Restrictive Practices Consent: Frequently Asked Questions

This document answers questions on obtaining informed consent from a Restrictive Practices Substitute Decision Maker (RPSDM) to use a restrictive practice on a care recipient under the Commonwealth hierarchy[1] which commenced on 1 December 2022. This document should be read in conjunction with our other resources on restrictive practice consent.

What is a Restrictive Practices Substitute Decision Maker?

A RPSDM can provide informed consent to the use of a restrictive practice for a care recipient on their behalf if the care recipient no longer has capacity to consent.

A RPSDM is a person or body that can give informed consent to a restrictive practice (or to the prescription of medication in the case of a chemical restraint), under the law of the state or territory where the care recipient is living in residential aged care.

The Commonwealth hierarchy to appoint a RPSDM, can only be used when:

- the care recipient cannot consent themselves; and
- no body or person is appointed as the RPSDM under state or territory law; and
    - there are no explicit legal avenues to appoint a RPSDM in the relevant state or territory; or
    - an application to appoint a RPSDM has been made but is experiencing significant delay.

What does 'informed consent' mean?

For consent to be valid, it must be informed, voluntary, current, and specific, and provided by someone with capacity to understand and communicate their consent.

Consent is informed when the decision-maker is provided sufficient information about the decision before giving their consent. The care recipient or RPSDM should be given accurate and relevant information on:

- the proposed restrictive practice, including whether it involves medication or an intervention;
- the reason for the use of the proposed restrictive practice;
- any alternative options available to them (including not taking or using the

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

medication or intervention); and

- the risks and benefits of the use of the proposed restrictive practice and any alternative options.

The care recipient or RPSDM should be given the opportunity and time to review and ask questions about the use of any proposed restrictive practice.

The approved provider should be satisfied that the care recipient or RPSDM has the capacity to understand the decision and to communicate their decision.

The care recipient or RPSDM must be able to come to a considered and independent decision, free from duress or coercion.

Further information regarding informed consent is available on the Aged Care Quality and Safety Commission's website under the heading consent and decision making.

Are approved providers still required to trial alternative strategies and only use restrictive practices as a last resort?

Yes. A restrictive practice can only be used as a last resort to prevent harm to the care recipient or others. Best practice alternative strategies must be used before a restrictive practice is used, and the alternative strategies considered or used must be documented in the care recipient's Behaviour Support Plan. Restrictive practices cannot be used without these requirements and other legislative requirements being met.

Can the RPSDM consent to restrictive practices before they are required?

Informed consent must be provided for each type of restrictive practice and the circumstances for when it is intended to be used on a care recipient.

The RPSDM can provide consent to more than one type of restrictive practice, or more than one use of that restrictive practice, provided that the specific requirements and appropriate detail for each one are given to the RPSDM to consider. The purpose of, and risks associated with, each type of restrictive practice will differ for each individual consumer. For this reason, these need to be reflected in discussions of, and consent (or not) to, the use of a restrictive practice.

Overarching or pre-emptive consent cannot be given for the use of restrictive practices for a care recipient.

Seeking and accepting 'blanket' consent for all types of restrictive practices for a care recipient is contrary to the aged care law, including the Aged Care Quality Standards and Charter of Aged Care Rights, and contravenes the principles of person-centred care.

Is there a time limit to the consent provided by the RPSDM?

- Consent is based on a specific proposed use of a restrictive practice and the provider must inform the RPSDM of the intended timeframe for use of the restrictive practice. The informed consent can be withdrawn at any time, is time limited and must be reviewed.

If the restrictive practice is later required to be used beyond the specified time period or outside the specified circumstances the approved provider must seek informed consent from the RPSDM for these uses.

As the RPSDM may withdraw consent at any time, the approved provider should take steps to communicate regularly with the RPSDM about the use of the restrictive practice. This includes confirming that their informed consent to the use of a restrictive practice is still current and accurate.

Where a chemical restraint is used or considered, how will approved providers determine if the medical or nurse practitioner gained informed consent to prescribe medication to be used as a chemical restraint?

The legislation requires an approved provider to be satisfied the medical or nurse practitioner obtained informed consent to prescribe medication as a chemical restraint. As such, the approved provider should seek from the prescriber details of the process undertaken to gain informed consent. Approved providers should have systems in place to ensure and demonstrate that:

- There is documentation on how the approved provider satisfied themselves that informed consent was obtained to prescribe medication as a chemical restraint; and
- Where a restrictive practice is used in an emergency, the approved provider informs the RPSDM about the use of the restrictive practice, which may include medication, and document that communication in the care recipient's Behaviour Support Plan.

Approved providers should determine how this system works for their service and care recipients, including links with medical or nurse practitioners who may prescribe medication as a chemical restraint, recording methods and practices for clinical notes, and the preferred method of communication between the service, care recipients and their families.

If the approved provider is not or cannot be satisfied that the prescriber has gained informed consent to prescribe medication as a chemical restraint, the chemical restraint cannot be used.

Is the approved provider responsible for documenting the individual/body's agreement to be the RPSDM in writing?

Yes. An approved provider must assist care recipients to seek an individual's agreement to be a RPSDM when appointed under the Commonwealth hierarchy and

keep a record of the written agreement, and if relevant, whether the individual has withdrawn that agreement. It is recommended the agreement is included in the care recipient's Behaviour Support Plan.

What is the correct form of written agreement to appoint a RPSDM?

The only requirement is a RPSDM agrees to the nomination in writing. There is no legal requirement on the form of the written agreement. For example, it may include a signed form stating the care recipient has capacity and nominates a person to be their RPSDM, and the RPSDM has capacity and agrees to be the RPSDM for the care recipient.

