Independent review of legislative provisions governing the use of restraint in residential aged care

Final report

December 2020

AHA Australian Healthcare Associates
Australia's largest health & human services consulting firm

Acknowledgement of country

In the spirit of reconciliation, the authors acknowledge and pay respect to the traditional custodians of Country, the Aboriginal and Torres Strait Islander peoples, and their continuing connection to land, waters, sea, and community.

AHA is located on the lands of the Kulin Nation. We pay our respects to Elders past and present.

Acknowledgements

Australian Healthcare Associates and the Australian Government Department of Health would like to acknowledge the involvement of the hundreds of individuals who contributed to this review.

Abbreviations

Term	Definition
the Advisory Group	the Advisory Group convened for this review of the Restraints Principles
AHA	Australian Healthcare Associates
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
BPSD	behavioural and psychological symptoms of dementia
CALD	culturally and linguistically diverse
the Charter	the Charter of Aged Care Rights
the Commission	Aged Care Quality and Safety Commission
COVID-19	coronavirus disease
DBMAS	Dementia Behaviour Management Advisory Service
the Department	the Australian Government Department of Health
DSA	Dementia Support Australia
the Joint Committee	Parliamentary Joint Committee on Human Rights
LGBTI	lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, gender, and bodily diverse people
NCAT	NSW Civil and Administrative Tribunal
NDIS	National Disability Insurance Scheme
NDIS Rules	*NDIS (Restrictive Practices and Behaviour Support) Rules 2018*
OPAN	Older Persons Advocacy Network
PBS	Pharmaceutical Benefits Scheme
PRN	*pro re nata* (as required)
provider	Approved residential aged care provider under the *Aged Care Act 1997*
Quality Indicator Program	National Aged Care Mandatory Quality Indicator Program
Quality Standards	Aged Care Quality Standards
Restraints Principles	Part 4A of the *Quality of Care Principles 2014*
the review	Independent review of legislative provisions governing the use of restraint in residential aged care (this review)
the Royal Commission	Royal Commission into Aged Care Quality and Safety
SBRT	Severe Behaviour Response Team
SIRS	Serious Incident Response Scheme

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Terms of reference

The Restraints Principles are contained in Part 4A of the *Quality of Care Principles 2014*. The legislation requires that a review of the Restraints Principles be undertaken, as follows:

15H Review of this Part

(1) The Minister must ensure that there is a review of the operation of this Part (except this section).

(2) Without limiting subsection (1), the review must consider the effectiveness of this Part in minimising the use of physical restraints and chemical restraints by approved providers in relation to consumers in the period 1 July 2019 to 30 June 2020.

(3) The review must make provision for consultation.

(4) The review must be completed by 31 December 2020.

(5) The Minister must ensure that a written report of the review is prepared.

(6) The Minister must ensure that a copy of the report is:

(a) published on the internet; and

(b) tabled in each House of the Parliament within 15 sitting days of that House after the report is given to the Minister.

Part 4A is provided in its entirety in Appendix A.

Objectives

The specific objectives of the review, as specified by the Australian Government Department of Health (the Department), are to evaluate whether there has been a:

- Reduction in the inappropriate use of chemical and physical restraint in residential aged care since the Restraints Principles were introduced.
- Change in the levels of awareness, attitudes, skills and behaviours in relation to restraint across the aged care sector since the Restraints Principles were introduced.

1 Executive summary

1.1 Introduction

The Restraints Principles are contained in Part 4A of the *Quality of Care Principles 2014*.

The Restraints Principles regulate approved providers of residential aged care (providers) under the Commonwealth *Aged Care Act 1997* and were put in place to protect senior Australians from the inappropriate use of restraint. Specifically, the legislation aims to promote the human right to health by regulating the circumstances in which a provider may use physical or chemical restraint, and engages the right to protection from exploitation, violence and abuse in the form of chemical and physical restraint (*Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, Explanatory Statement*).

As required under legislation, a review must be conducted to evaluate the effectiveness of the Restraints Principles in minimising the use of physical and chemical restraint in residential aged care in their first year of operation (1 July 2019 to 30 June 2020).

In May 2020, following a tender process, the Australian Government Department of Health (the Department) engaged Australian Healthcare Associates (AHA) to conduct an independent review, the findings from which are presented in this document.

This review comes at a time of significant reform in the aged care sector, including the Royal Commission into Aged Care Quality and Safety (the Royal Commission) which is underway at the time of writing. It provides an opportunity to shape the future design and delivery of the regulation of the use of physical and chemical restraint in aged care.

1.2 Review questions

The key review questions, defined by the Department, are as follows:

- Are the Restraints Principles effective in minimising restraint?
- To what extent have the Restraints Principles promoted the delivery of care in a restraint-free environment?
- Are there any unintended consequences arising from the implementation of the Restraints Principles?
- What are the opportunities to improve the Restraints Principles?

1.3 Method

Between 9 July 2020 and 13 October 2020, AHA consulted with a broad range of stakeholders via surveys, interviews and focus groups. Stakeholders included:

- Staff working in residential aged care
- Residential care recipients and family members
- Organisational stakeholders (including peak bodies representing providers, consumers, medical professionals, nurses, pharmacists and allied health workers)
- Subject matter experts.

We also reviewed a range of secondary data sources, including:

- National Aged Care Mandatory Quality Indicator Program (the Quality Indicator Program) data for physical restraint
- Pharmaceutical Benefits Scheme (PBS) dispensing data relating to medicines associated with chemical restraint
- Data on provider compliance with the Aged Care Quality Standards (the Quality Standards).

In addition, we conducted a literature and environmental scan to explore the background to the Restraints Principles, policy settings and other relevant contextual information.

1.4 Findings

1.4.1 Are the Restraints Principles effective in minimising restraint?

It is not possible to draw definitive conclusions about the effectiveness of the Restraints Principles at this time. This is due to the limitations of the secondary data, lack of a benchmark for restraint use prior to the Restraints Principles, and the short timeframe since the Restraints Principles and related initiatives were introduced.

Our consultations found that stakeholders had mixed views on the extent to which the Restraints Principles have led to a reduction in physical and chemical restraint.

Broadly, providers and other stakeholder groups in direct contact with aged care homes reported that the Restraints Principles have either led to a reduction in the use of restraint (physical, chemical or both), or supported an existing trend towards reduced use.

The Restraints Principles came into effect at the same time as several other reforms and non-regulatory initiatives, making it difficult to tease out the specific contribution of the Restraints Principles in shifting restraint practice. However, there are some indications that the use of restraint in residential aged care is declining, and that the Restraints Principles are one piece of the complex puzzle contributing to this change.

1.4.2 To what extent have the Restraints Principles promoted the delivery of care in a restraint-free environment?

Stakeholders from across the sector reported that most providers are making changes to minimise the use of restraint; however, some providers are very early in the change process and will require more support to shift their practice.

The review found that, in the first 12 months after the Restraints Principles were introduced, those providers not already actively working to minimise restraint were largely focused on establishing their organisational systems to comply with the legislation.

Indications that the Restraints Principles have promoted positive steps toward minimising restraint reported to this review include:

- The majority of providers participating in the review have established policies and processes to support the minimisation of restraint, in direct response to the Restraints Principles.
- The Restraints Principles have led to more collaborative and multidisciplinary approaches to care, including more involvement of geriatricians, mental health specialists, behaviour advisory services, pharmacists and other allied health professionals.
- Providers now conduct more frequent and thorough consultation with residents and families before using restraint.
- Providers now have a stronger focus on informed consent, and family members and others are more actively involved in the process.
- Pharmacists and prescribers now review residents' medications more frequently.

Stakeholders were passionate about sharing their views on the changes needed

to minimise the use of restraint in residential aged care (which, unsurprisingly, echo findings from recent inquiries such as the Royal Commission). Their suggestions encompass educational, policy and operational changes, and are presented in this review as 'other' (i.e. non-legislative) recommendations.

A critical lesson from the review is that the use of chemical and physical restraint will not be significantly reduced unless the sector is supported to better understand alternative strategies, and there are sufficient resources to implement them.

1.4.3 Are there any unintended consequences arising from the implementation of the Restraints Principles?

Our consultations identified a number of unintended consequences of the Restraints Principles, both positive and negative.

Positive consequences include promoting greater involvement of multidisciplinary teams, and an increased emphasis on holistic care and communication with aged care residents and their family members.

By far the most commonly reported negative unintended consequence of the Restraints Principles was the perceived need to cease all practices that could constitute restraint, without considering how this may impact quality of care for some residents or in some circumstances.

Other negative consequences reported included:

- Providers placing an undue emphasis on compliance with auditing and accreditation requirements at the expense of resident outcomes
- Increased workload for staff involved in resident care
- Compromised safety and wellbeing of residents and staff.

1.4.4 What are the opportunities to improve the Restraints Principles?

The review has identified a range of opportunities to minimise restraint in aged care homes. The recommendations in Section 1.5 include changes to the Restraints Principles themselves, along with broader, non-legislative ('other') changes to support the minimisation of restraint in residential aged care homes.

While these 'other' recommendations are outside the scope of the review, they represent important non-regulatory measures that could support the implementation of the Restraints Principles. They are designed to underpin cultural change across the aged care sector at an individual, organisational, and systemic level, supported by clearly defined governance roles.

1.5 Recommendations

The recommendations arising from this review are provided below. Further detail on the background, purpose, and reasoning behind each recommendation is provided in Section 4.

1. Emphasise and support person-centred care

Changes to the Restraints Principles

1a. Consider incorporating references to aged care consumer rights in the legislation.

Other changes

1b. Continue to support education opportunities for providers to build understanding and skills in person-centred care.

1c. Clarify providers' responsibilities in instances where restraint is the consumer's choice.

1d. Consider the optimal staffing numbers and skill mix (including allied health involvement) for each service to deliver safe, high-quality, person-centred care. This may vary between services based on residents' needs.

2. Strengthen and promote consent requirements

Changes to the Restraints Principles

This review identified a need to clarify consent requirements within the context of the Restraints Principles. Areas for consideration include:

2a. Clarify that state and territory requirements regarding informed consent apply to both physical and chemical restraint.

2b. Reinforce the rights of the consumer in making decisions about their care.

2c. Revise 'consumer representative' terminology or clarify its definition.

Other changes

2d. Work with provider and health professional peak bodies to develop and promote tools and educational materials to support best practice for assessing capacity and obtaining informed consent (where such material does not already exist). This should include when, how, and how often assessments and consent procedures should be conducted and documented.

2e. Work with relevant state and territory bodies to develop and disseminate clear, plain language information and tools to support providers and prescribers to comply with both the Restraints Principles and jurisdictional guardianship and related legislation (where such material does not already exist).

2f. Work with consumer peak bodies to develop and promote appropriately tailored, plain language resources on informed consent and the appointment of substitute decision makers (where such material does not already exist).

2g. Provide guidance on acceptable timeframes for informing a resident's representative that restraint has been used, if it was not possible to obtain informed consent prior to use. Include an operational meaning of 'as soon as practicable' to give providers a frame of reference to develop policies and measure practice.

2h. Develop resources and training to support staff to understand and comply with their responsibilities when informed consent cannot be obtained prior to the use of restraint (i.e. in an emergency).

3. Improve consumer awareness of the Restraints Principles

Changes to the Restraints Principles

No changes to the Restraints Principles are recommended.

Other changes

3a. Develop consumer resources about the Restraints Principles, with a focus on consumer rights. These resources should be easy to understand and available in different formats and languages.

3b. Encourage aged care homes to disseminate these resources to residents and their family members, and support staff to proactively engage with residents and their families to discuss restraint.

4. Clarify the definition of physical restraint

Changes to the Restraints Principles

4a. Consider adopting the definition of the five types of restrictive practices described in the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (NDIS Rules) (physical restraint, chemical restraint, mechanical restraint, environmental restraint and seclusion).

Other changes

4b. Continue to develop supporting materials and education resources for providers, to build a clear understanding of physical restraint. This should include a library of examples and scenarios to clarify areas of confusion.

5. Improve understanding of chemical restraint

Changes to the Restraints Principles

5a. Consider adopting the definition of chemical restraint described in the NDIS Rules.

Other changes

5b. Develop resources to support understanding of the legislated definition of chemical restraint.

5c. Encourage prescribers to document whether medication is being used for the purpose of restraint.

5d. Clarify the purpose of the Aged Care Quality and Safety Commission (the Commission) self-assessment tool in supporting services to monitor and review the use of psychotropic medications and their use as chemical restraint.

5e. Continue to offer and evaluate education initiatives that communicate the limited effectiveness of psychotropic medications in addressing behavioural and psychological symptoms of dementia (BPSD) and support the implementation of alternative strategies.

6. Clarify responsibilities for minimising, monitoring and reviewing chemical restraint

Changes to the Restraints Principles

6a. Expand requirements for providers to monitor other measures of consumer safety and wellbeing, in addition to distress and harm.

Other changes

6b. Identify and promote clinical guidelines for monitoring and reviewing psychotropic medications, and explain the circumstances where closer monitoring is required.

6c. Support mechanisms that promote collaborative approaches to medication review.

6d. Work with relevant stakeholders in other sectors to improve the interface between aged care providers and prescribers to support minimisation of chemical restraint.

7. Emphasise the importance of comprehensive assessment

Changes to the Restraints Principles

7a. Amend the Restraints Principles to state that an assessment for care planning, and development of a behaviour support plan, is required before using physical restraint, except in an emergency.

7b. Broaden the list of who is able to undertake an assessment of the need for physical restraint to include other staff with relevant skills and competencies, in addition to medical practitioners, nurse practitioners and registered nurses.

Other changes

7c. Consider strategies to support multidisciplinary assessment, including involvement of mental health specialists and geriatricians.

8. Support the use of alternative strategies

Changes to the Restraints Principles

8a. Strengthen requirements for the use of alternative strategies so the administration of PRN (*pro ne rata* [as required]) medication as a chemical restraint is a last resort.

Other changes

8b. Consider how to build sector capability in behaviour support and management to improve the use of alternative strategies. Consider learnings from both the disability sector, and the Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Teams (SBRT).

8c. Review existing guidelines and, where necessary, develop new guidelines and resources to support providers to identify and use alternative strategies.

8d. Update the Commission's *Restraint scenarios* resource to include examples that clearly articulate and demonstrate consideration of alternatives to restraint through a multidisciplinary approach.

8e. Support education and training initiatives to build skills of aged care staff in dementia management (including staff with diverse backgrounds, education and capability).

8f. Enable a multidisciplinary approach to care, with a particular focus on strengthening the allied health workforce within aged care.

8g. Continue to promote holistic approaches to supporting people with dementia, including providing dementia-friendly environments.

9. Enhance oversight of restraint

Changes to the Restraints Principles

9a. Consider requiring internal oversight of the use of restraint in residential aged care homes by a person with behaviour support expertise.

Other changes

9b. Consider options and triggers for independent review of behaviour support plans (e.g. by behaviour support specialists or the regulator).

9c. Consider how the role of the Commission chief clinical advisor could be strengthened by reviewing other models for sector support and oversight (e.g. the NDIS senior practitioner role).

9d. Consider how the use of restraint across the sector can be most effectively monitored, and adherence to the Restraints Principles enforced.

9e. Supplement the Quality Indicator Program with additional systematic benchmarking tools to help providers understand how their use of restraint compares with their peers, showcase best performers, and inform Commission assessments.

10. Harmonise arrangements between sectors as far as applicable

Changes to the Restraints Principles

10a. Noting key differences between aged care and NDIS regulatory frameworks and cohorts, consider how features of the NDIS Rules could be adapted to the aged care sector to harmonise the protection of the rights of vulnerable Australians, regardless of the sector through which they receive care.

Other changes

10b. Explore options to increase the availability of behaviour support specialists to facilitate development of behaviour support plans in residential aged care.

10c. Develop guidance and templates to support the development of behaviour support plans specific to the aged care (and dementia care) context.

10d. Develop educational strategies and resources for staff across sectors on best practice management of transition between community care, healthcare, and residential aged care sector.

10e. Develop information for families and residents to support understanding of restraint regulations in the aged care and healthcare sectors, including their rights and responsibilities and what they can request or expect.

10f. Continue to foster collaboration and opportunities for learnings to be shared across sectors as the legislative, policy, and practice landscape changes over time.

2 Introduction

2.1 Restraint in aged care

Reliable data on the prevalence of restraint is lacking, and collection of such data is challenging due to inconsistencies in the way restraint has been defined (Royal Commission into Aged Care Quality and Safety 2019a).

Restraint is defined as 'any practice, device, or action that interferes with someone's ability to make a decision or which restricts their free movement' (*Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019*).

Restraint can include using medication to control a person's behaviour (chemical restraint) or using devices and equipment that restrict a person's free movement (physical restraint). Examples of physical restraint include chairs with deep seats, seat belts on chairs, bed rails, seclusion and removing mobility aids such as walking frames (Department of Health and Ageing 2012).

There is a long history of concern about the use of restraint in residential care, including concerns about the:

- Human rights of those subjected to restraint and seclusion (Human Rights Watch 2019, Alzheimers Australia 2016)
- Safety and effectiveness of restraint practices (Royal Commission into Aged Care Quality and Safety 2019a, Melbourne Social Equity Institute 2014)
- Economic costs of restraint and seclusion – and, conversely, the cost-benefit of minimising or eliminating these practices (Chan et al 2012).
- Personal costs to the person subjected to these practices (Chan et al. 2012)
- Organisational costs, such as staff turnover and legal expenses (Chan et al. 2012)
- Opportunity costs when an individual is restrained or isolated instead of receiving treatment (Chan et al. 2012).

People with dementia represent approximately half of residents in aged care (Dementia Australia 2020) and are particularly vulnerable to restraint because they may find it difficult or impossible to articulate their needs or fully comprehend, recall, or report the quality of their care.

Behavioural symptoms such as aggression, agitation, anxiety and wandering are common in some forms of dementia – these symptoms are referred to as behavioural and psychological symptoms of dementia (BPSD) (Royal Australian College of General Practitioners 2019).

There is concern that restraint is used inappropriately in response to these symptoms (Aged Care Quality and Safety Commission 2019).

2.2 Context

On 8 October 2018, the Australian Government established the Royal Commission into Aged Care Quality and Safety (the Royal Commission) to examine the quality of residential and in-home aged care.

On 31 October 2019, the Royal Commission presented interim findings, based primarily on hearings conducted between February and July 2019, with evidence collected up to September 2019. The interim report included a summary of evidence on the use of restraint and suggested directions for reform. The final report will be provided by February 2021.

On 25 November 2019, in response to the Royal Commission's Interim Report, the Australian Government announced $25 million funding to reduce the use of medication as a chemical restraint in aged care, as well as new restrictions and education for prescribers on the use of medication as a chemical restraint.

Further, the Australian Government's 2020-21 Budget committed $408.5 million to improving the aged care system, in response to both the Royal Commission's interim findings and the COVID-19 pandemic.

The Budget also targeted the misuse of chemical and physical restraint for people living with dementia and committed a further $11.3 million to provide additional support and training services for the aged care sector and informal carers of people experiencing BPSD (Australian Government Department of Health 2020a, Australian Government Department of Health n.d.).

In its final submissions to the Royal Commission (22-23 October 2020), Counsel Assisting included Recommendation 29: Regulation of restraints (see box). A number of other recommendations were also relevant to restraint, including mandatory minimum qualifications and national registration of personal care workers, and restrictions on the prescription of antipsychotic medications.

Final Submission of the Counsel Assisting the Royal Commission into Aged Care Quality and Safety

Recommendation 29: Regulation of restraints

By 1 July 2021, the Australian Government should introduce new requirements regulating the use of chemical and physical restraints in residential aged care to replace Part 4A of the *Quality of Care Principles 2014* (Cth).

The new requirements should comprehensively regulate the use of chemical and physical restraints in residential aged care and should be informed by:

- The report of the review conducted pursuant to section 15H of the *Quality of Care Principles 2014* (Cth);[1]
- The report of the Parliamentary Joint Committee on Human Rights on the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth); and
- The operation of the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth).

A person receiving aged care who is the subject of a restraint should be readily able to seek an independent review of the lawfulness of the conduct.

Any breach by an approved provider of the new requirements should expose the provider to a civil penalty.

The Australian Commission on Safety and Quality in Health and Aged Care should review the operation of the new requirements as part of its first comprehensive review of the Aged Care Quality Standards.

[1] This report

2.3 Brief background to the Restraints Principles

The history of the Restraints Principles, begins in 2017, and the release of 3 landmark reports, presenting: the results of an inquiry into the quality of care being delivered at Oakden Older Persons Mental Health Service in the Northern Adelaide Local Health Network catchment (the Oakden report); the findings of an inquiry by the Australian Law Reform Commission (ALRC) into elder abuse; and the outcomes of an independent review of aged care quality regulatory processes.

The Oakden report (although confined in scope to a single aged care home) highlighted the likelihood of widespread excessive use of restraint and a lack of reporting of restrictive practices, and made a number of recommendations for state-wide and sector-wide reforms (Groves et al. 2017).

The ALRC report recommended that aged care legislation should regulate the use of restrictive practices in residential aged care, and made specific recommendations regarding the content of the legislation (Australian Law Reform Commission 2017).

