of the restrictive practice.

Case Study 4: RPSDM does not consent to the use of the restrictive practice

Jane lives in a residential aged care facility and no longer has capacity to make major decisions about her care. Jane has a partner, no children and had employed a carer prior to entering aged care.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Jane assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As there is no RPSDM appointed under the state/territory law and no explicit legal avenue in the state/territory law to appoint a RPSDM where Jane lives, the approved provider can rely on the Commonwealth hierarchy.

Jane does not have an individual or group nominee who can act as her RPSDM, so the approved provider is able to move to item two of the Commonwealth hierarchy. Jane has a partner who has a close continuing relationship with Jane and has full capacity. He agrees in writing to act as Jane's RPSDM.

The approved provider gives the RPSDM all necessary information regarding the proposed restrictive practice including its purpose and associated risks, frequency and duration of use, alternative strategies to be used and details around the monitoring and review. The RPSDM considered the information provided and decided not to consent to the use of the restrictive practice.

As the RPSDM has not provided consent to the use of the restrictive practice, it cannot be used. The approved provider is not able to seek or rely on consent from a person in a lower tier in the Commonwealth hierarchy.

Case Study 5: Care recipient without partner, relatives or friends

Barbara lives in a residential aged care facility and no longer has capacity to make major decisions about her care. Barbara does not have a partner, has no children, and has no close friends or relatives, and was not cared for on an unpaid basis before she entered

residential aged care. She has an appointed guardian with authority to make decisions about her medical treatment.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Barbara assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As there is no RPSDM appointed under the state/territory law and no explicit legal avenue in the state/territory law to appoint a RPSDM where Barbara lives, the approved provider can rely on the Commonwealth hierarchy.

As Barbara does not have an individual or group nominee or a partner, the approved provider cannot rely on items one or two of the Commonwealth hierarchy. Barbara also does not have any relatives or close friends and was not cared for informally by anyone before she entered residential aged care, so the approved provider is unable to rely on items three and four of the Commonwealth hierarchy.

Barbara does have a guardian appointed under the relevant state/territory laws who has authority to make decisions about her medical treatment and meets the definition of medical treatment authority. Therefore, under item five of the Commonwealth hierarchy the approved provider can seek consent from the guardian as Barbara's RPSDM.

Case Study 6: Approved provider seeking consent for additional restrictive practice

Eddie lives in a residential aged care facility and has been assessed by his treating General Practitioner that he no longer has capacity to make major decisions about his care and treatment. As he has a state appointed RPSDM, the approved provider cannot rely on the Commonwealth hierarchy.

The state appointed RPSDM previously provided informed consent for Eddie to reside in a secure (locked) memory support unit at the residential aged care facility, which was assessed by the approved provider as a restrictive practice (environmental). This intervention was assessed as a last resort to prevent harm to Eddie and after best practice behaviour support strategies were considered, trialled, and documented.

Since informed consent was provided by the RPSDM for environmental restraint, Eddie's changed behaviours, agitation and distress have escalated. The approved provider conducted behaviour assessments and liaised with external support services to prevent and support Eddie's changed behaviours. After trying best practice alternatives to an additional restrictive practice and individualised behaviour support strategies, Eddie's health team has recommended the use of an additional restrictive practice as a last resort and in the least restrictive form to prevent harm to Eddie and others. Eddie's general practitioner assessed him and prescribed a low dose of Risperidone (psychotropic medication) in the short-term to help with his behaviours and distress. The general practitioner consulted Eddie's RPSDM and obtained informed consent for the prescription of this medication.

As the informed consent provided to date was for environmental restraint, the approved provider also needs to be satisfied that separate informed consent has been sought from

and given by the RPSDM prior to using the chemical restraint and ensure the behaviour support plan includes a record of the RPSDM giving their informed consent.

The RPSDM does not have to agree to consent to the chemical restraint even though they have consented to the use of environmental restraint. These are two separate decisions. The RPSDM must be given all of the relevant information to enable them to decide whether or not to consent to the use of the chemical restraint.

Case Study 7: State/territory RPSDM does not provide consent

Amina is a residential care recipient and no longer has capacity to make major decisions about her care. Amina lives in a state that has an explicit legal avenue to appoint a RPSDM, however no RPSDM has been appointed under the state law. Amina does not have a partner, but she does have an adult son Jethro, who has a close continuing relationship with his mother.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Amina assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As Amina lives in a state with an explicit legal avenue to appoint a RPSDM the approved provider cannot rely on the Commonwealth hierarchy. An application is made to the relevant tribunal to appoint an individual who can act as a RPSDM under the state/territory law and Jethro, Amina's son, is appointed as the RPSDM.

The approved provider seeks consent from Jethro, providing him with all the necessary information regarding the proposed restrictive practice including the rationale for its use and associated risks, frequency and duration of use, alternative strategies to be used and details around the monitoring and review.

Upon review of the information, Jethro considers the restrictive practice is not the best option as not all alternative strategies have been trialled yet. Jethro does not consent to the use of the restrictive practice based on his decision that further alternative strategies need to be trialled and therefore the approved provider cannot use the restrictive practice.

Case Study 8: RPSDM differs from the appointed medical treatment authority

Suneel lives in a residential aged care facility and no longer has capacity to make major decisions about his care. Suneel has a partner, however his daughter has been appointed as his medical treatment authority to make decisions on medical and dental treatment, but this does not extend to restrictive practices.

The approved provider has tried alternatives to a restrictive practice, including the ongoing use of individualised behaviour support strategies. However, an approved health practitioner who has day-to-day knowledge of Suneel assessed a restrictive practice as necessary and recommended the use as a last resort after the risk of harm was assessed and considered.

As there is no RPSDM appointed under the state/territory law and no explicit legal avenue in the state/territory law to appoint a RPSDM where Suneel lives, the approved provider can rely on the Commonwealth hierarchy.

As Suneel does not have an individual or group nominee, the approved provider can move to item two of the Commonwealth hierarchy. Suneel has a partner who has a close continuing relationship with Suneel and who has capacity. Suneel's partner agrees in writing to act as Suneel's RPSDM.

Suneel's daughter, as the medical treatment authority (item five of the Commonwealth hierarchy) can only be relied on as the RPSDM where no one is eligible under items one to four of the Commonwealth hierarchy.

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