Does the approved provider need to make a capacity assessment of the RPSDM or is it presumed?

While a person is presumed to have capacity, an approved provider must be satisfied the RPSDM has the required cognitive capacity to understand the information provided about the use of the restrictive practice to make an informed decision about whether to give or withhold consent.

What if an eligible person in the hierarchy is unwilling to act as the RPSDM?

If an eligible person or body in the Commonwealth hierarchy declines the appointment the approved provider can move down the hierarchy to find an eligible person or body. The approved provider must document that the appropriate individual declined the appointment.

Can an approved provider move to a lower item of the hierarchy if the RPSDM does not consent to or declines to make a decision regarding the use of a restrictive practice?

No. If the RPSDM does not provide consent (by either refusing to consent or declining to decide) to the use of the restrictive practice then the restrictive practice cannot be used. Approved providers cannot seek consent from a person who is lower in the Commonwealth hierarchy.

Can the RPSDM withdraw consent?

Yes, the RPSDM who previously gave consent to the use of the restrictive practice can withdraw that consent at any time.

How many individual nominees or nominee groups can a care recipient nominate as the RPSDM?

There is no limit on the number of individual nominees a care recipient can nominate. If there is more than one nominee, the care recipient must provide the order of precedence.

A care recipient may only nominate one nominee group, which can have a maximum of three members.

If the care recipient nominates more than one nominee, do they all have to consent to the use of a restrictive practice before the restrictive practice can be used?

This is a decision for the care recipient and must be documented in their nomination of the nominees. If the care recipient does not require all nominees to consent to the use of a restrictive practice, they then need to identify which nominee takes precedence.

How is a dispute dealt with if the care recipient determined all nominees must agree that a restricted practice can be used?

This is a decision for the care recipient and must be documented in their nomination. This may include that the restrictive practice cannot be used or provide an avenue for the dispute to be resolved. For example, a separate individual can provide consent in this situation.

If a care recipient has an appointed medical treatment authority is this individual or body the RPSDM in the first instance?

No. It is only if items one to four of the Commonwealth hierarchy do not apply that the medical treatment authority can be relied on as the RPSDM under item five.

Who can act as a RPSDM for a care recipient with no family or friends in a state/territory without an explicit legal avenue to appoint a RPSDM?

If a care recipient is receiving aged care in a state/territory without an explicit legal avenue to appoint a RPSDM and has no family or friends who met the criteria set out in the Commonwealth hierarchy, then a person or body appointed as their medical treatment authority under state/territory laws can act as the RPSDM.

If the care recipient does not have a medical treatment authority, the approved provider can apply to the relevant court or tribunal to have someone appointed as the medical treatment authority. Otherwise, the approved provider cannot use a restrictive practice on the care recipient.

Who can a care recipient or representative contact if they are concerned about a decision of the RPSDM?

If a care recipient is concerned about a decision of the RPSDM, the care recipient or their representative should contact the approved provider to discuss their concerns. If they are not happy with the approved provider's response, the care recipient or their representative should contact the Aged Care Quality and Safety Commission (Commission).

The Commission provides a free service for anyone to raise a concern or make a complaint about the quality of care or services provided to people receiving aged care subsidised by the Government. The Commission can be contacted on 1800 951 822 or by visiting the website at: www.agedcarequality.gov.au.

Can the RPSDM seek a second opinion on the approved provider's recommendation to use a restrictive practice?

Yes. The RPSDM has the right to ask for, and should be supported to get, a second opinion for any treatment including medications or restrictive practices.

A RPSDM can refuse to consent to the use of a restricted practice even when an approved provider following advice from a health practitioner who has day-to-day knowledge of the care recipient, has determined a restrictive practice is necessary as a last resort to protect the care recipient and others. If a care recipient or RPSDM does not provide consent to the use of a restrictive practice, the approved provider cannot use the restrictive practice on the care recipient.

What does a 'significant delay' to the appointment of a RPSDM mean?

Consideration of whether a delay is 'significant' will depend on the individual circumstances for each care recipient and will be considered on a case-by-case basis.

The intention is to ensure informed consent can be given when there is a significant delay with a tribunal considering an application, recognising the time it may take for state/territory bodies to decide applications. Therefore a 'significant delay' would be considered months or years rather than days or weeks.

The following matters should also be considered when determining whether a significant delay is occurring:

- the relevant circumstances of the care recipient
- the impact and consequences of the timing of the decision on the care recipient
- whether the impacts and consequences are reversible, and
- whether the state or territory tribunal can make emergency decisions.

It is available 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 effect the Commonwealth hierarchy.

Do behavioural and psychological symptoms of dementia fall under 'diagnosed mental disorder'?

No. Any medications prescribed to treat behavioural and psychological symptoms of dementia are a chemical restraint and the requirements for the use of restrictive practices apply.

Are restrictive practices requirements in residential care the same for home and community care?

The requirements for the use of restrictive practices only applies to approved providers of residential care and flexible care in the form of short-term restorative care provided in a residential care setting.

Under the Serious Incident Response Scheme, all Commonwealth funded providers are required to report the inappropriate use of restrictive practices to the Commission. This provides additional safeguards when it comes to restrictive practices in home and community care.

Further information regarding the reporting requirements under the Serious Incident Response Scheme is available on the Commission website, available at https://www.agedcarequality.gov.au/sirs.

If a person is under 65 and an NDIS participant in residential aged care will the restrictive practices safeguards apply to them?

Any approved provider who is supporting a NDIS participant must be a registered NDIS provider. As such, the approved provider is required to meet the requirements of both the aged care legislation as well as the NDIS legislation regarding restrictive practices.