On 1 May 2017, the Australian Government announced the Independent Review of National Aged Care Quality Regulatory Processes, led by Ms Kate Carnell AO (chair) and Professor Ron Paterson ONZM, to examine why aged care processes did not address the failures of care described in the Oakden report. The resulting report included 10 recommendations to improve processes, including the recommendation that aged care standards limit the use of restrictive practices in residential aged care (Carnell and Paterson 2017).

These 3 reports prompted the development of the Restraints Principles.

Other legislative reforms directly or indirectly related to the issue of restraint which took effect at the same time included:

- Development of the Quality Standards, which include specific requirements regarding the use of restraint.[2]
- Introduction of a Charter of Aged Care Rights (the Charter), which specifies the consumer's right to be treated with dignity and respect and live without abuse and neglect.
- Introduction of the National Aged Care Mandatory Quality Indicator Program (the Quality Indicator Program), introducing mandatory reporting requirements for physical restraint.

2.4 Restraints Principles

On 17 January 2019, the Minister for Aged Care announced the government would strengthen regulations on approved providers' use of restraint in residential aged care. These regulations, articulated in Part 4A of the *Quality of Care Principles 2014* and referred to as the 'Restraints Principles', came into effect on 1 July 2019.

The Restraints Principles outline specific responsibilities for residential aged care providers in relation to the use of physical and chemical restraint and, for the first time, put explicit obligations on providers regarding the use of restraint.

The Restraints Principles require providers to satisfy a number of conditions before using physical or chemical restraint, including conducting an appropriate clinical assessment and obtaining informed consent for physical restraint or advising the resident's representative of the use of

[2] The Quality Standards require that clinical care is provided in line with best practice guidelines and supported by a clinical governance framework that minimises the use of restraint. The Quality Standards also require organisation-wide governance systems for regulatory compliance, which includes compliance with the Restraints Principles on minimising the use of restraint. A number of other requirements of the Quality Standards also relate to the use of restraint. Refer to *Supplementary Volume 1* to this report for additional details.

chemical restraint. The provider is also required to document alternatives to restraint that were considered or tried. If restraint is used, it must be the least restrictive form of restraint and, for physical restraint, used for the minimum time necessary, and the resident must be regularly monitored.

The introduction of the Restraints Principles was widely regarded by the sector as a positive step in the regulation of restraint. However, the Restraints Principles as implemented in July 2019 were the subject of significant interest, and have raised concerns in relation to human rights and informed consent. These concerns culminated in 2 formal inquiries conducted by the Parliamentary Joint Committee on Human Rights (Parliamentary Joint Committee on Human Rights 2019) and the Senate Standing Committee on Regulations and Ordinances (Senate Community Affairs References Committee 2018).

In response to the recommendations of these 2 committees, a further amendment to the legislation – the *Quality of Care Amendment (Reviewing Restraints Principles) Principles* – was introduced on 29 November 2019. This amendment:

- Clarified that restraint must only be used as a last resort
- Referred to state and territory legislation regarding prescribers' responsibilities in relation to informed consent
- Required a 12-month review of the Restraints Principles (this review).

2.4.1 Provider support and accountability

The Aged Care Quality and Safety Commission (the Commission) is responsible for assessing compliance with the Quality Standards.

From 1 July 2019, the Quality Indicator Program also began collecting data on the use of physical restraint from all residential aged care providers (Australian Government Department of Health 2020b).

To support providers in complying with the Quality Standards, the Commission published *Guidance and resources for providers to support the Aged Care Quality Standards* (Aged Care Quality and Safety Commission 2019) and other resources related to restraint. These resources include a self-assessment tool for recording details of the use of psychotropic medications,[3] restraint scenarios to illustrate providers' responsibilities, and a regulatory bulletin (Aged Care Quality and Safety Commission 2020a).

An Aged Care Clinical Advisory Committee was set up in January 2019 to advise the government on ways to reduce chemical restraint in residential aged care (Australian Government Department of Health 2020c). The government endorsed and is implementing all of the committee's recommendations to support the sector in minimising the use of restraint, including raising awareness around the appropriate use of certain medications in residential aged care, changes to the Pharmaceutical Benefits Scheme (PBS) requiring approval for prescription of the antipsychotic risperidone beyond 30 days, and workforce initiatives.

[3] Psychotropic medications are any drugs capable of affecting the mind, emotions and behaviour. The main classes include antidepressants, anxiolytics/hypnotics and antipsychotics (Aged Care Quality and Safety Commission 2020a).

2.5 This review

The requirement for a review of the Restraints Principles is set out in legislation, under the *Quality of Care Principles 2014*, Part 4A, Section 15H. As the Restraints Principles will be repealed on 1 July 2021, this review provides an opportunity to shape the future design and delivery of the regulations relating to the use of physical and chemical restraint in residential aged care.

The key review questions, defined by the Department, are as follows:

- Are the Restraints Principles effective in minimising restraint?
- To what extent have the Restraints Principles promoted the delivery of care in a restraint-free environment?
- Are there any unintended consequences arising from the implementation of the Restraints Principles?
- What are the opportunities to improve the Restraints Principles?

The Department also specified that the review should consider the extent to which non-regulatory initiatives supported the Restraints Principles to achieve their intended outcomes.

To guide the review, the Department convened an Advisory Group comprising 12 members, including experts and industry stakeholders, and representatives of the Commission. The Advisory Group provided input on key stakeholders to consult and consultation methods, as well as feedback on draft findings and opportunities.

This final report, to be submitted to the Minister for Aged Care by 31 December 2020, covers:

- Impact of the Restraints Principles, addressing effectiveness and unintended consequences (Section 3)
- Opportunities and recommendations for improving the Restraints Principles, and supporting aged care providers to follow them (Section 4)
- Discussion of the impact of the COVID-19 pandemic on restraint use in residential aged care (Section 5)

Two supplementary documents support the final report:

- ***Supplementary volume 1: literature and environmental scan*** *(Supplementary volume 1)* includes an overview of residential aged care in Australia, approaches to the regulation of restraint, background to the development of the Restraints Principles, relevant national aged care legislation and initiatives, state and territory policy settings, primary care and prescribing in residential aged care and an overview of COVID-19 and residential aged care.
- ***Supplementary volume 2: methodology and results*** *(Supplementary volume 2)* includes the review methodology, provider survey results, consumer consultation results, and analysis of secondary data on the use of physical and chemical restraint.

2.5.1 Consultation

Consultation to inform the review was Australia-wide, and included aged care residents and their family members, residential aged care staff, key organisational stakeholders (including provider, consumer, medical, nursing, pharmacy and allied health peak bodies), and subject matter experts. Consultation questions were tailored for each stakeholder group.

Consultations were conducted between 9 July and 13 October 2020 via interviews, focus groups, and an online survey for providers. Feedback provided through written submissions was also accepted.

Due to the COVID-19 pandemic and resulting restrictions on meeting face-to-face, all interviews and focus groups were conducted over the telephone or by video or audio conference.

The consultation process was promoted through Department, Commission and Advisory Group channels. Consultation was broad and inclusive, and input was accepted from all interested members of the community. The response to the review was strong, demonstrating the interest the sector and broader community has in the issue of restraint.

AHA received approval from the Bellberry Human Research Ethics Committee (HREC) to conduct interviews with aged care residents and their family members. The HREC stipulated that these consultations be conducted via telephone interviews (rather than online or paper-based surveys) to enable monitoring and intervention should the interviewee become distressed.

In total, 2 current residents of aged care homes and 41 family members provided input into the review.

Residential aged care (provider) staff were invited to complete an online survey. 531 respondents completed the survey, including: managers/nurse unit managers (54%), nursing staff (23%), allied health staff (11%), personal care workers (8%), and a mix of other groups such as advocates and retired staff (4%).

Interviews and focus groups were conducted with organisational stakeholders and subject matter experts. In total, 135 individuals representing 54 organisations participated, including management representatives from 17 providers. In addition, unsolicited written submissions were received from 5 individuals. A list of stakeholders, including provider, consumer, medical, nursing, pharmacy and allied health peak bodies, is provided in Appendix B.

Further details of the consultation are provided in *Supplementary volume 2*.

2.5.2 Other data sources

The review considered data on use of physical restraint collected through the Quality Indicator Program and analysed by the Australian Institute of Health and Welfare (AIHW). We also examined PBS data to identify any changes in dispensing patterns for medications associated with chemical restraint. The purpose of reviewing these sources was to consider whether there have been changes in the use of restraint since the introduction of the Restraints Principles.

Other secondary data sources were provided to AHA over the course of the project, including case study data from Dementia Support Australia and the Commission's non-compliance and complaints data.

In addition, we conducted a literature and environmental scan in parallel to the review, including a synthesis of key inquiries, policy settings, and regulatory and non-regulatory approaches to minimising restraint in residential aged care and related settings. The literature and environmental scan is provided in *Supplementary volume 1*.

3 Impact of the Restraints Principles

This chapter presents the review findings on the effectiveness of the Restraints Principles in minimising the use of restraint, their impact on the delivery of care, and unintended consequences of their introduction.

In summary, the review found that:

- Stakeholders who are in direct contact with providers reported that they have noticed increased efforts to minimise restraint, but noted that a trend towards minimising restraint had begun before the Restraints Principles were introduced.
- Staff of aged care homes reported a reduction in both physical and chemical restraint since the Restraints Principles were introduced.
- It is not possible to draw definitive conclusions about the effectiveness of the Restraints Principles at this time. This is due to the limitations of the secondary data, lack of a benchmark for restraint use prior to the Restraints Principles, and the short timeframe since the Restraints Principles and related initiatives were introduced.
- The extent to which the Restraints Principles have impacted practice was seen to vary between aged care homes, depending on organisational culture, resourcing and commitment to change. However, there was good evidence of positive change, including development of new policies and processes in response to the introduction of the Restraints Principles.
- A range of unintended consequences were reported through the review. Positive consequences included promoting greater involvement of multidisciplinary teams, and an increased emphasis on holistic care and communication with aged care residents and their family members. Negative consequences largely related to concerns about the withholding of appropriate care due to misinterpretation of the Restraints Principles.

3.1 Effectiveness of the Restraints Principles in reducing restraint

3.1.1 Stakeholder opinions

Stakeholders had differing views on whether the introduction of the Restraints Principles had led to a reduction in the use of physical and chemical restraint in residential aged care. Overall, it appears that aged care providers have been moving towards minimising the use of chemical and physical restraint, but that practice remains variable.

There was consensus among stakeholders that the effectiveness of the Restraints Principles could be enhanced by further developing resources to support their interpretation and application.

> The Restraints Principles aren't the issue; the interpretation, application, management of reporting requirements are.
>
> *– Provider peak representative*

Broadly, providers and their peak bodies, allied health peaks, and Commission assessors reported that the Restraints Principles have either led to a reduction in the use of restraint (physical, chemical or both), or supported an existing trend towards reduced use.

The majority of providers reported that both physical (n=302; 63%) and chemical restraint (n=309; 64%) are used less frequently **since** the introduction of the Restraints Principles. The proportion of

respondents who perceived a reduction in chemical or physical restraint was similar across management and nursing staff (around two-thirds). In comparison, the proportion of personal care worker staff that perceived a reduction in physical or chemical restraint was slightly lower (43% and 46% respectively).

Respondents who perceived no changes as a result of the Restraints Principles reported two distinct reasons:

- That the rate of restraint use was already low, or
- That the level of staff skill required to reduce the use of restraint (including skill to implement alternative strategies) was not yet sufficient to achieve a reduction.

Providers reported the following barriers to reducing the use of restraint:

- For physical restraint, the main barrier was resistance to change by management or direct care staff
- For chemical restraint, the main barrier was the perceived high rate of prescription of psychotropic medications by GPs and other medical practitioners (noting that providers felt that reduction of chemical restraint was largely the responsibility of prescribers, regulation of whom sits outside the Restraints Principles).

By contrast, consumer peaks and advocates were less sure about the effectiveness of Restraints Principles, partially because provider activity is less visible to them.

They suggested that awareness of the Restraints Principles by consumers remains low, and noted that they have not seen an increase in enquiries or complaints as a result of the introduction of the legislation. While they did report that public awareness of the issue of restraint has increased, they felt that this has been driven largely by media attention rather than the Restraints Principles.

One advocate group considered that the Restraints Principles have not had an effect on the use of restraint in practice, but made the point that this is not necessarily a surprise, because minimising the use of restraint is a change process that will take time, effort and investment.

3.1.2 Restraint use data

The review considered data collected through the Quality Indicator Program and the PBS to assess whether there has been a reduction in the use of physical and chemical restraint (respectively) since the introduction of the Restraints Principles. A summary of findings is provided below, with additional detail in *Supplementary volume 2*.

Physical restraint

Since 1 July 2019, the Quality Indicator Program has required all Australian Government-subsidised residential aged care providers to report quarterly data on use of physical restraint through 2 categories: **intent to restrain** and **physical restraint devices**.

Quality Indicator Program data available on the AIHW's Gen Aged Care website shows no evidence of progressive change in the intent to restrain or the use of physical restraints in residential aged care homes across the first three quarters of the Quality Indicator Program (1 July to 30 September 2019 through 1 January to 31 March 2020). However, there was an overall reduction of 4% between the first and third quarters for the physical restraint devices quality indicator (counts per 1,000 care recipient days). It is worth noting that the AIHW has advised caution when interpreting data at this early stage of the Quality Indicator Program.

Chemical restraint

On behalf of the Department, the AIHW analysed PBS dispensing data to establish whether there has been a change in dispensing rates of medications associated with chemical restraint since the introduction of the Restraints Principles. The analysis focused on 6 key medications of interest: haloperidol, olanzapine, quetiapine, risperidone, diazepam and oxazepam, and 17 other medications of interest.

Analysis for all aged care residents between 1 July 2017 and 31 March 2020 found that the only medication showing a decrease of any magnitude was haloperidol, which was prescribed for 6.2 per cent of residents in the year to 30 June 2018 and decreased to 4.1 per cent in the 9 months following the introduction of the Restraints Principles.

However, decreased dispensing rates of medications were observed for a subset of longer-term residents (those who had lived in residential aged care 9 months prior to and 9 months following the introduction of the Restraints Principles). The analysis, which focused on the 6 key medicines of interest, found reduced dispensing was most evident for risperidone; 6.4 per cent of the long-term resident subgroup received a risperidone prescription in the 1 January 2020 quarter, down from 9.2 per cent in the 1 October 2018 quarter. This pattern held when only those long-term residents with a dementia diagnosis were included in the analysis; in this case, risperidone dispensing rates reduced from 13.8 per cent in the 1 October 2018 quarter to 9.1 per cent in the 1 January 2020 quarter.

It is not possible to determine the extent to which the introduction of the Restraints Principles has contributed to these reductions.

Limitations of secondary data

There are several limitations to both datasets, which are described in *Supplementary volume 2*. More broadly, however, there are complex contextual factors that may influence the use and subsequent reporting of physical and chemical restraint that these data are unable to account for. These factors include the size, setting, funding structure and staffing levels of any given aged care home, the care needs of residents, and staff understanding of restraint, and are discussed in detail in other sections of this report.

3.2 Impact of the Restraints Principles on the delivery of care

The review explored the extent to which the Restraints Principles have minimised restraint. Unsurprisingly, stakeholders told us that providers were at different stages of the change process, depending on organisational culture, resourcing and commitment to change. Stakeholders also noted that it takes time to change practice and culture.

> Aged care homes are like human beings, they vary, some do it well and some don't … they vary even in the same organisation.
>
> *– Consumer advocate*

Almost all providers who responded to the survey stated that they had policies and processes in place to support the minimisation of restraint, and almost 70 per cent reported that they had established these measures as a result of the introduction of the Restraints Principles.

Stakeholders commented that larger organisations have the resources to enable consistent communication of policies and processes throughout their organisations, and thus are perceived to have progressed further in implementing the Restraints Principles.

Stakeholders who spend a lot of time in aged care homes, including consumer advocates and Commission assessors, suggested that, although the Restraints Principles are well understood at management level, policies and processes to minimise restraint may not have filtered down to the direct-care level.

The most commonly-reported challenges associated with implementing new policies and procedures related to:

- Insufficient staffing to support person-centred care
- Inadequate skills to respond to behaviours of concern
- Developing staff skills in using alternative strategies in place of restraint
- Building staff understanding of the necessary practice changes
- Raising staff awareness of the Restraints Principles.

Managers and other stakeholders commented that communication of changes related to the Restraints Principles was further complicated by a diverse workforce that has a high proportion of individuals from culturally and linguistically diverse (CALD) backgrounds. Stakeholders told us that staff with limited English may not adequately comprehend the complex concepts related to restraint, or have limited experience working in the Australian aged care context.

> Most of our workforce is from a CALD background and does not fully grasp the intended principles, even with education strategies in place. While staff may be able to speak English, their comprehension of complex concepts in English is very limited. It has taken months to educate on this matter and it is still difficult for staff to articulate the principles of restraint minimisation.
>
> *– Head office manager*

> Some of the work we do in training delivery, some of the basic things aren't there. Frontline workers are from CALD backgrounds [and] a large percentage have been in Australia less than 5 years. They don't all have experience in aged care or even in hospitals; even those that do have that [experience] in their own country, the approach is quite different.
>
> *– Consumer advocate*

The review found indications that the Restraints Principles have had a positive impact on the delivery of care beyond the development of policies and processes. For example, they have promoted:

- More frequent and thorough consultation with residents and families before restraint is used
- More collaborative and multidisciplinary approaches to care, including more involvement of geriatricians, mental health specialists, behaviour advisory services, pharmacists, and other health professionals
- Increased focus on informed consent, with family members and others now more actively involved in that process
- More frequent medication reviews.

3.3 Unintended consequences of the Restraints Principles

As noted above, the introduction of the Restraints Principles appears to have contributed to existing momentum towards a reduction in the use of restraint in residential aged care. However, the legislation was reported to have also led to a number of unintended effects, many of which appear to be due to a misinterpretation of the Restraints Principles. Some of these have been observed directly by consumers, providers, and organisational stakeholders, while others remained hypothetical at the time of our consultations.

Encouragingly, participants in this review identified several positive impacts of the Restraints Principles, over and above reducing the use of restraint. We heard, for example, that they had prompted greater emphasis on team-based, holistic care, with staff seen to be making more effort to understand the resident's life prior to admission and engage with them accordingly.

Provider staff noted that some changes to practice could be confusing and confronting for families (e.g. increased requests for consent). However, these challenges were reflective of positive changes and were mitigated by the increased communication between providers, residents and staff, which was seen as beneficial.

> It has improved work satisfaction … aged care workers want to do their best and a lot of confusion comes from not knowing what to do or say. The Restraints Principles have helped them better understand, and have empowered them to have conversations [with residents] and know what they are doing.
>
> *– Provider peak representative*

Participants also reported less-positive unintended consequences of the Restraints Principles. By far the most common was that a number of providers mistakenly believed that Restraints Principles applied to all psychotropic medications including those used to treat diagnosed mental disorders. Some stakeholders reported that, in some instances, residents may not receive medications from which they may benefit. This misinterpretation of the Restraints Principles therefore appears to be inconsistent with a person-centred approach to care as described in the Quality Standards (see Section 4.1).

Several organisational stakeholders raised concerns that providers may be putting an under emphasis on ritualistic regulatory compliance with the Restraints Principles, focusing more on Commission audits than improving resident outcomes. Providers may engage in undesirable practices at both ends of the spectrum, from not documenting restraints to being overly cautious and over-documenting, including seeking the appointment of substitute decision makers where these were not required (see Section 4.2).

Some stakeholders, including providers, felt that provider obligations outlined within the Restraints Principles had resulted – or could result – in an increased workload. It is worth noting that, in many cases, this perception was driven by uncertainty around or misinterpretation of the Restraints Principles and supporting materials (e.g. requirements for review and documentation of medications not used for the purpose of restraint), suggesting that much of the impact could be reduced with clarification of these requirements. Further, it was noted that while aged care staff require time to negotiate with and obtain consent from residents and families, liaise with prescribers, conduct risk assessments, and document all the above, these activities are not specific to the Restraints Principles but represent good practice more broadly. Therefore, there

was a sense that complying the Restraints Principles would have considerable workload impacts only for providers not already following expected practices. Importantly, while some providers described the required documentation as onerous, consumers who participated in this review saw this documentation as imperative. They placed a high value on having written information about restraint, records of its use, monitoring and review, and information about informed consent and records of it being sought and obtained.

Some stakeholders believed there was a risk that the Restraints Principles could negatively impact the safety and wellbeing of both residents and staff. Their concerns included:

- The potential that increased freedom of movement for one person could reduce the degree to which others felt they could move about freely;
- Lack of consideration as to how the resident would want to be perceived (e.g. if restraint would serve to protect their dignity during an acute episode);
- The potential for reduced workplace health and safety; and the possibility that implementing alternatives to restraint would require spending a disproportionate amount of time with one resident to the detriment of others, which could reduce their job satisfaction.

These concerns highlighted issues around the interpretation of the Restraints Principles, as well as the need for staff to develop the knowledge and skills to implement alternative strategies, and the need to further embed a person-centred approach in the delivery of care.

3.4 Discussion

The effectiveness of the Restraints Principles in reducing chemical and physical restraint remains unclear, partly due to the relatively short period of time that has elapsed since the legislation was introduced, and limitations of available data sources.

Further, the Restraints Principles came into effect at the same time as several other reforms and non-regulatory initiatives (described in *Supplementary volume 1*), making it difficult to tease out the specific contribution of the Restraints Principles in shifting restraint practice.

However, there are some indications that the use of restraint in residential aged care is declining, and that the Restraints Principles are one piece of the complex puzzle contributing to this change.

It is clear that changing practice and culture takes time, and that aged care providers are at different stages of this process. Nonetheless, most provider staff indicated that, since the Restraints Principles were introduced, their organisation had developed policies aiming to minimise the use of restraint. Thus, while it may be too early to see the quantitative impact of the Restraints Principles on the prevalence of restraint, there are promising signs that providers are moving towards ensuring their staff adhere to their obligations under the legislation. Already, provider staff are reporting positive impacts for residents by minimising restraint, for example increased freedom of movement and meaningful engagement in activities.

Stakeholders also identified a number of unintended consequences of the Restraints Principles, both positive and negative. Importantly, in most cases the negative consequences that participants in the Review identified flowed from uncertainty or misinterpretation of the Restraints Principles, rather than from the intention behind the legislation. This finding suggests that the negative impacts of the Restraints Principles could be reduced (and positive impacts enhanced) by further developing resources to build sector capability to support their implementation

4 Opportunities to minimise restraint

The 697 individuals who contributed to this review generously shared their perspectives on the effectiveness of the Restraints Principles to date, and how they could be enhanced in the future.

These perspectives were remarkably consistent across stakeholder groups, and present clear opportunities to support the aged care sector to further minimise restraint.

Drawing on the wealth of information provided to this review, we make the following 10 overarching recommendations. Within each of these overarching recommendations we have developed, as relevant, specific recommendations related to the Restraints Principles legislation and non-regulatory measures. These recommendations, and the evidence behind them, are detailed in the sections that follow.

Overarching recommendations

1. Emphasise and support person-centred care
2. Strengthen and promote consent requirements
3. Improve consumer awareness of the Restraints Principles
4. Clarify the definition of physical restraint
5. Improve understanding of chemical restraint
6. Clarify responsibilities for minimising, monitoring and reviewing chemical restraint
7. Emphasise the importance of comprehensive assessment
8. Support the use of alternative strategies
9. Enhance oversight of restraint
10. Harmonise arrangements between sectors as far as applicable

4.1 Emphasise and support person-centred care

Summary

- Person-centred care is recognised by stakeholders as a fundamental ingredient to minimising restraint.
- Barriers to providing person-centred care include lack of staff time, inadequate staff skills, and a workforce culture that has not traditionally placed sufficient emphasis on ensuring residents are actively involved in decisions about their care –particularly for residents with dementia or mental illness.
- Stakeholders raised a number of instances where a person-centred approach had not been applied. Consumer rights, such as the right to make choices about their own care, were incorrectly perceived as being at odds with the requirements of the Restraints Principles. For example, some providers were reported to have introduced blanket restraint-free policies, which meant that requests for items such as an attachable tray table were not granted.

Recommendation 1: Emphasise and support person-centred care

Changes to the Restraints Principles

1a Consider incorporating references to aged care consumer rights in the legislation.

Other changes

1b Continue to support education opportunities for providers to build understanding and skills in person-centred care.

1c Clarify providers' responsibilities in instances where restraint is the consumer's choice.

1d Consider the optimal staffing numbers and skill mix (including allied health involvement) for each service to deliver safe, high-quality, person-centred care. This may vary between services based on residents' needs.

Relevant aspects of the legislation

Section 15F 2c of the Restraints Principles states that a 'care and services plan documented for the consumer in accordance with the Aged Care Quality Standards set out in Schedule 2' must be created.

The consumer rights specified in the **Charter** underpin a person-centred approach to care. This includes the right to complain free from reprisal, and the right to have control over and make choices about their care, personal and social life

Quality Standard 1 addresses consumer dignity and choice.

Quality Standard 2 affirms that a consumer is 'a partner in ongoing assessment and planning … it's expected when planning or making changes to care and services plans, consumers are given options and helped to make informed decisions about their options' (Aged Care Quality and Safety Commission 2019, p 31).

Consultation findings

Organisational culture plays a significant role in delivering person-centred care

Stakeholders identified that organisational culture is a significant determinant of whether organisations deliver person-centre care that minimises restraint.

They argued that organisations that minimise restraint value holistic care, taking into account factors such as environment, planning, and understanding of residents' goals and needs. Such organisations also have a strong focus on, and commitment to, staff training and trying new approaches.

For example, some aged care homes have successfully introduced staff champions to support person-centred care and diversional strategies. Some stakeholders suggested that this innovative approach could be adopted by other aged care homes, with training or mentoring from a qualified diversional therapist.

However, changing organisational culture can be challenging. Some stakeholders highlighted that, even with training, staff attitudes can be difficult to influence. They suggested this was particularly true when staff have been working in aged care for a long time and certain ideas or approaches had become entrenched. For example, staff may be used to being 'task-orientated', which was seen as the opposite of person-centred; or they may have outdated views on the use of restraint.

> The challenges are mainly due to staff who have worked in residential aged care for a long time having to re-program their thinking in line with the intent of the Restraints Principles.
>
> *– Head Office Manager or CEO*

Consumers should be involved in decisions about their own care

Almost all stakeholders identified person-centred care as a key ingredient to successfully reducing restraint without compromising resident safety.

Although the sector as a whole is shifting towards person-centred care, stakeholders spoke of the need for providers to **see residents as active participants in their care**.

They also identified a parallel need to **support residents and families** to be more confident in asking questions, making decisions and expressing choices about their care (including, where relevant, restraint).

Consumer advocates pointed out that people with dementia or mental illness need to be involved in making decisions about their own care, but are often excluded. There is **widespread (and false) assumption that people with dementia or mental illness do not have the capacity to make decisions about their care**. As a result, service providers may make decisions without consultation, or may consult the resident's family without talking to the resident at all.

Stakeholders suggested that this misconception stems from a limited understanding of dementia and mental illness, and of the legal concept of capacity. Regardless of origin, this misconception was recognised as a key barrier to person-centred care, and was seen to undermine residents' rights.

Several stakeholders also noted that consumers may be **reluctant to speak up** for fear it will compromise their care and/or because the current generation of aged care recipients are known as the 'grateful generation' and don't typically complain or challenge authority.

Furthermore, residents and families from some cultural backgrounds may find it particularly difficult to question authority or withhold consent.

Inadequate staffing levels are significant barrier to person-centred care

Stakeholders spoke of the importance of spending time with residents to understand their life experience, culture and beliefs, in order to respond appropriately to their needs. This was seen as fundamental not only to the provision of person-centred care, but also to minimising the need for restraint by helping to avoid triggers, and to have appropriate diversional strategies in place to prevent or address behaviours of concern.

Consistent with this, DBMAS observed that the use of psychotropic medications is lower in rural and regional areas compared with metropolitan areas. They attributed this difference to the assumption that providers in rural and regional areas were more likely to know residents before they entered residential care, understand their life story, and therefore be in a better position to monitor and manage behaviours of concern without the need for chemical restraint.

However, stakeholders repeatedly told us that staffing levels (and skill mix) are a barrier to the provision of person-centred care and to minimising the use of restraint.

Inadequate staffing was reported to result in insufficient time to:

- Appropriately assess the resident (see Section 4.7)
- Trial alternatives to restraint (see Section 4.8)
- Supervise and support residents who present a safety risk (to themselves or others) and who may otherwise be restrained
- Meet the care needs of all residents.

Nursing and provider peak bodies suggested that mandated staffing ratios and more funding may help overcome this barrier. Allied health peak bodies suggested that allied health professionals are underutilised and could support holistic, person-centred care.

Staff need more training to provide appropriate support, especially to vulnerable residents

Consumer peak bodies stressed the need for aged care staff to receive mandatory training in elder abuse, human rights, the Charter and cultural awareness.

Further, advocates, guardians and providers called for aged care staff to receive mandatory training in how to support residents with dementia or mental illness. In an extension of this idea, advocates suggested that staff receive training in supported decision-making, to support residents to make choices about their own care.

Proving compliance needs to be balanced with person-centred care

Stakeholder groups, including providers, raised concerns that the Restraints Principles put an undue emphasis on regulatory compliance.

Many provider staff commented that the documentation (e.g. recording alternative strategies considered or tried, each use of restraint, consultation with family) was taking time away from residents. Rather than viewing the documentation requirements of the Restraints Principles as expected practice in the delivery of quality care, it appears that some staff considered the requirements as actions only undertaken to demonstrate compliance.

Several stakeholders acknowledged that the introduction of the Restraints Principles and the Quality Standards meant substantial change for providers, and it will take some time to establish and embed the policies, processes and skills to minimise restraint.

The Restraints Principles are not being implemented as intended with respect to consumer rights

Providers spoke about the ways in which consumers' rights, as set out in the Charter, can add to confusion about restraint. In particular, they perceived that the right to safe and high-quality care, the right to be treated with dignity and respect, the right to independence (and dignity of risk), and the right to choices about care were sometimes in conflict with providers' obligations under the Restraints Principles.

Providers sought clarification over whether it was acceptable to use restraint if it was requested by the resident or their family (or substitute decision maker) and if so, what providers' obligations were. The examples given referred mainly to physical restraints such as bed rails.

Feedback from consumers echoed this concern, with many indicating that the introduction of blanket 'restraint-free' policies has limited their ability to choose how they would like to be cared for. Based on descriptions given by stakeholders, restraint-free policies are an overly cautious interpretation of the Restraints Principles as not allowing restraint *even if it would be in the best interests of the resident*. For example, a number of residents and family members reported that the aged care home was either hesitant or unwilling to accommodate their requests for equipment to improve safety, wellbeing, or quality of care (e.g. bed rails, attachable tray tables).

In some cases, this led to confusion and distress for residents, particularly for those who had access to these arrangements in acute care settings (see also Section 4.10 regarding harmonisation of arrangements across sectors).

Further, a number of stakeholders expressed concern that some residents were missing out on clinically-indicated medication because of concerns (by providers and/or medical practitioners) that it would be considered chemical restraint.

While family members supported the Restraints Principles aim to minimise restraint, they felt the complete avoidance of restraint could compromise resident safety and wellbeing and believed that, in certain situations restraint, was necessary for the safety of their loved one or those around them.

> I have observed first hand my mother's behaviour causing physical harm to several staff and destruction of property. When she is in this state, she risks harming herself and others. I see it as entirely appropriate that when a resident is in a state that is harmful to themselves or threatens the staff at the home; there should be no question they should be able to use the means necessary to them to manage it.
>
> *– Family member of a resident*

Discussion

A cultural shift towards person-centred and consumer-directed care in the residential aged care sector has been occurring over a number of years. This shift is in line with changing community expectations, and with progress in other areas, such as the disability sector.

The Charter reinforces the consumer's right to complain free from reprisal and to have control over and to make choices about their care, personal and social life. Further, under the Quality Standards, providers have the responsibility to support each consumer to exercise choice and independence. The Quality Standards also require assessment and care planning to be based on an ongoing partnership with the consumer and others the consumer wishes to involve.

A number of recent reports addressing restraint in aged care have stressed the need to protect the rights of older people to receive appropriate, person-centred care (Australian Law Reform Commission 2017, Carnell and Paterson 2017, Human Rights Watch 2019, Royal Commission into Aged Care Quality and Safety 2019, Duckett et al. 2020).

The findings of this review demonstrate that there is awareness across the sector of the importance of providing person-centred care, but more could be done to put this into practice. Providers need to engage in conversations, share information and help educate residents and families. In order to enable this, provider must have sufficient resources and staffing levels to support the time needed with each resident.

These findings are consistent with the Royal Commission in highlighting the importance of adequate numbers of appropriately skilled staff in delivering person-centred care (Royal Commission into Aged Care Quality and Safety 2019b). Earlier reports have also included similar findings: 'Instead of using restraint, aged care staff need to be supported and given adequate time to provide responsive and flexible and individualised care' (Carnell & Paterson 2017, p 125).

The Counsel Assisting the Royal Commission (Counsel Assisting) recently proposed a minimum staff time standard, including a skill mix. The standard proposes a plan that increases the time that staff spend with residents per day by 1 July 2024, and specifically relates to registered nurses, enrolled nurses and personal care workers.

Counsel Assisting also recommended increasing allied health services in residential aged care (Royal Commission into Aged Care Quality and Safety 2020a). This recommendation emphasises the central role of allied health in delivering person-centred care and, by extension, minimising restraint, and is aligned with the findings of this review. (see also Sections 4.6 to 4.8).

Resources and initiatives

Information and training have been identified as key strategies to encourage a shift to person-centred care, and a review of current resources and initiatives demonstrates that much is already being done.

Provider resources and initiatives

Helpsheet: Providing one-to-one care for the person living with dementia (Dementia Australia)

The helpsheet recommends implementing one-to-one care when a person living with dementia is experiencing high levels of stress or distress to reduce the risk of harm to themselves or others. It suggests a nominated care partner spend time to develop rapport, observe their behaviours, and provide individualised solutions to reduce distress. The care partner is then encouraged to share their observations with other care staff who provide ongoing care so they are more able to offer person-centred care.

Aged care learning information solution (the Commission)

The Commission has recently released an online learning platform to help providers understand the intent and application of the Quality Standards, key concepts within them, the importance of working with consumers, and how to prepare for performance assessments. The platform includes learning modules on dignity of risk and optimising independence.

Six steps for Safe Prescribing: antipsychotics and benzodiazepines in residential aged care (Department of Health)

This factsheet, developed by the Department, is aimed at medical practitioners and nurse practitioners who work in residential aged care. It advises prescribers to 'consult the team' as a first step, and speak to family and frontline workers who know the resident best. Prescribers are asked to understand the resident's behaviours, triggers, and their likes and dislikes prior to assessing them or investigating other management strategies.

Aged Care Diversity Framework Action Plans (Department of Health)

These plans – developed by the Department – assist providers, governments and consumers to address specific barriers that people from 3 vulnerable populations face in accessing inclusive, person-centred aged care. Action plans are available to support older Aboriginal and Torres Strait Islander, CALD, and LGBTI people.

'This is me' [support tool] (Alzheimer's Society UK)

The tool aims to help providers of dementia services deliver person-centred care. The consumer or their representative completes the tool, which includes details of the consumer's background, interests, routines, communication, mobility and personal habits. The information can then be shared with direct care staff. It serves to reduce stress for people with dementia and their families by enabling them to receive care in line with their needs and preferences.

TOP 5 Toolkit for Residential Aged Care Facilities (Central Coast Local Health District, NSW)

Top 5 is a communication tool that encourages health professionals to engage with carers to gain valuable non-clinical information to help personalise care.

Consumer resources and initiatives

Medication: It's your choice. It's your right (OPAN on behalf of the Commission)

Older Persons Advocacy Network (OPAN) has produced a video and an accompanying brochure and booklet to empower older consumers to learn more about their medications. Consumers are reminded of their right to be involved in decisions about their care, and encouraged to make informed decisions about the medication they take.

The booklet outlines the roles of the GP, pharmacist, aged care provider and decision maker. It suggests questions consumers could ask about their medication when next visiting their GP.

There is a focus on psychotropic medications, specifically advising consumers that it is important to understand what these medications are, what they are for and how they may affect decisions.

Charter of Aged Care Rights

From 1 July 2019, the Charter was legislated under the *Aged Care Act 1997*. The Charter outlines the rights of all aged care consumers, including the right to be treated with dignity and respect; be informed about care and services in a way they understand; have control over and make choices about their care, personal and social life; have independence; and be listened to and understood.

4.2 Strengthen and promote consent requirements

Summary

- Organisational stakeholders and providers highlighted the challenges associated with providers and prescribers having dual responsibilities in obtaining informed consent for the use of chemical restraint.
- A number of stakeholders reflected on the challenges associated with ensuring that consent was obtained from the person with authority to provide it, noting that the term 'consumer representative' is vague and has no legal standing.
- As chemical restraint is defined as the use of medications excluding those that constitute medical treatment, the person with authority to consent to medical treatment may not legally be able to provide consent for the use of restraint.
- There was support for clarifying that consent should be sought from the resident themselves wherever possible.
- It was recognised that assessing capacity to consent is challenging and provider staff required additional education and resources to support them to make these assessments.
- A number of organisational stakeholders pointed out the complexity for providers in ensuring their consent practices were also compliant with relevant state and territory laws. They suggested a need for clear guidance and resources to safeguard against providers inadvertently seeking consent from someone without authority to provide it.
- Providers and organisational stakeholders felt that the Restraints Principles required interpretation as to when and how often consent should be sought, and how often it should be re-established.
- Organisational stakeholders noted that some providers could routinely avoid obtaining consent prior to the use of restraint by claiming it was an emergency and that informing the resident's representative 'as soon as practicable' afterwards.
- Residents' representatives and guardians reported that they are not always asked to provide consent prior to restraint use, nor proactively informed of its use afterwards.
- Providers, consumers and consumer peaks identified a need for transparency and documentation of both consent procedures and the information provided to residents and family members.

Recommendation 2: Strengthen and promote consent requirements

Changes to the Restraints Principles

This review identified a need to clarify consent requirements within the context of the Restraints Principles. Areas for consideration include:

2a Clarify that state and territory requirements regarding informed consent apply to both physical and chemical restraint.

2b Reinforce the rights of the consumer in making decisions about their care.

2c Revise 'consumer representative' terminology or clarify its definition.

Other changes

In addition to the suggested changes to the Restraints Principles, it is apparent that providers and consumers alike need support to understand and implement consent procedures that are consistent with best practice and relevant state and territory law. Our findings suggest a need for broad change management reform, requiring the Department and Commission to:

2d Work with provider and health professional peak bodies to develop and promote tools and educational materials to support best practice for assessing capacity and obtaining informed consent (where such material does not already exist). This should include when, how, and how often assessments and consent procedures should be conducted and documented.

2e Work with relevant state and territory bodies to develop and disseminate clear, plain language information and tools to support providers and prescribers to comply with both the Restraints Principles and jurisdictional guardianship and related legislation (where such material does not already exist).

2f Work with consumer peak bodies to develop and promote appropriately tailored, plain language resources on informed consent and the appointment of substitute decision makers (where such material does not already exist).

2g Provide guidance on acceptable timeframes for informing a resident's representative that restraint has been used, if it was not possible to obtain informed consent prior to use. Include an operational meaning of 'as soon as practicable' to give providers a frame of reference to develop policies and measure practice.

2h Develop resources and training to support staff to understand and comply with their responsibilities when informed consent cannot be obtained prior to the use of restraint (i.e. in an emergency).

Relevant aspects of the legislation

There are 5 components of the Restraints Principles relevant to the issue of consent. They state that:

- Part 4A of the *Quality of Care Principles* does not affect the operation of state or territory laws related to restraint (**15E**).
- An approved provider must not use physical restraint without the informed consent of the consumer or the consumer's representative, unless the use of the restraint is necessary in an emergency (**15F 1e**).
- If physical restraint is used without prior consent, the approved provider must inform the consumer's representative as soon as practicable after the restraint starts to be used (**15F 2b**).
- An approved provider must not use a chemical restraint unless the consumer's representative is informed before the restraint is used if it is practicable to do so (**15G 1c**).

  Two notes were added to this point in the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019*, signposting that:

  - medical practitioners and nurse practitioners are required to obtain informed consent prior to prescribing

medication, as outlined in relevant codes of professional conduct (themselves approved under the *Health Practitioner Regulation National Law*).[4]

- the question of who can consent to chemical restraint when the consumer themselves is unable to do so (due to physical or mental incapacity) is addressed by state and territory legislation. If the consumer's representative has not been informed of the use of the restraint, the approved provider must inform the consumer's representative as soon as practicable after the restraint starts to be used (**15G 2a**).

The explanatory statement indicates that consent may be withdrawn at any time, and that providers should communicate regularly with the consumer (or their representative) and 'obtain informed consent contemporaneously'.

The statement goes on to note that providers should communicate in a way that gives consumers and representatives an opportunity to discuss concerns and expectations, including providing information for families to keep and refer back to, if possible. The explanatory statement that accompanies the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* also lists applicable state and territory legislation and offers the names of organisations that may be able to provide further information.

Consultation findings

The lack of clarity around consent requirements and procedures was a common issue for consumers, providers and organisational stakeholders alike. Interestingly, no review participants discussed issues related to consent being withdrawn, or not being provided at all; there appeared to be an assumption that, if sought, consent to the use of restraint would be given and maintained.

There was however substantial uncertainty around requirements and procedures for seeking consent, for both physical and chemical restraint. This uncertainty was particularly evident in relation to the use of chemical consent, which was seen to be more complicated due to the number of parties involved.

All stakeholder groups raised questions about who is responsible for seeking consent, from whom, when and how often.

Improve clarity in providers' roles and responsibilities

Organisational stakeholders and providers highlighted the challenges associated with providers and prescribers both having responsibilities related to informed consent and providing the consumer and their representative with information about the use of chemical restraint.

Stakeholders recognised that the *Aged Care Act 1997* regulates the behaviours and responsibilities of approved aged care providers, and that prescriber practice is out of scope. However, they suggested that rather than simply noting that codes of professional practice 'provide for' prescribers to obtain informed consent before prescribing medications, the Restraints Principles need to explicitly state that the prescriber (not the aged care provider) is responsible for doing so. Provider staff reported that not all prescribers were willing to confirm or document consent, or understood how this affects providers.

There was also a sense that the involvement of prescribers does not necessarily ensure that appropriate consent procedures are followed. For example, though outside the remit of the Restraints Principles, consumer advocates were unclear on when and how prescribers were obtaining consent if the consumer was unable to consent for themselves, and the resident's

[4] The National Registration and Accreditation Scheme for health professionals is governed by the *Health Practitioner Regulation National Law,* a nationally consistent law passed by the Federal Parliament and each state and territory parliament. See https://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx for links to the respective national and jurisdictional Acts.

representative was not available when prescribers were visiting the aged care home.

In addition, organisational stakeholders were concerned that, while the Restraints Principles, note that prescribers are bound by codes of practice regarding consent for the **prescription** of medication for restraint purposes, they do not stipulate whether providers have a requirement to obtain consent prior to each **administration** of that medication. Differences in how consent requirements for physical and chemical restraint are worded were seen to contribute to confusion on this issue. Representatives of medical peak bodies acknowledged that, historically, medical practitioners have not always documented consent appropriately or communicated decisions to provider staff. They suggested that clearer guidelines and structured tools could help to clarify each party's responsibilities and ensure all steps in the consent process were completed.

Consent should be sought from residents themselves wherever possible

> Nothing in [the] Principles says it's about what the patients would want. Consider taking into account the values and wishes of individuals that are either documented or known. I think that is a high-level thing which is part of that consent process; at the moment we don't have that balance.
>
> *– Medical peak representative*

Consistent with broader calls for greater emphasis on person-centred care (outlined in Section 4.1), stakeholders noted that consent should be sought from the resident themselves wherever possible, and that the Restraints Principles should specify that substitute decision makers be considered a back-up rather than first point of contact.

Stakeholders also identified a need for clear guidance on how to assess capacity to consent, and how often that capacity should be reviewed. They recognised that capacity could be dynamic, and that while residents were unlikely to be able to consent to restraint at the time it was required, this did not prevent them from participating in care planning discussions and decisions ahead of time (analogous to advance care planning).

Where a substitute decision maker is required, staff face substantial challenges in understanding who has legal authority to fill this role

Some provider staff and several organisational stakeholders reflected on the challenges associated with ensuring that, if the resident is unable to consent for themselves, consent is obtained from the person with authority to provide it. Consumer advocates and public guardians noted that the term 'consumer representative' does not have legal standing, and commentary from many stakeholders suggests that both providers and family members default to a family member serving as the 'consumer representative', but that this is not always appropriate (legally or otherwise).

Advocates and guardians highlighted the burden on provider staff associated with understanding who has the legal authority to consent to restraint in light of 2 complicating factors:

- First, defining chemical restraint as medications that are **not** medical treatment has significant legal consequences; the person with authority to make decisions about the resident's medical care does not necessarily have authority to make decisions about chemical restraint. Advocates and guardians felt that providers would not necessarily be aware of this distinction, and needed additional guidance on these different guardianship roles.
- Second, public advocates and guardians held strong views (echoed by a range of other organisational stakeholders) that clause 15E of the Restraints Principles is insufficient in saying only that state and territory laws continue to apply. They considered that 'this does not underline the specific need to obtain consent for physical

and chemical restraint according to jurisdictional law', and there is a need to direct providers more explicitly to their obligations under those laws, and to provide practical guidance on how to apply the Restraints Principles in their jurisdiction.

Stakeholders expressed concern that, without such guidance, providers could demonstrate compliance with the Restraints Principles, but both they and the person from whom they sought consent could be open to liability at the state or territory level, if the consenting person did not have legal authority to make decisions about the use of restraint.

They noted that 'each state has different laws about who is the consumer representative' and that in some jurisdictions, different authorisation processes are required for different types of restraint (e.g. restraint involving physical force or deception).

Some stakeholders also noted that there are no checks and balances in place to ensure that providers are also compliant with state and territory laws.

> [In our jurisdiction] a power of attorney only has authority over financial and legal matters, there's no way they could approve restrictive practices. So if you're an aged care provider and you turn to the power of attorney – because that's who the Commonwealth legislation says can be a consumer representative – and get their consent, you'd probably appropriately put that on the file and put it in the cupboard, but aren't you potentially open to a claim? Because the reality is all you've done is comply with the regulatory regime required by the Commonwealth that regulates aged care services; that is not actually true consent.
>
> *– Public guardian*

Most public guardians and advocates were unsure as to how the appointment of a substitute decision maker would play out in their jurisdiction, highlighting the complexity faced by provider staff (and residents' families) in understanding who has authority to make decisions around the use of restraint.

All public guardians and advocates who participated in this review reported that at the time of our consultations, their jurisdiction was awaiting a 'test case' to explore the interplay between the Restraints Principles and their guardianship laws. However, it is worth noting that the issue of substitute decision makers was seen to be less pertinent in Queensland and Victoria due to the different approach to regulating restraint in those states (more closely aligned to a medical model).

Public advocates and guardians reflected on the potential for both over-correction and under-correction by providers unaware of these complexities. On one hand, there was substantial concern that the Restraints Principles would lead to a 'tsunami' of applications for guardianship where it was not required (e.g. where the resident was not subject to restraint, or in jurisdictions where alternative substitute decision makers are allowed by law). One family member had direct experience of such a scenario, telling the story of their provider lodging an application for guardianship despite the family requesting a tray table for reasons unrelated to restraint.

On the other hand, at the time of our consultations, public guardians reported that they had not been asked to provide consent for the residents under their guardianship to be restrained. As these guardians considered it likely that some residents had been restrained since 1 July 2019, they questioned whom providers were obtaining consent from. Feedback from some providers supported the advocates and guardians' position that providers would find it difficult to know who to turn to for consent.

There is substantial variation in when consent is sought, if at all

Providers and organisational stakeholders were unclear on when and how often consent should be sought and how often it should be re-established. They felt that the Restraints Principles were open to a range of different interpretations, resulting in consent variously being sought when first using restraint, at the time the prescription is written, at regular intervals (e.g. quarterly), immediately prior to every instance of restraint use, or only after the use of restraint (if restraint is used in an emergency).

This last scenario was a particular source of concern for organisational stakeholders. Many held the view that the provisions within the legislation for the use of restraint in an emergency could be interpreted to mean that consent is not essential prior to the use of restraint, and that informing the resident's representative 'as soon as practicable' afterwards is sufficient. This issue was raised in relation to both physical and chemical restraint.

Stakeholders noted that providers could interpret the term 'emergency' and the situations it applied it to differently. Consumer and provider peaks in particular identified that there are no checks and balances on what constitutes an emergency, and who is responsible for determining that consent need not be sought prior to its use.

Further, these groups desired greater clarity on provider responsibilities when informed consent cannot be obtained prior to restraint use, including acceptable timeframes for informing a resident's representative after the use of restraint in an emergency.

> It is still early in the piece, there is probably some additional scope to look at how the Principles could be operationalised in a way that would make them flow more smoothly, particularly around … what does 'emergency' mean.
>
> *– Provider peak representative*

Stakeholders' concerns that consent was not always sought was evident in feedback from consumers. Family members commented that not only were they not always asked to provide consent **prior** to restraint use, they were not always appropriately informed of its use **after** the fact. A common experience amongst both family members and public guardians was that they needed to be quite proactive and specifically request information in order to find out if restraint had been used. Others reported that providers involved them in a way they were not comfortable with and that potentially impacted their ability to provide truly informed (voluntary) consent: 'basically the provider had sprung a meeting on me. I attended the meeting but felt intimidated'.

On the other hand, some providers reported challenges in engaging families in consent discussions, for example where family members could not be contacted at the time restraint was required, did not understand the circumstances leading to the need for restraint or the provider's obligation to obtain consent, were uninterested in the resident's medication regime, or were unaware that the equipment or medication was considered restraint.

Similarly, providers and their peak bodies were uncertain of providers' consent obligations when families had requested the use of restraint (e.g. bed rails or medication) (see recommendation 1c). They noted that it could be confronting, frustrating, or confusing for families to be asked to sign off on equipment or medication they had requested or that the resident had used for some time, although, as one provider peak noted, 'it isn't necessarily a bad thing to do that because it ensures they [families] understand things'.

Resources are required to ensure consent is informed and appropriately documented

As well as calls for greater clarity on consent requirements within the Restraints Principles, we also heard that there is a need for resources to support greater transparency and documentation of consent procedures.

Family members and representatives did not feel they were provided with sufficient information to be able to provide informed consent. In particular, they wanted to know more about crucial topics such as the purpose of the restraint, the type of restraint being used and why that particular restraint was chosen over potential alternatives, how long the restraint would be used for, how the resident would be monitored while restrained, and possible side effects (for chemical restraint). Providers similarly indicated the challenges associated with ensuring residents and families had sufficient information to make an informed decision, with some reporting they had developed scripts to ensure staff felt confident having consent conversations, including the questions to ask when seeking informed consent, and how to answer common queries.

Families and providers alike emphasised the importance of written documentation, addressing both restraint use and the consent process itself. Families desired information they could refer back to and share with other members of the resident's support network. Providers commented that, at times, family members could forget what they had consented to and when, or were reluctant to engage in consent discussions. Thus, provider staff considered that informing family members of the consent process, obtaining written consent, and documenting all relevant conversations was important in protecting both residents and themselves. However, some reported that documentation of consent was often poor, and many aged care homes would not be able to demonstrate evidence of consent if required.

Discussion

The challenges associated with ensuring that informed consent is obtained in a way that protects both consumers and providers have been discussed at length in previous inquiries; the prominence of the issue in this Review is therefore not surprising. Of concern, and like many of those previous inquiries, we heard consumers report that consent is not always obtained, nor are residents' families always informed of its use after the fact (Human Rights Watch 2019, Royal Commission into Aged Care Quality and Safety 2019b).

In its interim report, the Royal Commission noted the that laws relating to informed consent are complex, differ across states and territories, and are poorly understood and applied in aged care (Royal Commission into Aged Care Quality and Safety 2019b).

Our findings were consistent with the Royal Commission's view that a key challenge is understanding who is able to provide consent for the use of restraint when the person requiring restraint does not have capacity to do so.

It has also been noted previously that lack of capacity should not be assumed (and, in fact, such an assumption is at odds with both law and good clinical practice), and that providers should be required to seek consent for restraint from the resident themselves where possible (Human Rights Watch 2019, Peisah & Skladzien 2014). This caveat notwithstanding, both the ALRC review (2017) and the Carnell–Paterson (2017) review concluded that any restrictive practice should be used only with consent from a person with appropriate legal authority. For an overview of substitute decision makers in each state and territory please see *Supplementary volume 1*.

Consistent with our consultations, the Parliamentary Joint Committee on Human Rights (the Joint Committee) heard that a resident's 'representative' as defined in the Restraints Principles may not have authority to make decisions about all aspects of a person's life, and that even where they can make decisions about one aspect (e.g. care and medical treatment), such authority may not extend to decisions about restraint.

This position was recently supported by the NSW Civil and Administrative Tribunal (NCAT), who determined that aged care providers who sought the consent of a 'consumer's representative' would comply with the Restraints Principles but not NSW law (*VZM* 2020).

Previous inquiries have also identified the lack of a clearly defined timeframe for informing a consumers' representative of the use of restraint (if prior informed consent is not able to be obtained) as a key issue. Prior to the introduction of the Restraints Principles, the House of Representatives Standing Committee on Health, Aged Care and Sport (House of Representatives Standing Committee) recommended that the *Aged Care Act 1997* be amended to legislate that consumers' representatives be informed **immediately** (Parliament of the Commonwealth of Australia 2018). Instead, as discussed above, the Restraints Principles require that representatives are informed 'as soon as practicable' – a term that was considered ambiguous by stakeholders who participated in the Department's public consultation on the Serious Incident Response Scheme (Department of Health 2019a).

Further, concerns have been raised that, although this clause applies only in *emergency situations for physical restraint*, the Restraints Principles could be interpreted to mean that it applies to *all uses of chemical restraint* (Peisah et al. 2019, Parliamentary Joint Committee on Human Rights 2019). As we heard from a number of organisational stakeholders, there is no explicit requirement that providers must obtain or confirm informed consent prior to the **administration** of chemical restraint, despite previous recommendations to this effect (Parliamentary Joint Committee on Human Rights 2019).

It is clear that the use of restraint in an emergency, and providers' responsibilities therein, are contentious issues that require greater clarity in both legislation and supporting resources. The NDIS Practice Standards (NDIS Quality and Safeguards Commission 2018) may provide a useful reference point. They state that each use of restraint in an emergency must be reviewed, and stipulate a number of indicators that providers must demonstrate to confirm that a review has occurred. Incorporating similar requirements in the Restraints Principles would serve to further safeguard against aged care consumers being repeatedly restrained without appropriate authorisation, and offer clarity for providers as to the steps required when restraint is used without consent in an emergency.

In addition, previous reports have identified a number of opportunities to strengthen the regulatory environment and protect residents' rights to free and informed consent, noting that consent practice should be improved beyond the requirements specified in the Restraints Principles (Peisah et al. 2019).

Human Rights Watch proposed options such as formalising consent procedures through requiring the use of a standardised consent protocol, introducing penalties for non-compliance, and implementing supported decision-making models (Human Rights Watch 2019).

Resources and initiatives

The Commission's *Guidance and Resources for Providers to support the Aged Care Quality Standards* provides examples of actions and evidence of appropriate consent procedures, including:

- Where physical or chemical restraint is in use, consumers or their representatives say they have given informed consent, consistent with state and territory law.
- The workforce can describe advance care planning and understand the substitute decision maker should be consulted in medical decisions including consent, refusal and/or withdrawal of treatment.
- Consumer representatives (including carers) say they are actively involved, with the consumer's consent, in the assessment, planning and review of care and services.
- Evidence of appropriate authorisation and consent for the use of restraint in compliance with legislation.

However, as far as we are aware, there are currently no resources available to assist provider staff understand their consent responsibilities under the Restraints Principles, nor are there resources to help them implement policies and procedures that can serve as

evidence that consent was appropriately sought and obtained. There is, however, some activity in this space, such as the work conducted by NCAT to develop plain language explanations of who has authority to consent to the use of restraint in NSW (NCAT 2019).

It is also worth noting the plethora of resources available to support informed consent practices in health and dementia care, such as:

- *Informed consent in healthcare* (Australian Commission on Safety and Quality in Health Care 2020)
- *Consent for psychotropic use in dementia: A guide for prescribers across Australia* (Empowered Project 2020)
- *Capacity & dementia: A guide for South Australian health care professionals* (ACCEPD 2013)
- *Informed consent* [information for consumers] (ACT Government 2020)

4.3 Improve consumer awareness of the Restraints Principles

Summary

- Consumer awareness of the Restraints Principles appears to be low.
- This lack of awareness may mean residents and their families do not look to the law when questioning whether the care they receive is appropriate and sanctioned.
- Providers may knowingly or unknowingly communicate in a way that prevents the resident or family member from realising that a particular practice constitutes restraint and, therefore, that the Restraints Principles apply.
- Stakeholders felt that providers are well-placed to educate residents and family members about the Restraints Principles, but also suggested a central, external source of advice and information is needed to help consumers exercise their rights.

Recommendation 3: Improve consumer awareness of the Restraints Principles

Changes to the Restraints Principles

No changes to the Restraints Principles are recommended.

Other changes

3a Develop consumer resources about the Restraints Principles with a focus on consumer rights. These resources should be easy to understand and available in different formats and languages.

3b Encourage aged care homes to disseminate these resources to residents and their family members, and support staff to proactively engage with residents and their families to discuss restraint.

Relevant aspects of the legislation

The **Restraints Principles** do not explicitly state that consumers need to be made aware of the legislation.

In Schedule 2 of the *Quality of Care Principles 2014*, **Quality Standard 2** outlines requirements for ongoing assessment and planning in partnership with the consumer.

The Charter includes specific provisions for consumers to be informed about their care and services in a way they understand; to have a person of their choice, including an aged care advocate support them or speak on their behalf.

Consultation findings

Stakeholders who participated in this Review felt that there is little to no consumer awareness of the Restraints Principles. Consumer peaks noted that limited empirical data on consumer awareness was available and, anecdotally, they had not received any questions about the legislation itself, nor had they seen a significant increase in enquiries about restraint since 1 July 2019.

They found the lack of consumer awareness to be unsurprising in light of poor awareness of resident rights more broadly, and a lack of awareness-raising activities specific to the Restraints Principles. However, they did perceive an increase in general awareness of the issue of restraint, largely due to media reports arising from the Royal Commission and Human Rights Watch activities.

Though a number of representatives noted that consumers could not be expected to know the specific details of any piece of legislation, one consumer peak organisation observed that the location of the Restraints Principles within the *Aged Care Act 1997* is particularly problematic. This individual noted that because the Restraints Principles are embedded within the Quality of Care Principles of the Act, they are not easily accessible to the average consumer, meaning that most people do not know the Restraints Principles exist.

> It would take a very proactive person or appointed substitute decision maker to know about them.
>
> *– Consumer peak representative*

Despite the low rates of community awareness perceived by stakeholders, a relatively high proportion of consumers who took part in the review indicated that they had previously been aware of the legislation (n=19; 58% of those who responded to this question). It is likely that this subgroup have a particular interest in the topic, which encouraged them to become informed, and, subsequently, to discover the review and decide to take part, suggesting that they are not a representative sample of the general population.

When this subgroup were asked about particular aspects of the legislation, they were most likely to be aware that 'Restraint can only be used after alternative strategies have been tried', and least likely to be aware that 'Medications prescribed to treat a diagnosed mental health condition are not considered chemical restraint'. This finding echoes the provider survey results, which suggests that more work needs to be done to educate staff and consumers on the distinction between chemical restraint and treatment of a mental health disorder.

Without awareness of the Restraints Principles, consumers may not be able to advocate for themselves

Consumer peaks noted that, generally speaking, residents and their families are very unlikely to reference legislative frameworks when questioning whether the care they are receiving is appropriate and sanctioned. Rather, people are more likely to go by their 'gut feeling' that something is not right. These stakeholders felt, however, that although a comprehensive understanding of legislation is not necessary, it is important for consumers to have at least a high-level awareness of their rights in order to invoke them. Without such awareness, there was a sense that providers could engage – unchecked – in practices inconsistent with the Restraints Principles.

Even where consumers are aware of their rights, consumer peaks reported that providers can knowingly or unknowingly communicate in a way that prevents the resident or family member from realising that a particular practice constitutes restraint and, therefore, that the Restraints Principles apply. Consumer peaks provided examples of aged care staff using terms such as 'sedatives' or indicating that the purpose of a medication is to 'help Mum be a bit more calm', rather than referring to chemical restraint.

Providers have an important - but not exclusive - role to play in educating consumers about restraint and the Restraints Principles

Stakeholders suggested that responsibility for educating consumers about the Restraints Principles most appropriately sits with providers, but, at present, providers are not typically taking this task on proactively or as matter of course; instead there is a sense that information is provided on a case-by-case basis, when the need for restraint arises.

Stakeholders called for education and awareness-raising activities to be conducted on-site, taking advantage of key touchpoints such as entry into residential aged care. They also highlighted the importance of ensuring information about restraint and the Restraints Principles is provided in a language and format (e.g. verbal, written, pictorial) that is appropriate and accessible to the consumer.

> You could make it a requirement that they [consumers] are given information about restraint at the same time they get information on the Standards and the Charter. A good provider will talk about their policies of restraint along with other policies.
>
> *– Consumer peak representative*

Developing a more proactive approach to educating residents and families about the Restraints Principles was seen as an important step forward. This would represent a significant shift from the status quo, in which the onus is on consumers to recognise that they need additional information, to know where to find it, and then to reach out to consumer peaks to get the information they need.

Further, some consumer peaks noted that their role in supporting family members tapers off once the person enters residential aged care and no longer needs informal support, thus reducing opportunities for consumers to seek information on restraint. Conversely, consumer advocates who were active in residential aged care considered it part of their role to facilitate awareness and understanding, and help consumers 'speak the language' to effectively invoke their rights[5].

In addition to an increased educational role for providers, one consumer suggested a need for a centralised service that residents or family can contact for further information or advice about restraint. This consumer noted that, in their experience, the Commission was a service to contact for complaints, but they were unsure where to turn for support to understand and advocate for their rights under the Restraints Principles. This emphasises the point above that many consumers are unaware of information available, or of the existence of organisations such as OPAN and their role in providing support. It suggests the need for further promotion of available resources within residential aged care homes.

Discussion

Our consultations with consumer advocates and peak bodies indicated that, despite increasing community awareness of the problem of restraint in residential aged care, awareness of the Restraints Principles amongst aged care residents and their families remains low. Moreover, we heard that there is poor awareness of consumer rights more generally, confirming the findings of previous inquiries (Carnell and Paterson 2017, Parliament of the Commonwealth of Australia 2018).

These previous inquiries have also raised the question of where responsibility for promoting consumer awareness lies. Carnell and Paterson (2017) suggested the (then still-to-be-established) Commission to lead the way in educating consumers about their rights and

[5] The Charter provides for the resident to have a person of their choice, including an aged care advocate, support them or speak on their behalf.

ensuring that they are supported to exercise them, including establishing a Consumer Commissioner.

The Aged Care Diversity Framework (Department of Health 2017) states that providers should offer information in an appropriate format and in a language the consumer understands. This position was reiterated in submissions to the House of Representatives Standing Committee (Parliament of the Commonwealth of Australia 2018). Participants in that inquiry noted the important role of advocacy organisations in educating aged care residents.

However, it is worth noting the gate-keeper role played by aged care providers in facilitating access to external information and support. For example, OPAN reported that they deliver information sessions to aged care residents on advocacy and rights, but that a large number of aged care homes decline the offer of a free consumer seminar (Parliament of the Commonwealth of Australia 2018).

Ultimately it is evident, through previous inquiries and this review, that responsibility for improving consumer awareness of the Restraints Principles is shared, and that more needs to be done to inform consumers of their rights in a way they understand.

Resources and initiatives

To the best of our knowledge there are currently no resources designed specifically to raise consumers' awareness and understanding of the Restraints Principles; however, OPAN recently conducted 2 education campaigns aiming to support consumers to understand their rights more broadly:

Medication: It's your choice. It's your right[6]

A 6-minute video and an accompanying brochure and booklet designed to empower older consumers to learn more about their medications and remain involved in decisions about their care.

These resources highlight the role of psychotropic medications in restraint and the consumer's right to expect their use to be closely monitored and regularly reviewed.

Understanding the new Charter of Aged Care Rights[7]

Includes a 6-minute explainer video available in 4 different languages, plus weblinks and a telephone number for further information, and 6 recorded webinars and community events.

6 https://opan.com.au/yourchoice/

7 https://opan.com.au/charter/

4.4 Clarify the definition of physical restraint

Summary

- Many stakeholders, and providers in particular, were confused about what constitutes physical restraint and felt a clearer definition is needed.
- There was strong support for more explicitly aligning the definition of physical restraint in aged care legislation with the definitions of restrictive practices set out in the NDIS Rules.
- Stakeholders believed there is an opportunity to consider what role 'intent to restrain', or the purpose of using restraint plays in determining whether a particular device or action would be considered physical restraint.
- Consultation findings are consistent with previous reviews and a recent NSW case law example, which recognised that the current definition of restraint is not sufficiently clear.

Recommendation 4: Clarify the definition of physical restraint

Changes to the Restraints Principles

4a Consider adopting the definition of the five types of restrictive practices described in the NDIS Rules (physical restraint, chemical restraint, mechanical restraint, environmental restraint and seclusion).

Other changes

4b Continue to develop supporting materials and education resources for providers, to build a clear understanding of physical restraint. This should include a library of examples and scenarios to clarify areas of confusion.

Relevant aspects of the legislation

Part 4A of the *Quality of Care Principles 2014* defines restraint as 'any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement.'

Physical restraint is defined as 'any restraint other than (a) a chemical restraint; or (b) the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.'

The explanatory statement to the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* expands on the definition, stating:

> Physical restraint includes but is not limited to: the intentional restriction of a consumer's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force; and limiting a consumer to a particular environment.

Consultation findings

The importance of clearly and consistently defining restraint came through strongly in all consultations. Stakeholders noted that providers' understanding of what does and does not constitute restraint is fundamental to their ability to adhere to the Restraints Principles across all aspects of the legislation.

The definition of physical restraint is vague and open to interpretation

Almost all respondents to the provider survey (91%) indicated that they have a good understanding of what physical restraint means. However, comments made in other parts of the survey, and consultations with other stakeholders, demonstrate that there is considerable ambiguity and uncertainty around the definition of physical restraint. For many providers, this created confusion and difficulty in adhering to the Restraints Principles in their day-to-day work. Further, some noted that Commission assessors appear to have differing interpretations of what constitutes physical restraint, and that data on physical restraint from the Quality Indicator Program is difficult to interpret due to variations in how restraint is 'counted'.

> There is no clear definition of what is and is not restraint.
>
> *– Provider focus group participant*

Participants in the Review identified a number of opportunities to clarify the definition of physical restraint. Stakeholders, including disability sector representatives, noted that the definition of physical restraint in the Restraints Principles is not sufficiently specific as it does not differentiate between physical, mechanical and environmental restraint and seclusion (unlike the NDIS Rules that do differentiate between these types of restraint).

Broadly, the disability sector's term and definition of 'restrictive practices' was considered to be more contemporary and consistent with terms and definitions used internationally.

> [The disability sector has] a more contemporary definition of restrictive practices. They're more defined, more discrete, not so loose, consistent with most international definitions. The definitions are tighter. Physical restraint definition in the Restraints Principles is messy – it covers environmental, mechanical restraint.
>
> *– Disability sector representative*

Allied health peak bodies noted that restricted access to objects, relationships or communication aids would be considered restrictive practices in the disability sector definition, but such aspects were not addressed in the Restraints Principles.

Providers also felt that it was unclear whether use of physical force in the course of routine care (for example to stabilise a person when attending to personal care or to prevent a fall) would constitute physical restraint. Stakeholders also noted that documents developed to support the Restraints Principles, such as the *Restraints scenarios*, do not provide enough examples to address some areas of confusion in relation to use of physical force.

The same practice, device or action can be considered restraint in some circumstances and not others

A number of stakeholders suggested there is a need to clarify the role of **intent** in determining whether a particular device or action constitutes physical restraint. While the legislation defines restraint as 'any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement', stakeholders felt there needed to be more focus on the reasons why a resident's movement might be restricted, or the **purpose** of restraint. Throughout our consultations, several examples were presented by providers and organisational stakeholders to illustrate this point, including:

- Applying wheelchair brakes so that a person has a stable base from which to stand up and walk
- A bed placed against a wall due to space restrictions in a small room (where one side is open to get out)
- A bed rail or lap belt for a person that is not ambulant, for safety
- Keypads for security.

Many providers believed that distinction between 'restraint devices' and 'intent to restrain' categories in the Quality Indicator Program has caused confusion, because the category of restraint devices does not include all possible items that could be used to prevent movement, and conversely, restraint devices may be used without the intention to restrain.

Further to this, providers were confused about how to apply the concept of 'least restrictive form of restraint' as described in the Restraints Principles. Providers gave examples of bed rails being replaced by wedges as a less restrictive alternative, the wedges in turn being replaced by pillows, and staff being unclear as to whether the use of pillows in this instance would be considered physical restraint.

Discussion

In relation to physical restraint, the findings of this review are, unsurprisingly, consistent with those of the Royal Commission. In its interim report, the Royal Commission highlighted the lack of consistent understanding within the aged care sector about what constitutes restraint, and the issues that this creates:

> A view of restrictive practices that focuses on restraint attached or adjacent to a person's body might fail to recognise other limitations on free movement, such as secured doors, as restrictive practices. Definitions of 'restrictive practices' used in legislation and guidance also vary. This creates issues with identifying, measuring and responding to the issue.
> (Royal Commission into Aged Care Quality and Safety 2019b, p 195)

In addition to the issues noted above, different definitions also vary in how easily they are interpreted and applied. The Restraints Principles take the view that the critical factor is the impact of a particular device or action has on the aged care resident; if it interferes with their ability to make a decision or restricts their free movement, it should be considered restraint regardless of the intentions of the person applying the restraint or their motivation for restricting the resident's free movement.

The importance of considering the impact of the device or action on the resident was highlighted in a recent NSW Civil and Administrative Tribunal (NCAT) hearing (*VZM* 2020). The hearing considered an application for guardianship by the husband of an aged care resident who, as a result of a stroke, required a high level of care 24 hours a day. The application for guardianship was made because the aged care facility had advised, in January 2020, that consent from an appointed guardian would be required in order for the resident to have bed rails in place to prevent her falling out of bed, even though bed rails had been used for the resident for many years. This advice was based on the aged care home's interpretation of the Restraints Principles.

NCAT dismissed the application for guardianship as it found that the use of bed rails in this case did not constitute a restrictive practice or a 'physical restraint' because they did not restrict the resident's free movement; rather, free movement was restricted by the resident's physical condition. However, the tribunal did acknowledge that the definitions of restraint in the Restraints Principles may not 'encapsulate all types of restrictive practices … and it may not easily encompass, for example, a restraint that restricts a person's access to items in the environment' (*VZM* 2020, p 15).

The findings from the hearing are consistent with feedback we received from stakeholders in this review, and concluded that definitions of physical restraint should be understood as 'part of a regulatory framework in which restraint is used to address what may be termed 'behaviours of concern' (*VZM* 2020, p 15).

Restraint definitions in the NDIS Rules

A number of stakeholders consulted as part of the review believe that the term 'restrictive practices', and its definition as set out in the NDIS Rules, are a viable alternative to the current definitions of restraint in the Restraints Principles. The NDIS Rules define the nature and purpose of 5 regulated restrictive practices, as follows:

- **Seclusion** – the sole confinement of a person with disability 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.
- **Chemical restraint** – the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
- **Mechanical restraint** – the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.
- **Physical restraint** – the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered as the exercise of care towards a person.
- **Environmental restraint** – restricts a person's free access to all parts of their environment, including items or activities.

Provider resources

A range of resources exist to support providers in understanding what constitutes physical restraint. Two key sources of guidance developed by the Commission include:

Perimeter restraint self-assessment tool

This tool addresses some core areas of confusion described above. In particular, it prompts aged care staff to consider the impact of clinical conditions on a resident's movement, and therefore, whether a practice should be considered a restraint for that person. It also prompts staff to consider whether restraint is necessary to prevent harm to the resident or someone else, and the different actions that may be required as a result.

Restraint scenarios

This resource provides a number of illustrative scenarios regarding the use of restraint. For each of the scenarios presented, a statement is made regarding whether the circumstances described do or do not constitute physical (or chemical) restraint. Our findings suggest that there is scope to expand this resource to include scenarios exploring some commonly cited areas of ambiguity (e.g. use of physical force).

4.5 Improve understanding of chemical restraint

Summary

- The definition of chemical restraint as set out in the Restraints Principles (particularly the distinction between medication for treatment of a mental disorder as opposed to the management of behaviour) is not well understood.
- Some providers mistakenly believe that the use of *any* psychotropic medication (regardless of its intended purpose) constitutes chemical restraint. This has reportedly resulted in residents missing out on necessary medical treatment.
- Commission resources, which focus on minimisation of psychotropic medications, are not well understood by providers. There is widespread uncertainty over whether all psychotropic medications should be recorded, or only those that are used for the purposes of chemical restraint.
- Providers expressed confusion about whether *pro ne rata* [PRN - as required]) and small doses of psychotropic medications are considered restraint.
- Providers reported that prescribers do not always clearly communicate or document the purpose of, or indications for, psychotropic medications. As a result, it is difficult for providers to determine whether the administration of certain medications constitutes chemical restraint.

Recommendation 5: Improve understanding of chemical restraint

Changes to the Restraints Principles

5a Consider adopting the definition of chemical restraint as described in the NDIS Rules.

Other changes

5b Develop resources to support understanding of the legislated definition of chemical restraint.

5c Encourage prescribers to document whether medication is being used for the purpose of restraint.

5d Clarify the purpose of the Aged Care Quality and Safety Commission (the Commission) self-assessment tool in supporting services to monitor and review the use of psychotropic medications and their use as chemical restraint.

5e Continue to offer and evaluate education initiatives that communicate the limited effectiveness of psychotropic medications in addressing behavioural and psychological symptoms of dementia (BPSD) and support the implementation of alternative strategies.

Relevant aspect of the legislation

The definition of chemical restraint is contained in **Part 1** (Definitions) of the *Quality of Care Principles 2014*:

> Chemical restraint means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

Section 15G 1a in Part 4A provides additional information, indicating that the medication does not need to *only* be for the purpose of restraint, stating that the medication prescribed 'is, or is involved in, the restraint'.

If psychotropic medications are used as chemical restraint, providers are required to inform the consumer's representative, document all relevant aspects of care (specified in **15G 2b**), and monitor the consumer for signs of distress or harm.

The explanatory statement to the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* expands on the definition, stating:

> Examples of pharmacological agents used as chemical restraint are antipsychotics and benzodiazepines. However, it is not chemical restraint if those medications are used to treat a diagnosed mental disorder (e.g. antipsychotics to treat psychosis associated with disorders such as schizophrenia or bipolar).

Consultation findings

The majority of respondents to the provider survey indicated that they have a good understanding of what chemical restraint means. However, comments from some staff and feedback received in consultations with other stakeholders suggest that some providers are unsure of, or are misinterpreting, what is, and what is not chemical restraint.

The distinction between medication as treatment and as chemical restraint is not well understood

Many stakeholders, including medical peak bodies, observed that some aged care staff do not realise that psychotropic medications constitute legitimate treatment for certain mental health disorders, and mistakenly believe that all psychotropic medications should be stopped in order to comply with the Restraints Principles. Aged care staff may not be in a position to comprehend important clinical nuances (for example, that a particular medicine might be therapeutic for one person, but constitute chemical restraint for someone else).

These stakeholders considered that the introduction of the legislation has therefore had the unintended consequence of triggering the withdrawal or avoidance of psychotropic medications for therapeutic purposes, including, in some instances, medications that individuals had been taking well before entering residential aged care and that remained appropriate to their needs.

> I'm not suggesting that chemical restraint isn't occurring but suggesting that, in the current blanket approach of the terminology, individuals are now not getting appropriate and very planned (by a very trained individual) medication that they need to treat their mental health issues.
>
> *– Medical peak representative*

Stakeholder opinions were supported by results of the provider survey, with almost one quarter of staff (22%; n=518) – across a variety of staff types and organisation sizes – responding that they were not aware, or were unsure, that under the Restraints Principles, medication prescribed for the treatment of a diagnosed mental illness is not considered restraint.

A number of stakeholders felt that resources developed by the Commission further add to the confusion. Most supporting resources from the Commission aim to minimise use of psychotropic medications (rather than chemical restraint specifically), yet at the same time encourage providers to follow the steps required under the Restraints Principles where chemical restraint is used.

For example, the Commission's *self-assessment tool for recording consumers receiving psychotropic medications* has fields to record **all** psychotropic medications used in the aged care home (regardless of purpose). It requires providers to demonstrate they are complying with the Restraints Principles, such as noting that 'alternatives to restraint' have been considered, and that the consumer's representative was 'informed prior to restraint use'. Stakeholders felt that the self-assessment tool therefore does not support providers to differentiate between the use of psychotropic medications for therapeutic reasons as opposed to chemical restraint.

[It has been a] chaotic process of the introduction and subtle changes to the Principles, followed by introduction of self-assessment tools which were non-specific, followed by the trial of a mandatory reporting tool (which was different again) with no strong defined guidelines, just a series of suggestions which are being interpreted differently.

– Head office manager or CEO

Provider staff do not have sufficient information to understand whether a prescribed medication constitutes chemical restraint

Even where providers are aware of the distinction between medical treatment and restraint as defined in the Restraints Principles, they face the additional challenge of applying this knowledge in practice. Provider staff who participated in this review indicated that they want more clarity on medications that may be deemed chemical restraint (e.g. 'is melatonin a chemical restraint?') and also clarity around what diagnoses are indications for which medications.

Feedback from numerous providers demonstrated that they are confused over where the line between 'treating a diagnosed mental disorder' and 'influencing a person's behaviour' lies. For example, many are unsure whether using medication to manage behavioural and psychological symptoms of dementia (BPSD) would be considered restraint, given that this occurs in the context of a dementia diagnosis but is targeting specific behaviours (e.g. agitation). Stakeholder feedback also suggested that providers may not be aware of the limited effectiveness of psychotropic medications in managing BPSD.

There is no clarity from the Commission or other sources regarding BPSD – is it a valid indicator for use of psychotropic medications (e.g. risperidone) PRN? It is indicated for risperidone but this contradicts the restraint guidelines (using a medication to alter behaviour).

– Head office manager or CEO

Talking to colleagues, there is confusion around, for example, someone prescribed PRN risperidone. I thought [it] would be chemical restraint but I'm being told if you have a diagnosis it's not, but this drug is not prescribed for dementia but to calm agitation.

– Clinical compliance manager

Ongoing issues with identifying the use of chemical restraint for symptom management as opposed to treating a disease.

– On-site manager

The current definition of chemical restraint does not require the medication to be clinically indicated for the diagnosis specified, which some stakeholders felt was a loophole.

Similarly, providers and pharmacy peaks indicated a need for prescribers to clearly and comprehensively document the purpose of each medication they prescribe. Providers indicated that they often do not have the information they need from prescribers to identify whether administration of a medicine constitutes chemical restraint. Therefore, some providers felt they were put in the position of needing to determine a resident's diagnosis, and whether the medication may constitute chemical restraint. Many stakeholders did not consider it the providers' role to question the prescriber's clinical judgement.

> The responsibilities should be on doctors who prescribed medication for chemical restraint to specify it as restraint. It shouldn't be left on [the] nursing home to determine if there is a diagnosis to support the medication.
>
> *– On-site manager*

Staff are confused about the relationship between PRN and low-dose medications and chemical restraint

The use of PRN psychotropic medications represent a particular point of confusion when differentiating between medical treatment and chemical restraint.

Comments from respondents to the provider survey revealed that some staff believe that any psychotropic medication prescribed for PRN use constitutes chemical restraint, regardless of whether or not the resident had a current diagnosis for which the medication is indicated.

Several comments also suggested that some providers consider that administration of only a small dose of medication, which does not sedate the resident, does not constitute chemical restraint. This interpretation was also raised in a case study of a complaint provided for this review by the Office of the Public Guardian, Qld, in which the clinical manager involved interpreted chemical restraint as medication that is so sedating that it prevents the person from walking.

Discussion

This review has identified a clear need to support providers to understand the distinction between medication for treatment and medication for restraint. Further educational strategies should be put in place to help providers understand that chemical restraint applies to medication used for behaviour management, not for therapeutic or medical care of older people with mental illness, who may benefit from psychotropic medications.

As emphasised by Peisah et al (2019), providers should also understand that, while the legislation applies to chemical restraint, residents with mental illness (taking medication for therapeutic reasons) are entitled to the same standards of care (including minimisation of chemical restraint, using person-centred assessment and alternatives to restraint) as those residents for whom protection against chemical restraint is being sought.

Furthermore, responses to this review indicate that some providers may misinterpret the legislation, and not understand that using psychotropic medications for behaviour management of people with dementia or mental disorders can still constitute restraint – a concern also raised by Peisah et al (2019). On a simple reading of the legislation, providers may miss the few words that indicate that if the medication prescribed 'is, *or is involved in*, the restraint', it falls under the umbrella of chemical restraint and is subject to regulation under the Restraints Principles. This is an important point and should be emphasised to prescribers and providers in educational strategies.

Existing guidelines may not be consistent with the legislation on this matter and could add to the confusion. For example, the AMA's position paper on *Restraint in the care of peoples in residential aged care facilities – 2015*, states that:

> Psychotropic drugs may have an important role in the reduction of distressing symptoms and the specific treatment of medical conditions such as delirium, anxiety, depression, psychosis and behavioural and psychological symptoms of dementia (BPSD). Use of these drugs in such a context does not constitute restraint and they should not be withheld. (Australian Medical Association 2015)

Clearly, while the Restraints Principles regulate **provider** practice, there is also a need to support **prescribers** to understand and apply the legislation. Doing so has the dual benefits of facilitating appropriate prescribing and further supporting provider understanding and compliance.

There is an implicit expectation in the Restraints Principles that prescribers will understand whether the medication they are prescribing is for the purpose of chemical restraint, and will document this and advise providers accordingly. However, our findings suggest that this does not always occur in practice.

It is perhaps not surprising that providers have difficulty interpreting whether or not a medication constitutes restraint, given the well-recognised complexity associated with unpacking the varied reasons for prescribing and the multitude of mental health conditions for which psychotropic medications may be appropriate (Royal Commission into Aged Care Quality and Safety 2019b). The following excerpt from the Royal Commission's interim report illustrates this complexity:

> There are specific challenges defining 'chemical restraint'. Particular medicines can restrict people's movements or ability to make decisions. Psychotropic medications affect the mind, emotions and behaviours of a person. Within the broad cluster of such medications, the ones most commonly used to provide chemical restraint in aged care are antipsychotics (often referred to as tranquilisers) and benzodiazepines (minor tranquilisers or sleeping pills). At the Sydney Hearing, Scientia Professor at the Centre for Healthy Brain Ageing at the University of New South Wales, Professor Henry Brodaty AO, explained the distinction between using medication for treating psychotic symptoms, such as delusions or hallucinations, and restraining a person through sedation. In his view, the boundary between treatment for an illness and restraint can become blurred, which makes defining 'chemical restraint' difficult. The Australian Commission on Safety and Quality in Health Care contends that there is a lack of consensus on the definition of chemical restraint because of the difficulties in determining whether a clinician's intent is primarily to treat a person's symptoms or to control their behaviour. (p 195)

The Counsel Assisting the Royal Commission has recommended that only a psychiatrist or a geriatrician should initially prescribe antipsychotics (Royal Commission into Aged Care Quality and Safety 2020b). Drawing on the expertise of these specialists could reduce the current burden on GPs and providers to distinguish between chemical restraint and medical treatment, and this recommendation is likely to be welcomed by providers who perceived specialist input to have significant benefits for residents and staff alike. Of note, however, this review also heard that access to geriatricians is difficult in regional or rural areas.

Resources and initiatives

Stakeholders highlighted the need for a greater understanding of psychotropic medications in general. This need has also been recognised by the Commission who have developed several resources since the Restraints Principles came into effect. For example:

- *Psychotropic medications used in Australia - information for aged care*, is the key resource from the Commission, aimed at increasing knowledge of the main classes of psychotropic medications and their role in dementia care (Aged Care Quality and Safety Commission 2020b).
- The Commission's *self-assessment tool for recording consumers receiving psychotropic medications* aims to help providers record how their use of chemical restraints is managed (although this tool is the source of some confusion, as described above).

The findings of this review suggest that both of these resources should be reviewed to determine how they can support providers to understand whether or not a particular medication constitutes chemical restraint for individual residents under their care.

Other resources include:

- Guiding principles for medication management in residential aged care facilities available on the Department's website

- Residential Medication Management Review (RMMR) Program and the Quality Use of Medicines Program (QUM)
- The pharmacy unit within the Commission
- The NPS MedicineWise multifaceted industry education program for general practitioners and residential aged care services. The NPS MedicineWise website contains information on insights, resources, webinars, research and references on dementia and psychotropic medicines.

4.6 Clarify responsibilities for minimising, monitoring and reviewing chemical restraint

Summary

- Because the Restraints Principles do not regulate the actions of prescribers, many providers feel they are unfairly held accountable for prescriber decisions to choose psychotropic medications for the purposes of chemical restraint.
- Many providers felt that GPs are continuing to over-prescribe psychotropic medications.
- Providers argued that prescribers do not fully understand the requirements that providers must fulfil in relation to documenting chemical restraint.
- Many provider staff do not have a clear understanding of what needs to be monitored when using chemical restraint, including how often and for how long.
- Monitoring for distress or harm is considered insufficient for chemical restraint, and stakeholders believe that the need to assess several other factors, such as changes in mood and food intake, should be specified in the legislation.
- A major barrier to effective review of residents subject to chemical restraint is the short amount of time that many GPs spend at the aged care home.
- Stakeholders believe review of chemical restraint should also include a re-test of alternatives to restraint.
- Providers have also requested guidance on timeframes for review.
- Other stakeholders suggested providers need advice on how to manage symptoms that could arise if medications are reduced or ceased.

Recommendation 6: Clarify responsibilities for minimising, monitoring and reviewing chemical restraint

Changes to the Restraints Principles

6a Expand requirements for providers to monitor other measures of consumer safety and wellbeing, in addition to distress and harm.

Other changes

In addition to the suggested legislative change, we recommend that the Department and Commission, in consultation with provider peak bodies:

6b Identify and promote clinical guidelines for monitoring and reviewing psychotropic medications, and explain the circumstances where closer monitoring is required.

6c Support mechanisms that promote collaborative approaches to medication review.

6d Work with relevant stakeholders in other sectors to improve the interface between aged care providers and prescribers to support minimisation of chemical restraint.

Relevant aspect of the legislation

For chemical restraint, the Restraints Principles state that a medical practitioner or nurse practitioner must assess the resident as requiring the restraint. Section **15G 2c** of the legislation further stipulates that while the resident is subject to chemical restraint they must be monitored for signs of distress or harm.

The explanatory statement accompanying the *Quality of Care Amendment (Minimising the use of Restraints) Principles 2019* provides the following information regarding monitoring and review:

> The provider must also provide information to the practitioner regarding use of the restraint. This review process aims to trigger reassessment of the need for the use of restraint by the practitioner and, where possible, to implement alternatives to using restraint.

Consultation findings

It is unclear where responsibility for minimising chemical restraint lies

Stakeholders highlighted the complexity of minimising chemical restraint, noting that this was in part due to the multiple parties involved – such as GPs, specialists and nurses, all potentially working across different settings.

Many providers felt that GPs and other medical practitioners (e.g. geriatricians, hospital-based clinicians) may too readily prescribe medications that could be considered restraint within the residential aged care setting, despite providers' desire to minimise restraint use.

> GPs still prescribe, families still request. Hasn't changed resident outcomes but created huge workload for staff, who complete paperwork for GPs, to remain compliant.
>
> *– Quality and clinical governance representative*

> GPs over-prescribe psychotropic medication, as does the acute hospital sector. Residential care providers are left with the workload as a result – consent, chasing indications for use, dealing with the associated side effects and watching poor outcomes occur for our residents at times.
>
> *– Head office manager*

Many providers expressed concern that decisions made by prescribers reflected badly on them and affected their accreditation. In one example, a provider reported being advised by Commission assessors that they (the provider) were responsible for ensuring GPs' compliance with documenting chemical restraint. The provider reported they were subsequently penalised for not meeting that requirement, despite the GP refusing to comply and discuss the matter with the Commission.

Providers argued that because medical and nurse practitioners are responsible for prescribing psychotropic medications, they should also take primary responsibility for minimising their use. However, stakeholders (including providers) acknowledged that provider staff also have a role to play, as they can administer PRN medications at their discretion and, at times, do so as a first-line strategy to manage behaviours of concern.

Furthermore, consumer advocates noted that there is still the perception that prescribers will provide the medications that providers ask for. This highlights the need and opportunity to minimise – or at least, reduce – the use of restraint by attempting to address behaviours of concern through alternative strategies before contacting the medical or nurse practitioner.

Prescribers' documentation of chemical restraint is not always clear or comprehensive

Many providers reported that GPs are not willing to engage with them to reduce chemical restraint, or provide the relevant documentation for residents who have been prescribed psychotropic medication.

Medical representatives acknowledged that, historically, medical practitioners have not always worked collaboratively with other staff in aged care – they have not explained why they prescribe certain medications, or paid enough attention to the necessary documentation (including consent), or clearly documented risks associated with taking medicines.

Further, many providers suggested that medical practitioners were unaware of the requirements of the Restraints Principles, or the information and documentation that providers need to fulfil their obligations under the legislation.

> I don't think the legislation needs to change. I think it's a good improvement and I think it links well with the Quality Standards. But I think … they are targeting the wrong people in a way. GPs do know about it because they have their own support systems, but I still think GPs lack understanding of what's actually required.
>
> *– Provider focus group participant*

> Prescribers do not seem to have consistent understanding of the Restraints Principles, so maybe there hasn't been much education/support at that level?
>
> *– Medication management service provider*

Stakeholders suggested that there could be benefit in engaging prescribers in a conversation about the different roles in and responsibilities for minimising the use of chemical restraint, and exploring options to support a more team-based approach to monitoring and reviewing use of restraint.

Providers reporting a reduction in use of chemical restraint noted that a close working relationship with medical practitioners and a shared understanding of the Restraints Principles has supported change.

> We have worked closely with [our visiting medical officers] in developing their understanding and support for the chemical restraint laws and guidelines we need to abide by. We have established a robust monitoring and review schedule for residents on psychotropic medications which has facilitated the ceasing of a significant number of long-term psychotropics.
>
> *– On-site manager*

Staff need structure and guidance to support appropriate monitoring when chemical restraint is used

Although providers reported that monitoring consumers is an established part of practice, many stakeholders highlighted that there is potential to improve the way in which monitoring occurs. These stakeholders suggested that the Restraints Principles require more clarity in terms of monitoring requirements, including what needs to be monitored, how often, for how long, and by whom.

What should be monitored?

Stakeholders noted that, while the Restraints Principles require residents to be monitored for distress or harm, there are other factors that should be monitored, including:[8]

- Effectiveness (is the medication working?)
- Changes in mood or behaviour (e.g. engagement and socialisation with others)
- Changes in circumstances (e.g. change to other medication)
- Food intake
- Other needs (e.g. bathroom, thirst).

Further, providers noted that monitoring would also need to examine the effect of changing the restraint itself (e.g. changes in medication dose). They also suggested that an ideal monitoring process would also include re-testing alternative strategies. The current lack of detail in the legislation or reference to good practice guidelines was seen to result in variable monitoring in practice.

> The reason why people are concerned – and rightly so – is the cases where [a resident] became terribly depressed or stopped eating, or had falls and other consequences and adverse reactions. So [it is important to] have some quite good guiding principles … if commencing on these medications, these are the things you need to monitor. Just so there's a bit of uniformity and, for those who aren't sure what to do, to have some best practice around it.
>
> *– Provider focus group participant*

The roles and capabilities of different staff in relation to monitoring chemical restraint were also raised. Provider management commented that personal care workers play an important role because they have the most contact with residents. However, they suggested personal care workers need more training to understand the side effects of medications (e.g. if they observe someone sleeping a lot, it may indicate over-sedation).

How often and for how long should residents be monitored?

Providers reported that medications, including chemical restraint, are generally reviewed at the time of admission into an aged care home. However, after this initial review, the frequency and quality of restraint reviews by prescribers was variable across facilities.

Many providers desired greater clarity on how frequently they should monitor chemical restraint, and how this related to duration of medication (e.g. how frequently a resident's prescription of risperidone should be monitored during a 3-month period), the dose, and the intensity of its effect.

> There's nothing in the act that says a time period, it just says regularly monitor them … If they are going to judge you by [your compliance with the Restraints Principles, they] need to have prescriptive things in there. Everyone's idea of regularly checking could be different.
>
> *– Provider focus group participant*

Stakeholders suggested that the Restraints Principles should be aligned with clinical practice guidelines in relation to frequency and duration of monitoring. However, one provider suggested that recommendations on frequency and duration should be included in supporting documentation or resources, rather than the legislation itself, in recognition of the difficulties in stipulating guidelines that would be appropriate for every situation of chemical (and physical) restraint, and the timeframes involved in changing the legislation as evidence and practice evolves.

[8] The Restraints Principles do provide direction on what should be monitored for **physical** restraint – including 'the comfort and safety of the consumer through maintaining activities of daily living including; regular toileting, hydration, nutrition, exercise and mobility, skin care, pain relief, and social interaction'.

There are promising signs of a cultural shift towards regular review of chemical restraint

Many stakeholders, including providers, pointed to the small amount of time that many GPs spend with residents as a barrier to effective review. They also noted that GPs may not always respond to provider requests for more frequent reviews. There were also reports that GPs may not see residents in-person when they are renewing prescriptions. As noted earlier, providers felt that their ability to influence prescriber behaviour was limited.

> The GPs come in and write 'medication review, no changes', that is their whole documentation and that is supposed to be a whole review of medication. The prescription is given for 12 weeks and then it says at 6 weeks you should be reviewing it to [aim for] reduction. No GP does that.
>
> *– Provider focus group participant*

Although providers are not responsible for medication reviews under the legislation, they expressed interest in being more involved in this activity. Providers commented that GPs often complete the review process on their own; however, there is value in having nurses involved because they are the people who assess behaviour and request, monitor and administer psychotropic medication. Documenting planned review dates at the time of prescription was seen as a useful strategy to ensure all people involved in a resident's care know when a review is due and can follow up on it.

Some providers reported an increase in reviews by DBMAS, geriatricians and pharmacists since the Restraints Principles were introduced. Although the impact on resident wellbeing is unknown, providers noted their involvement as a positive change.

A medication management service provider reported that medication reviews they did for medicines that they define as high-risk increased from between 2 and 6 per cent of medication reviews (before the Quality Standards and the Restraints Principles) to between 16 and 27 per cent (after their introduction).

This increase demonstrates an improved focus on psychotropic medications; however, they also reported that some providers are reluctant to review and/or cease these medications due to concern that the symptoms they were prescribed for will return. They suggested that there needs to be more education for families and staff about what to expect if medication is reduced or ceased, which may avoid such instances of concern.

Discussion

This review has highlighted that the responsibility for minimising restraint is shared between providers and prescribers, but that the roles of each stakeholder group remain unclear.

A criticism of the Restraints Principles is that they will not reduce the inappropriate use of psychotropic medications because they do not regulate the behaviour of prescribing medical practitioners (Royal Commission into Aged Care Quality and Safety 2019a). This viewpoint was supported by providers contributing to this review, who felt somewhat disempowered by the fact that they were expected to minimise the use of chemical restraint despite the fact that prescribing practices were out of their hands.

However, there have been several recent initiatives have, directed at prescribers, with the aim of influencing prescribing of psychotropic medications:

- Changes to the PBS rules for risperidone, requiring prescribers to request authority approval to prescribe 'continuing' PBS subsidised risperidone beyond the initial 12-week treatment (Department of Health 2019b)
- The infographic resource *Six Steps for Safe Prescribing Antipsychotics and Benzodiazepines in Residential Aged Care* (Department of Health 2020d).

- The Chief Medical Officer wrote to 28,500 health practitioners who were identified as prescribing PBS medications to residential aged care recipients to highlight concern over the use of psychotropic medications to manage BPSD in residential aged care homes.
- The NPS MedicineWise multifaceted industry education program for general practitioners and residential aged care services.

Tighter controls around prescribing, for instance the proposed recommendation by the Counsel Assisting the Royal Commission that only a psychiatrist or a geriatrician should initially prescribe antipsychotics, could help to alleviate the issues around inappropriate prescribing (Royal Commission into Aged Care Quality and Safety 2020b).

This review found that, although review of chemical restraint is not the legislated responsibility of providers, minimisation of restraint could be facilitated by increased collaboration with a multidisciplinary team. Guidelines recommend that review of restraint should involve a medical practitioner, the resident (or representative), a registered nurse, and an accredited pharmacist (Department of Health and Ageing 2012). Existing research suggests this is a valid approach; for example, the RedUSe study, which aimed to reduce psychotropic medications use in aged care homes, found that an interdisciplinary review (GP, pharmacist and nurse) at 3 months contributed to a reduction in use of antipsychotics (Westbury et al. 2018).

A number of approaches to promoting collaborative and multidisciplinary approaches to reviewing the use of chemical restraint are currently being explored. One such approach is a model of embedded pharmacists now being trialled in all aged care homes in the ACT. The trial commenced in February 2020 and is expected to finish in December 2021 (Department of Health 2020f).

Another initiative is the Commission's pharmacist project, where pharmacists visit services that request the RedUSe training and a range of other pharmacist education (Aged Care Quality and Safety Commission 2020c).

The need for collaborative prescribing arrangements was also raised by the Royal Commission (Royal Commission into Aged Care Quality and Safety 2019b) and previous research (Disalvo et al. 2019). In response, Residential Medication Management Review programme funding is now available for 2 follow-up services with the resident and the medical practitioner if required.

The involvement of pharmacists could also be strengthened under a proposed recommendation for increased access to medication management reviews by the Counsel Assisting the Royal Commission (Royal Commission into Aged Care Quality and Safety 2020b).

4.7 Emphasise the importance of comprehensive assessment

Summary

- Stakeholders recognise that assessment is required before using restraint, but many suggest that the Restraints Principles are not explicit that a comprehensive care planning assessment is necessary.
- Although multidisciplinary or team-based approaches to assessment are seen to support delivery of person-centred care (and therefore minimisation of restraint), allied health staff are perceived to be underutilised in assessment and planning.
- Stakeholders believe that the specific components of a comprehensive assessment should not be addressed in the legislation itself (due to varied needs and circumstances of residents, and changes in emerging evidence) but may be more appropriately addressed through clinical guidelines.
- The Restraints Principles regulate providers, not prescribers, and as such cannot regulate the way prescribers assess the need for restraint.

Recommendation 7: Emphasise the importance of comprehensive assessment

Changes to the Restraints Principles

7a Amend the Restraints Principles to state that an assessment for care planning and development of a behaviour support plan is required before using physical restraint, except in an emergency.

7b Broaden the list of who is able to undertake an assessment of the need for physical restraint to include other staff with relevant skills and competencies, in addition to medical practitioners, nurse practitioners and registered nurses.

Other changes

7c Consider strategies to support multidisciplinary assessment, including involvement of mental health specialists and geriatricians.

Relevant aspect of the legislation

The Restraints Principles require that physical restraint must not be used unless an approved health practitioner (medical practitioner, nurse practitioner, registered nurse), who has day-to-day knowledge of the consumer, has assessed the consumer as posing a risk of harm to themselves or any other person, and as requiring the restraint (**15F 1a[i]**).

Assessment for chemical restraint must be carried out by a medical practitioner or nurse practitioner; however, there is no requirement to have day-to-day knowledge of the consumer and the consumer does not need to pose a risk of harm to themselves or others (**15G 1a**).

The requirements for physical and chemical restraint differ because the Restraints Principles regulate providers and cannot regulate medical practitioners, who may undertake assessment and prescription of medicine independently of the provider.

The explanatory statement that accompanied the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* provides more clarity around what is expected of providers. It refers providers to the *Decision-Making Tool: Supporting a restraint free environment in residential aged care* (Decision Making Tool) (Department of Health and Ageing 2012), which states that the use of restraint should be informed by a comprehensive assessment of a consumer and their interactions (p 22).

Quality Standard 2 outlines requirements for ongoing assessment and planning with consumers, with providers required to demonstrate that these activities include:

- Consideration of risks to the individual's health and wellbeing, and inform the delivery of safe and effective care (3a)
- Organisations, individuals, and providers of other care and services that are involved in the consumer's care (3c[ii]).

Consultation findings

Almost all provider staff who responded to the survey were aware that assessment must occur prior to using restraint, with awareness slightly higher for chemical restraint compared to physical restraint.

Although providers reported that they have established processes for assessment, stakeholders raised concerns that the requirement for a comprehensive assessment was not always met. Allied health peak bodies and a medical expert commented that the legislation does not clearly describe what is meant by assessment. The lack of definition means that it is easy to default to restraint without a full consideration of the person's needs and strategies to address these, while still complying with the legislation.

> There is no definition of the minimum standard for assessment prior to commencing restraint and there is no definition or criteria around the last resort.
>
> *– Medical expert*

> When considering the use of a restraint, there should be evidence of multidisciplinary assessments (inclusive of allied health) into possible triggers for the need for restraint, for example pain … These assessments should be evidenced based and in line with what is considered 'best practice'.
>
> *– Allied health peak representative*

Though stakeholders called for the legislation to clarify that the assessment should be **comprehensive**, they felt that the specific **components** of a comprehensive assessment should not be addressed in the legislation itself (due to varied needs and circumstances of residents and changes in emerging evidence) but may be more appropriately addressed through clinical guidelines.

The benefits of comprehensive assessment are widely recognised and providers are increasingly engaging specialist input

Allied health professionals contributing to the review highlighted the benefits of a comprehensive assessment prior to making decisions about restraint. They argued that assessment enables consideration of interventions that address unmet needs, and therefore may prevent the perceived need to use chemical or physical restraint as a reaction to behaviours of concern. Examples of such intervention included use of physiotherapy to address pain (instead of addressing the expressed behaviour with chemical restraint), or to develop strength to prevent falls (rather than using physical restraint), and music therapy or diversional therapy to prevent behaviours of concern.

Allied health representatives further noted that, in addition to determining triggers for behaviours of concern, assessment is also important for establishing resident goals and providing enabling strategies for maximising function and quality of life, including meaningful participation in day-to-day tasks.

More broadly, allied health peak bodies were consistent in their calls for a more prominent role in assessment, pointing to a range of promising models including residential in-reach. The review Advisory Group suggested that the list of health professionals with the relevant skills and competencies to undertake assessment for physical restraint could be broadened in the legislation.

The potential for geriatricians and psychiatrists to support proactive assessment of residents was also recognised by medical peak bodies and providers. Medical peak bodies felt this specialist expertise should be available as a matter of course, and not only as a last resort. Several providers commented on the benefits of engaging a geriatrician.

> The geriatrician has been a HUGE success. Accessing good GPs to support aged care is highly challenging!
>
> *– On-site manager*

Some stakeholders suggested that, since the Restraints Principles were introduced, care plans show evidence of more thorough assessment through, for example, documentation of triggers for restraint. There were also some reports suggesting that the use of DBMAS and involvement of psychologists and other allied health staff has increased,[9] suggesting that providers are more frequently seeking expert input in assessing and making decisions about care. However most stakeholders were of the opinion that such assessments were occurring on an ad-hoc basis.

Barriers to comprehensive assessment exist at the individual, organisation, and system level

Although the benefits of comprehensive assessment were widely acknowledged, a number of barriers were also discussed. Key among these was staffing. For example, providers noted that care workers may not recognise BPSD (mistaking it for delirium) or may not identify untreated pain as a potential trigger for behaviours of concern. This finding indicates there is huge pressure on a relatively unskilled workforce to respond to behaviours of concern in a clinically appropriate manner, in the absence of assessment by more highly qualified staff.

Further, interpretation of 'last resort' was seen to differ according to the number and skills of the staff available, as well as their relationship to the resident in question, and the emotional charge of the situation. Providers also mentioned that assessment may not occur at times when there is minimal staff, such as at night.

Other barriers to effective assessment included:

- **Lack of awareness of the requirement for comprehensive assessment:** Assessment may not occur when physical restraint has been requested by residents or family members, due to the belief that consumer choice overrides the need for assessment. Similarly, survey respondents frequently used the term 'risk assessment' and did not make reference to comprehensive assessment. This finding may reflect the focus on harm in the legislation, which stipulates that physical restraint must not be used unless a qualified health professional has assessed the consumer as 'posing a risk of harm'.[10]
- **Lack of knowledge of the resident:** We heard reports of doctors and nurses working in professional silos, without consulting other staff members to consider alternatives to restraint. A medical peak body reported that GPs may not spend enough time getting to know residents, which can inhibit full exploration of alternatives to restraint (this was noted to be a particular issue for GPs who did not act as the individual's doctor before they moved into aged care).
- **Funding arrangements:** Some stakeholders indicated that the current funding arrangements disincentivise comprehensive assessment and management, because improvements in the resident's functioning may result in reduced funding for the aged care home.

[9] Although DBMAS have observed increased enquiries about restraint, a report from DSA for this review indicates that the COVID-19 pandemic has impacted the capacity of staff to proactively seek advice during mid-to late 2020.

[10] Review of Commission non-compliance data found a number of instances of non-compliance relating to failure to conduct a risk assessment prior to the use of restraint.

Discussion

Our findings suggest that providers are aware of the requirement to assess residents prior to the use of restraint, and that assessments are generally undertaken; however, they may not be sufficiently thorough or frequent.

The Quality Standards specify that assessment and planning is an ongoing process that includes consideration of risks (including restraint) to the consumer's health and wellbeing and informs the delivery of safe and effective care and services. More guidance about when and what is involved in a comprehensive assessment is available in the Decision-Making Tool, which states that a comprehensive assessment should occur at entry into residential aged care, at regular review, and 'whenever there is any change in the functioning, situation or behaviour of a resident'. The tool specifies that a comprehensive assessment involves considering physical, functional, psycho-social and environmental triggers (Department of Health and Ageing 2012, p 8). Although the explanatory statement accompanying the Restraints Principles reference the Decision-Making Tool, findings suggest that, because the requirement for comprehensive assessment is not reflected in the text of the legislation, it may be overlooked or minimised.

Criticism related to the requirements for assessment have been heard previously at the Joint Commission:

> The way it's [the legislation] written is: 'It's when you've exhausted what's in your head that you can restrain someone; and if you think someone is dangerous, you can restrain.' There's no gradation about what is dangerous or what is reasonable. And we're leaving those decisions to relatively inexperienced, junior people with limited training … I think one of the recommendations that we'd made back in 2017 was that anyone who was being considered for a form of restraint required a specialist multidisciplinary team assessment. If you seriously believe someone needs restraint because they're a danger to themselves or someone else, that problem is not solved by shackling them or giving them a medication. That does not solve the underlying problem. So anyone who requires restraint ought to have a very formal, structured assessment that includes, I'd say, at least a psychiatrist and a psychologist in that team, to work out what is happening. (Prof. J Ibrahim, cited in Parliamentary Joint Committee on Human Rights 2019, p 19)

Recent findings from the Royal Commission further support the need for assessment in highlighting that the perceived need to restrain occurs due to a focus on behaviours rather than identifying and addressing the underlying cause, as demonstrated in the following excerpt:

> The evidence suggests that an overarching reason for the use of restraint in residential aged care is a care model that focuses on managing symptoms, rather than addressing people's underlying needs and concerns. According to Associate Professor Edward Strivens, President of the Australian and New Zealand Society for Geriatric Medicine, the changed behaviours associated with dementia are often an expression of unmet need, including untreated pain, a desire to interact with the physical environment, and/or unmet psychosocial needs. Psychosocial needs of people in residential care can include loneliness and anxiety… Professor Ibrahim's evidence was that the use of physical restraint means that staff are not employing evidence-based interventions to address the risk of falls or behavioural and psychological symptoms of dementia. He elaborated in his oral evidence: 'The use of physical restraint means that you've not sufficiently examined, worked up the resident with sufficient help from other professionals, to work out why that person is agitated or distressed for you to initiate restraint.' (Royal Commission into Aged Care Quality and Safety 2019b,p 203).

Skills in identifying triggers and symptoms were seen as critical for those caring for people living with dementia (Royal Commission into Aged Care Quality and Safety 2019c). The link between pain and changed behaviour has also been recognised (Peisah & Skladzien 2014), which supports the DBMAS suggestion that provider staff undergo mandatory training in pain assessment. The Department of Health has recently developed a resource for personal care workers called '3 simple checks to support your residents' that directs staff to assess factors, including pain, that may be contributing to a change in behaviour (Department of Health 2020e).

Our finding that assessment should be collaborative, with mental health, allied health, and other specialist input as required, is well supported (Mckay et al. 2015) and aligns with the Quality Standards that specify input from 'relevant, qualified practitioners about assessing and managing specific and common risks' including use of restrictive practices (p 35). We also note that Counsel Assisting has recently called for improved access to medical and allied health services for assessment (Royal Commission into Aged Care Quality and Safety 2020a).

It is recognised that the Restraints Principles regulate providers and cannot require prescribers to complete a comprehensive assessment prior to prescribing medications as chemical restraint. However, our findings suggest that by supporting and promoting proactive comprehensive, multidisciplinary assessment, residents may be more likely to receive behaviour support interventions without the need to resort to chemical restraint.

4.8 Support the use of alternative strategies

Summary

- There is broad awareness of and support for the concept of implementing alternatives to restraint. However, more detailed understanding of alternative strategies (including what they are, how to apply them, and the importance of documenting their use) amongst aged care staff is required.
- The majority of providers indicated they always attempted alternative strategies prior to restraint, but feedback from providers and stakeholders suggests that the legislation can be interpreted to mean that alternative strategies need not actually be tried. Providers can meet their obligations by simply **considering** these strategies or documenting that they were not used.
- The resourcing (staff and time) required to implement alternative strategies is not always available, and provider staff worry that diverting resources to deliver alternative strategies for one resident could be to the detriment of others.
- Providers, consumers and consumer peak bodies noted that resourcing issues are compounded by the fact that alternative strategies are often used in an effort to manage challenging behaviours, rather than to prevent the need for residents to engage in those behaviours.
- There is consensus across the sector on the need for aged care staff to have access to high quality, ongoing training and education in dementia and restraint alternatives. In addition, tailored, accessible educational materials are needed to address identified gaps in staff knowledge.
- There is strong support for multidisciplinary input into the identification and implementation of alternative strategies, and recognition that this may require expansion of the aged care funding structure.
- Stakeholders perceive the disability sector to more explicitly require all alternative strategies to be exhausted prior to restraint use, through mandating behaviour support practitioner input into the development of behaviour support plans.

Recommendation 8: Support the use of alternative strategies

Changes to the Restraints Principles

8a Strengthen requirements for the use of alternative strategies so the administration of PRN (*pro ne rata* [as required]) medication as a chemical restraint is a last resort.

Other changes

8b Consider how to build sector capability in behaviour support and management to improve the use of alternative strategies. Consider learnings from both the disability sector and the Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Teams (SBRT).

8c Review existing guidelines and, where necessary, develop new guidelines and resources to support providers to identify and use alternative strategies.

8d Update the Commission's *Restraint scenarios* resource to include examples that clearly articulate and demonstrate consideration of alternatives to restraint through a multidisciplinary approach.

8e Support education and training initiatives to build skills of aged care staff in dementia management (including those with diverse backgrounds, education and capability).

8f Enable a multidisciplinary approach to care, with a particular focus on strengthening the allied health workforce within aged care.

8g Continue to promote holistic approaches to supporting people with dementia, including providing dementia-friendly environments.

Relevant aspect of the legislation

The Restraints Principles state that physical restraint must not be used unless alternatives to restraint have been used for the consumer to the extent possible (**15F 1b**) and that the alternatives to restraint that have been considered or used have been documented, unless the use of the restraint is necessary in an emergency (**15F 1c**). If physical restraint is used, the approved provider must ensure the care and services plan identifies the alternatives to restraint that have been used (if any) (**15F 2c[ii]**).

This requirement also applies if chemical restraint is used (**15G 2b [ii]**); however, there is no equivalent to **15F 1b** or **1c** in relation to chemical restraint. The explanatory statement notes that: 'Where a consumer entered the residential aged care service, and has existing chemical restraint medication prescribed, the provider will not have had the opportunity to have explored alternatives to the use of restraint prior to entry. In this circumstance, it is expected the provider will thoroughly investigate the reasons for the restraint, and communicate with the practitioner as soon as practicable with a view to implementing alternatives to restraint.'

No changes to the above aspects of the legislation were made in the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019*; however, in specifying that the use of restraint must always be the last resort, the amendment does strengthen the inference that alternative options should be attempted first.

Consultation findings

Amongst provider staff, awareness of the requirement to implement alternatives to restraint was high, with 95 per cent of survey respondents indicating they were aware of this aspect of the Restraints Principles. Staff also reported reasonable adherence to this requirement, with just under three-quarters (72%; n=143) reporting that alternative strategies were always tried before using physical restraint, and two-thirds (67%; n=132) indicating that these strategies were always tried before using chemical restraint. We also heard that there has been an increase in enquiries to DBMAS from providers seeking guidance on alternative strategies since the Restraints Principles came into effect. Nonetheless, despite broad awareness of and support for the concept of implementing alternatives to restraint, we heard that there a number of barriers to these strategies being widely or routinely used, as described below.

Effective use of alternative strategies is hindered by limited knowledge and skills amongst staff

Comments from provider staff and organisational stakeholders highlighted that there is scope for understanding of alternative strategies to be improved, including what is meant by the term, how to identify and implement appropriate strategies (and who is responsible for this), and what to do when they are unsuccessful. Consumer peaks, advocates and public guardians, experts and industry stakeholders were concerned that this lack of understanding could result in no net change in the use of restraint, because one type of restraint could be interpreted as an alternative to another (e.g. chemical restraint used instead of physical restraint, or one medication substituted for another). There also appeared to be some confusion amongst provider staff over whether the Restraints Principles require providers to *use* alternative strategies or simply to *offer* these to the resident or their representative. Relatedly, consumer peak bodies were concerned that differences between the physical restraint and chemical restraint aspects of the legislation imply that there is no requirement to try alternatives prior to the use of chemical restraint.

> Even when staff understand the Principles, many of them don't really have any idea about alternatives they might be able to try, what things would be alternatives to restraint.
>
> *– Provider focus group participant*

Understanding of restraint alternatives was seen to be particularly limited amongst personal care workers, due in part (or perhaps, contributing) to a belief amongst this section of the workforce that this aspect of resident care was not their responsibility. However, advocates and public guardians suggested that prescribers also possessed an insufficient understanding of alternatives, which saw them default to chemical restraint. Consumer feedback indicated that limited understanding of alternative strategies amongst staff may translate into a lack of information being provided to residents and their representatives; consumers indicated they were unsure if the available alternatives were sufficient to reduce the need for restraint, or why restraint was used in preference to other management strategies.

A provider peak body and many staff reported that there has been an increase in behaviours of concern from residents with the removal of chemical restraint since the Restraints Principles were introduced, indicating behaviour is not being well managed through alternative strategies. Staff feedback is provided in *Supplementary volume 2*.

In addition to limited understanding of alternative strategies themselves, we also heard from providers that not all staff understood their responsibility to document the use of these interventions, or the process of doing so. This sentiment was echoed by consumer advocates and Commission representatives who noted that, when asked, providers were unable to provide documentation of the strategies tried or whether or not they were effective. Case studies of complaints received by the Commission further supported this finding, with one noting that 'there was no evidence that the service used non-pharmacological interventions before the introduction of medications to manage the consumer's behaviours'.

There were some early signs that the Restraints Principles were leading to practice change; however, one medication management service provider noted that they had seen more in-depth documentation of both medication and behavioural strategies that had been tried prior to its introduction. Overall, stakeholders felt that appropriate record keeping was important to ensure that restraint was truly only used as a last resort, and pointed to the disability sector's mandated behaviour support plans (see Alternative strategies and the NDIS Rules below) as a safeguard that aged care could look to emulate.

> [Under the NDIS Rules], if you want to be a provider who uses any form of restrictive practices, you must be registered and … have a positive behaviour support plan, tailored towards using alternatives, and work towards elimination of the practice.
>
> *– Disability sector representative*

Implementing alternative strategies is perceived to have significant resourcing implications

Provider staff, consumer peak bodies, and allied health peak bodies were concerned about the significant barrier that the workload and staff resourcing implications posed to the use and documentation of alternative strategies. Identifying and implementing alternatives was seen to be a more time-consuming approach and one that presented an undue burden to staff already overwhelmed and often working unpaid overtime. Providers noted that in some cases, additional time spent implementing alternative strategies for one resident resulted in poor outcomes for other residents and staff alike.

> Reducing restraints for residents with dementia and or wandering tendencies has impacted our resources and demands staff (or multiple staff) away from direct care to managing challenging behaviours. Funding isn't sufficient to add additional staff to manage these frequent and lengthy behaviours, so direct care for other residents is put in a precarious spot
>
> *– Head office manager or CEO*

Providers, organisational stakeholders, and consumers alike highlighted a need for minimum staffing ratios (nursing and provider peaks referenced those outlined in the Victorian Nurses Enterprise Agreement and the disability sector's Butterfly House model), flexibility to adjust these according to resident need, and the importance of having access to clinical expertise to either help identify alternative strategies or to support their use. The challenge of ensuring sufficient funding within the aged care sector to build the front-line and specialist workforce was well recognised; however, one representative of a for-profit provider organisation noted that the cost associated with increasing staffing numbers and education was offset by better outcomes for residents and families.

Interestingly, feedback from providers indicated that alternative strategies are often tried as a reaction to challenging behaviour, rather than as a way of preventing these behaviours, and staff commented about the particular challenges associated with managing aggression.

> When behaviour is escalating, ensuring all non-pharmacological interventions are trialled first is challenging as staff want the behaviour to de-escalate quickly, so tend to want to reach for medication.
>
> *– Head office manager or CEO*

Consumers and consumer peaks commented that with more staff, alternative strategies could be used as a preventive approach, reducing the risk of these more difficult situations occurring and, in turn, reducing the likelihood that restraint would be required. In this light, it is worth considering the impact of COVID-19 on the capacity of providers to implement alternative strategies. DSA commented that they have seen an increase in Severe Behaviour Response Team (SBRT) referrals during the pandemic, which may reflect facility staff being overwhelmed with other matters and unable to identify and address the triggers of BPSD early. The potential benefits of a holistic approach to preventing the need for restraint was also raised by consumer advocates, DSA, and provider peaks who suggested a need for sector-wide commitment to dementia-friendly building design.

To support the use of alternative strategies, improved education and training is essential

Feedback from providers, consumers, and organisational stakeholders alike highlighted that the likelihood of alternative strategies being used effectively would be greatly enhanced by improved training in dementia and its management. There was strong support across the board for the introduction of mandatory minimum training requirements, with several groups drawing a parallel with the requirement to complete manual handling training. Advocates and nursing peaks explicitly suggested that such training be embedded in certificate 3 and 4, while others suggested that education should target staff at all levels of provider organisations. Pharmacy peaks, providers, and consumers noted that training should be provided on a regular basis, not as a once-off, to account for staff turnover and support ongoing professional development for individuals. Providers and provider peaks noted some of the challenges in providing access to training, in that there is a need to ensure providers of all sizes have access to high quality education but that doing so comes with costs – both those associated with training delivery (e.g. facilitator time and/or access to resources) and release of staff from normal duties to attend.

> More realistic scenario-based sessions that staff can relate to, with alternatives. Instead of staff just having to read things all the time. [We need] demonstrated practical alternatives to restraint. We keep saying restraint is a last resort, but unless you've actually studied dementia support and behaviour management there isn't any practical demonstration.
>
> *– Provider focus group participant*

Providers indicated that education and training should include practical demonstrations and interactive activities rather than requiring extensive reading, and be appropriate for staff from culturally and linguistically diverse backgrounds. They also noted that training should not stand alone but needed to be accompanied by ongoing assessment of competency. Finally, feedback from provider staff also suggested the potential for formal education to be supplemented with innovative solutions such as peer-based support and training; for example, staff working in dementia specific facilities were considered to have specialist skills and strategies that other providers could potentially learn from.

Effective delivery of alternatives to restraint requires multidisciplinary input

Stakeholders identified the need for multidisciplinary and specialist input to identify and implement alternative strategies, and argued that it was key to successfully reducing inappropriate restraint. However, providers felt that, at present, they had insufficient access to timely and appropriate specialist input (including DBMAS), and faced significant challenges to engaging GPs in considering alternatives to restraint.

Stakeholders also highlighted the limited availability of behavioural specialists in aged care, and allied health peaks noted the limited access to mental health services through the Medicare Benefits Schedule, as well as under-utilisation of allied health professionals that do work in residential aged care facilities.

A number of organisational stakeholders (including public advocates and guardians, consumer peaks, allied health peaks, and disability sector representatives), suggested that the Restraints Principles should explicitly require the involvement of allied health professionals in considering and testing alternatives. They highlighted the NDIS Rules' requirement for behaviour support practitioner input as providing a good example from which the aged care sector could learn.

Most stakeholders recognised though that in practice, minimising the use of restraint by improving access to multidisciplinary, team-based care would require a shift in the aged care funding structure in addition to legislative change.

Discussion

Clinical practice guidelines are clear that first-line management for BPSD should comprise behavioural interventions and a multidisciplinary approach (Royal Australian College of General Practitioners 2019, The Royal Australian & New Zealand College of Psychiatrists 2013). However, our findings are consistent with a number of reviews and inquiries, which have found that there are substantial barriers to the implementation of these strategies in the aged care setting; in particular, there is general agreement that aged care facilities lack the necessary workforce, and that the workforce lacks the necessary training to manage residents' behaviours without using restraint (Belcher et al. 2020, Groves et al. 2017, Royal Commission into Aged Care Quality and Safety 2019b, Human Rights Watch 2019). To address this barrier, there have been widespread calls for minimum qualifications and staffing levels in aged care (Human Rights Watch 2019, Royal Commission into Aged Care Quality and Safety 2019b, Aged Care Workforce Strategy Taskforce 2018), most recently in Counsel Assisting's proposed recommendations to the Royal Commission (Royal Commission into Aged Care Quality and Safety 2020b). The

Royal Commission also supported improved dementia training, but noted that even when training was available and sufficient, staff were not always supported to use alternative strategies (Royal Commission into Aged Care Quality and Safety 2019b). This hints at the broader cultural shift required to change practice on the ground.

In addition to upsizing and upskilling the frontline workforce, the importance of building the sector's capacity to provide timely and appropriate multidisciplinary care is well recognised. The Aged Care Workforce Taskforce (2018) put forward that allied health 'will play an increasingly bigger and critical role in delivering holistic care services that support positive ageing and reablement and improve the quality of life of consumers' (p 34). Counsel Assisting further recommended that all aged care providers be required to engage at least 10 different types of allied health professionals, and that the funding structure be revised to support them in this endeavour (Royal Commission into Aged Care Quality and Safety 2020b). Of course, it is important that professionals have the requisite training and skills to support the planning and use of alternative strategies, in order to effectively reduce the use of restraint. On this point, the Royal Commissioners suggested in their interim report that GPs would also benefit from improved dementia training (Royal Commission into Aged Care Quality and Safety 2019b), and Counsel Assisting extended this to recommend that the undergraduate curricula for all health professions be reviewed and updated to address age-related conditions including dementia, to 'ensure that graduates have the education and knowledge to meet the care needs of older people' (Royal Commission into Aged Care Quality and Safety 2020b).

Previous research has found that multidisciplinary input, including that of GPs, is often sought at crisis point (e.g. when the resident becomes aggressive), limiting the opportunity for careful consideration and application of appropriate behavioural management techniques (Belcher et al. 2020). Our findings reiterate this experience and supports calls for increased funding to support primary prevention strategies, such as dementia-friendly building design (Royal Commission into Aged Care Quality and Safety 2019b, Royal Commission into Aged Care Quality and Safety 2020a). This approach aims to reduce the triggers that lead to challenging behaviours (including BPSD), rather than placing the onus on staff to manage those behaviours. As such, the preventative approach may go some way to addressing the ongoing resourcing implications associated with implementing alternative strategies to restraint, but may require a greater initial outlay.

The challenges of workforce capacity, education, and building design speak to the need for broader reforms required to support the use of behavioural interventions in residential aged care. However, it is clear that there is also a feeling across the sector that a stronger regulatory environment is needed to ensure such approaches are used in preference to restraint. It is worth noting that the Restraints Principles were developed following early recommendations that legislation be introduced to require alternative strategies to be **considered** prior to using restrictive practice (Australian Law Reform Commission 2017, Carnell and Paterson 2017). As we heard, however, the current requirements are thought to be insufficient as they do not explicitly require providers to **try** these strategies, and suggest that providers can meet their obligations by simply documenting that no alternatives had been attempted (2019). Our findings therefore support the Joint Committee's recommendation that the legislation be strengthened to make the requirement to exhaust restraint alternatives explicit (Parliamentary Joint Committee on Human Rights 2019). The Joint Committee highlighted the approach taken by the NDIS Rules in this regard, amongst several others, as described below.

Alternative strategies and the NDIS Rules

Stakeholders in this review echoed the Joint Committee, Royal Commission, the ALRC, and others in suggesting that aged care should bolster its commitment to the use of alternatives to restraint through legislating the requirement for providers to engage a behaviour support practitioner and develop a written behaviour support plan (Parliamentary Joint Committee on Human Rights 2019, Community Affairs References Committee 2018, Royal Commission into Aged Care Quality and Safety 2019b, Australian Law Reform Commission 2017). The omission of comparable requirements in the aged care sector has been identified as a missed opportunity.

Resources and initiatives

In light of Royal Commission recommendations to revise the aged care funding structure to better support allied health involvement, it is worth noting that there are also system reforms currently underway in this space. For example, the proposed *Australian National Aged Care Classification* outlines a model for system reform that would incentivise the delivery of reablement and restorative care. Further, the *Psychological treatment services for people with mental illness in residential aged care facilities* initiative (Department of Health 2018), facilitated by Primary Health Networks (PHNs), seeks to redress aged care residents' lack of access to the subsidised mental health care available to the broader Australian population.

We also note that formally upskilling the aged care workforce will take time. In the interim, a number of resources are available and could be further refined and promoted to support awareness and understanding of alternative strategies amongst provider staff. Examples include:

- *Decision Making Tool: Supporting a restraint free environment in residential aged care* (Department of Health): Includes a menu of restraint free options for providers to consider
- *Self-assessment tool for recording consumers receiving psychotropic medications* (the Commission): Prompts providers to record alternatives considered and used
- *Restraint scenarios* (the Commission): Provides some examples of alternative strategies being tried (see for example the case of Hazel)
- *Six steps for safe prescribing* (the Commission): Outlines some examples of alternative strategies, and provides the Dementia Support Australia number that providers can call for further information and assistance
- Online training and resources available through Massive Open Online Courses, Dementia Support Australia, DBMAS, and SBRT.

4.9 Enhance oversight of restraint

Summary

- Most stakeholder groups suggested a need for the use of restraint and alternatives to be overseen by appropriately trained behaviour support professionals.
- Almost all organisational stakeholders perceived there to be insufficient reporting requirements through which compliance with the Restraints Principles can be monitored.
- Some stakeholders suggested that enhanced monitoring and oversight of restraint use requires a correspondingly empowered regulator.
- Few participants in this review commented on the practicalities of increasing the oversight of restraint in the aged care sector.
- Supporting providers to benchmark their restraint use against similar organisations, and adjust practices accordingly, represents an important area for further development.

Recommendation 9: Enhance oversight of restraint

Changes to the Restraints Principles

9a Consider requiring internal oversight of the use of restraint in aged care homes by a person with behaviour support expertise.

Other changes

9b Consider options and triggers for independent review of behaviour support plans (e.g. by behaviour support specialists or the regulator).

9c Consider how the role of the Commission chief clinical advisor could be strengthened by reviewing other models for sector support and oversight (e.g. the NDIS senior practitioner role).

9d Consider how the use of restraint across the sector can be most effectively monitored, and adherence to the Restraints Principles enforced.

9e Supplement the Quality Indicator Program with additional systematic benchmarking tools to help providers understand how their use of restraint compares with their peers, showcase best performers, and inform Commission assessments.

Relevant aspect of the legislation

Oversight of restraint use is not addressed within Part 4A of either the *Minimising the Use of Restraints* or *Reviewing Restraints Principles* amendments to the *Quality of Care Principles 2014*.

Quality Standard 8 (organisational governance) requires that organisations can demonstrate effective governance systems related to regulatory compliance (3(a)iv). Where clinical care is provided, the organisation is also required to demonstrate a clinical governance framework that includes minimising the use of restraint (3(e)ii).

Consultation findings

We did not hear comments in relation to the oversight of restraint from providers or consumers; however, it was a significant concern for organisational stakeholders across the board. There was a sense amongst many groups that there is a lack of accountability in the aged care sector that is at odds with the arrangements in disability. Though the Restraints Principles were seen to represent a step in the right direction, stakeholders were generally of the opinion that they require strengthening and to be supported by systems to monitor and enforce adherence. Without sufficient oversight, stakeholders were concerned that the Restraints Principles would have limited impact on the inappropriate use of

restraint and that poor practice (and poor resident outcomes) could continue.

Three distinct but related issues emerged, namely the need for improved:

- Clinical oversight
- Regulatory oversight
- Support for clinical governance and benchmarking.

Ready access to expert review and oversight would help providers to comply with the Restraints Principles

Stakeholders noted that the NDIS Rules require an individual's behaviour support plan to be developed and regularly reviewed by an approved behaviour support practitioner (see Section 4.8). They considered this model to be beneficial in providing rigorous expert oversight of both restraint use and alternatives, and provide stronger protection against restraint being used unnecessarily or contrary to the resident's wishes. As noted in Section 4.8, a strengthened allied health workforce was seen to be key to achieving this.

In addition to enhanced internal monitoring of restraint use in aged care homes, most organisational stakeholders suggested that options to introduce greater external and independent oversight could also be explored.

Several suggested the sector consider how a senior practitioner role, similar to that established in the disability sector. This role could potentially compliment the current role of the aged care clinical advisor[11]. Consumer peaks and advocates, and disability representatives, saw this as a useful model in supporting providers to 'understand restraint and work through behaviour plans', as well as ensuring restraint practices were subject to independent review. Feedback from disability sector representatives suggested that these practitioners, in turn, could be supported to develop a nationally consistent approach through regular peer group meetings.

> [The senior practitioner model] isn't fool proof but it means there is an independent set of eyes … it adds barriers around when restrictive practices are used, introduces a specific plan to be implemented and accountability around this.
>
> *– Consumer advocate*

Further consideration is needed as to how compliance across the sector is monitored and enforced

In addition to increased clinical oversight, there was support from stakeholders for greater regulatory oversight of restraint use across the sector, including through the expansion of current reporting requirements. Several groups perceived that current reporting requirements (e.g. under the Quality Indicator Program or as part of Commission assessments) do not require providers to report specifically on their compliance with the Restraints Principles. They were unsure how, without such reporting, non-compliance could be identified and addressed by the regulator. However, some stakeholders (including nursing peaks, consumer advocates, and experts) expressed doubts over the effectiveness or validity of compulsory self-reporting of restraint use.

One often mentioned approach to complementing current reporting and assessment procedures was to make behaviour support plans available to the Commission for review. Many stakeholders referenced the disability sector's requirement for behaviour support plans to be lodged with the NDIS Commission and regularly reported against. Consumer advocates and allied health peaks also commented on state-specific

[11] The NDIS senior practitioner leads the behaviour support function within the NDIS Commission, and is responsible for overseeing behaviour support practitioners and providers who use behaviour support strategies and restrictive practices; provide best practice advice to practitioners, providers, and consumers; review reports on the use of restrictive practices; and follow up on reportable incidents (NDIS Quality and Safeguards Commission n.d.). A number of jurisdictions also have their own senior practitioner role with responsibility for protecting the rights of people who are subject to restrictive practices; we heard particular praise for the ACT model (ACT Government n.d.) from consumer peaks and advocates.

documentation and reporting requirements (e.g. to submit behaviour support plans to the relevant state government department, or to record how the restraint has resulted in improved quality of life for the individual).

However, some stakeholders also noted differences between sectors (see 'A note of caution' in Section 4.10) suggesting that a requirement for every behaviour support plan to be centrally lodged and reviewed may not directly translate to aged care.

Provider benchmarking is an important area for development

There was a feeling amongst a number of stakeholders (including provider, health practitioner, and consumer peaks and industry representatives) that to effectively reduce the use of inappropriate restraint, providers need access to reliable and timely data to understand their performance relative to their peers, and to adjust their practice accordingly. However, benchmarking was not seen to be a strength of the aged care sector generally, and thus was identified as an important area for further development to support providers to follow the Restraints Principles.

> It would be great if there was a benchmark so that facilities knew if they were under-restraining or over-restraining, if they have 30% of residents chemically restrained they don't know if that is too much and how much they should be reducing that. Places are unaware of their performance. We should showcase who is doing it well, and show the rest of the industry.
>
> *– Provider peak representative*

Since 1 July 2019, the Quality Indicator Program has required all Australian Government-subsidised residential aged care providers to report data on physical restraint and from July 2021, the Quality Indicator Program will be expanded to include a new indicator relating to medication management. This indicator will capture all medications, including but not limited to, those prescribed for the purposes of restraint.

Further from 1 April 2021, the Serious Incident Response Scheme (SIRS) will commence. Under the SIRS, residential aged care providers will be required to report a broader range of serious incidents in residential aged care, including inappropriate physical or chemical restraint.

Stakeholders identified 2 minimum requirements to be met in order for facilities to be able to use data to inform practice changes. First, as noted by a consumer peak, nursing and allied health representatives, there needs to be a commitment to transparent and accurate reporting, and continuous monitoring of progress and outcomes, at all levels of the provider organisation. This requires both appropriate policies and procedures, and an organisational culture that places a high value on adherence to these. Second, allied health, nursing and industry stakeholders commented on the need for appropriate IT infrastructure and software to facilitate both data capture and feedback.

Assuming restraint use is appropriately recorded and reported, stakeholders identified a number of ways in which this information could be used. One allied health peak noted that the data should be publicly available to help families make informed decisions when selecting an aged care facility. Provider and medical peaks further proposed that, in addition to allowing on-demand benchmarking for providers, data be used to showcase best performers and inform Commission assessment; they perceived that the current assessment framework could see providers assessed as non-compliant if they did not report a reduction in restraint use, and suggested that additional data would enable assessors to understand the prevalence of restraint use – or reductions thereof – in

context.[12] Stakeholders suggested that with access to comprehensive benchmarking data, assessors would be able to interpret the meaning of this practice inertia – whether it represented a problem or was to be expected, given the aged care home's low baseline rates of prescribing or the characteristics of the resident population (e.g. a high prevalence of mental health conditions).

Discussion

Our findings add to growing calls for enhanced oversight of restraint use within aged care homes and across the sector. Mandated recording and reporting have been recommended as additional safeguards against inappropriate restraint use in residential aged care (Australian Law Reform Commission 2014, Carnell and Paterson 2017) although, as we heard, the reliance on providers to self-report restraint use has been identified as problematic (Department of Health 2019a). In this context it is worth noting Counsel Assisting's recommendations that aged care residents be able to request independent review of the lawfulness of their restraint, and strengthened investigative and enforcement powers for the regulator (Royal Commission into Aged Care Quality and Safety 2020b).

Monitoring of antipsychotic prescribing in aged care has been a particular source of concern for many commentators, as it was for participants in this review. This concern has resulted in a number of recommendations to strengthen legislation and policy accordingly, such as by requiring all psychotropic prescriptions in aged care homes to be approved by a chief clinical advisor within the Commission (Carnell and Paterson 2017, Senate Community Affairs Reference Committee 2017). Similarly, the Royal Commission suggested scope to introduce greater monitoring and enforcement of PBS authority requirements (Royal Commission into Aged Care Quality and Safety 2019b), with legislative amendments subsequently made to mandate data capture for all medicines dispensed in residential aged care settings (see Resources and initiatives, below).

It is worth noting that the role of chief clinical advisor, established in 2019, shares many similarities to that of the disability senior practitioner, viewed as a worthwhile model by many stakeholders in this review. It was unclear from consultation feedback whether stakeholders were unaware of the chief clinical advisor role or perceived a need for it to be made more robust. Further consideration could therefore be given to how this role can best provide support for and oversight to the aged care sector in relation to restraint. In addition to endorsing previous calls for improved central oversight, our findings are consistent with suggestions to better support providers to improve their own internal monitoring. Research suggests that providing aged care homes with data that supports them to understand, monitor, and adjust their own restraint practices contributes to reduced prescribing rates of both antipsychotics and benzodiazepines (Westbury et al. 2018). However, the lack of consistent and reliable data available across the sector – on all types of restraint use – is a well-recognised barrier to routine performance benchmarking and quality improvement (Parliament of the Commonwealth of Australia 2018, Human Rights Watch 2019, Community Affairs References Committee 2018, Royal Commission into Aged Care Quality and Safety 2019b).

Incoming changes to the Quality Indicator Program (see below) are intended to go some way to addressing this, by introducing medication management indicators. Over time, this data will provide an evidence base that can be used to improve the quality of services provided to care recipients.

Counsel Assisting the Royal Commission recently recommended even broader reform, proposing that a methodology be developed to

[12] For example, one medical peak representative commented that 'we have a facility locally that is excellent in dementia care. When they were reviewed, they failed on their 'have not reduced psychotropic medications' because their use was so low anyway. They couldn't lower it any further.'. It should be noted that this interpretation reflects stakeholder opinion only; it is not consistent with the Restraints Principles or Quality Standards and no evidence of such an outcome was identified in the non-compliance data provided by the Commission.

enable reporting and benchmarking across **all** aspects of provider performance. They proposed that this methodology should allow providers to compare themselves against similar organisations; the Government to track performance at the sector-level and provider-level and to adjust targets over time; and for performance information to be released publicly to support consumers to make informed decisions when seeking care (Royal Commission into Aged Care Quality and Safety 2020a). Our findings support the inclusion of restraint indicators in any such reporting.

Resources and initiatives

A number of recent initiatives aim to support improved monitoring, governance and oversight of restraint use. Consistent with inquiry findings, these initiatives place particular emphasis on addressing the issue of chemical restraint. It is clear, however, that despite significant activity in this space, there remains more work to be done:

- The Commission's self-assessment tool provides a method for aged care homes to keep a record of residents using psychotropic medications. However, as noted above, this tool does not identify chemical restraint but records instances of these medication being administered, and data is not centrally collated or fed back to give homes insight into their performance relative to others.
- In July 2021, the Quality Indicator Program will be expanded to include a new indicator relating to medication management. This indicator will capture all medications, including but not limited to, those prescribed for the purposes of restraint. Aged care homes will be required to report the percentage of their residents prescribed 9 or more medications, and the percentage of residents who received antipsychotic medications.
- In response to the Royal Commission's COVID-19 report recommendations, the Government is bringing forward implementation of a SIRS in residential aged care to early 2021. The SIRS expands the responsibilities of residential aged care providers to include identifying, recording, managing, resolving and reporting a broader range of serious incidents in residential aged care, including the use of inappropriate physical or chemical restraint.
- In July 2020, changes to the PBS came into effect, which require a facility ID to be recorded for all medications supplied in residential aged care. This information is designed to assist the Department understand prescribing patterns and is subject to the usual limitations of PBS data (e.g. does not capture reason for prescribing, or actual medication use).
- In Victoria, public sector residential aged care services are required to collect and report data on 5 quality indicators to the Department of Health and Human Services. The 5 indicators are: pressure injuries, falls and fall-related fractures, use of physical restraint, use of 9 or more medicines, unplanned weight loss.
- Industry solutions have also been developed with the aim of supporting aged care facilities monitor and benchmark their own performance, and could provide a model to inform future systems for sector-wide reporting, tracking and reporting. Current systems include, for example:
  - **The Registry of Senior Australians Outcome Monitoring System** – collects data on 12 safety and quality indicators, which are relevant (if not specific) to restraint: high sedative load, antipsychotic use, chronic opioid use, premature mortality, delirium and/or dementia hospitalisations, fractures, medication-related adverse events, weight loss and malnutrition, falls, pressure injury, and emergency department presentation. Data is risk-adjusted to account for resident population characteristics.
  - **Ward Medication Management** – provides facilities with access to an electronic dashboard displaying their use of high-risk medications, benchmarked across all facilities subscribed to the service.

4.10 Harmonise arrangements between sectors as far as applicable

Summary

- Differences in regulation of restraint between sectors were viewed by some stakeholders as problematic, because they could result in people being treated differently in different settings.
- Almost every organisational stakeholder group highlighted that there are differences between the Restraints Principles and NDIS Rules, which increase the complexity of interpreting and applying the legislation.
- Stakeholders recognise that differences between the disability and aged care sectors, cohorts and broader regulatory arrangements, mean that the same legislative framework for restraint may not be appropriate or applicable. However, there was broad support for learning and harmonising arrangements between aged care and disability.
- We heard that the lack of a consistent approach to restraint use (or its minimisation) across community, healthcare, and residential aged care settings is a source of substantial confusion and distress for residents, families and providers, given that residents frequently move between these environments.

Recommendation 10: Harmonise arrangements between sectors as far as applicable

Changes to the Restraints Principles

The Restraints Principles could be reviewed against specific aspects of the NDIS Rules, noting key differences between aged care and NDIS regulatory frameworks and cohorts (also see Sections 4.4, 4.8, and 4.9). Cross-sector alignment came through so strongly in our consultations that it warrants inclusion as a recommendation in its own right. Our findings reiterate those of previous inquiries in suggesting the need to:

10a Noting key differences between aged care and NDIS regulatory frameworks and cohorts, consider how the features of the NDIS Rules could be adapted to the aged care sector, to harmonise the rights protecting vulnerable Australians, regardless of the sector through which they receive care

Other changes

In addition to the suggested legislative change, our findings give rise to a number of other recommendations that would further support a consistent approach to restraint use (and more importantly, minimisation thereof):

10b Explore options to increase the availability of behaviour support specialists to facilitate development of behaviour support plans in residential aged care.

10c Develop guidance and templates to support the development of behaviour support plans specific to the aged care (and dementia care) context.

10d Develop educational strategies and resources for staff across sectors on best practice management of transition between community care, healthcare, and residential aged care sector.

10e Develop information for families and residents to support understanding of restraint regulations in the aged care and healthcare sectors including their rights and responsibilities, and what they can request or expect.

10f Continue to foster collaboration and opportunities for learnings to be shared across sectors as the legislative, policy, and practice landscape changes over time.

Relevant aspect of the legislation

This section considers opportunities for overarching harmonisation between the Restraints Principles and the NDIS Rules, where applicable given the different characteristics of both sectors.

Consultation findings

Consistent with previous reports, we heard that inconsistency between sectors presents a key challenge to the implementation of the Restraints Principles. Inconsistency was seen by some stakeholders to imply that people have different rights and could be treated differently in different settings

The NDIS Rules are perceived to provide a stronger regulatory framework and greater protection for consumers with disability

Almost every organisational stakeholder group highlighted that the Restraints Principles and disability legislation take different approaches to the regulation of restraint, and that this introduces unnecessary complexity for providers. There was consensus amongst stakeholders that though neither the NDIS Rules nor the Restraints Principles were perfect, harmonising these 2 overlapping legislative frameworks (and the resourcing and guidance that support them) would reduce confusion at all levels. Some aspects of the legislation suggested for consideration included:

- The NDIS terminology of 'restrictive practices' and the 5 types of restraint defined within (seclusion, physical restraint, chemical restraint, environmental restraint, and chemical restraint; see Section 4.4)
- The emphasis on positive behaviour support, including development of written behaviour support plans by appropriately trained and skilled professionals (see Section 4.8)
- Mechanisms for monitoring the use of restraints with residential aged care (Section 4.9).

> Let's not reinvent the wheel, let's look at other industries and see what they are doing. NDIS spent years working on issues around restraints, and so let's use their hard work.
>
> *– Provider peak representative*

Stakeholders noted that the increasing prevalence of NDIS participants in aged care, and incoming requirement for providers caring for these individuals to register with the NDIS Commission, will in effect introduce dual requirements on aged care providers; a common example provided was the scenario in which a resident in one room was on the NDIS while their neighbour was not. They expressed concerns that the added complexity of understanding and adhering to 2 sets of restraint legislation could result in providers ultimately not accepting NDIS participants into their facilities.

> I have early onset dementia, but I also have an acquired brain injury. Where would it leave me?
>
> *– Consumer peak (representative with lived experience)*

A note of caution

While the disability sector was seen to provide a useful model from which aged care could learn, a number of stakeholders (including representatives of the disability sector, and consumer, nursing, and provider peaks, as well as the Advisory Group) noted that the same legislative framework may not be immediately applicable in aged care. These stakeholders highlighted the range of different contextual factors at play in the 2 sectors. They noted, for example, that memory loss may make it difficult for some people with dementia to develop new skills, and that symptoms of dementia tend to be less static than the behavioural issues seen in disability. As such, they identified that behaviour support plans may need to be modified rapidly and incrementally to ensure consumer-centred care. These stakeholders also

highlighted differences in funding structures and resourcing, including front-line staff and behaviour support specialists, that have implications for the degree to which restraint regulation and practice could be harmonised between sectors.

Transitions in care are common and highlight discrepancies between restraint use across sectors

We heard that although residents frequently move between community, healthcare, and residential aged care settings, there is no consistent approach to restraint use or minimisation. This lack of consistency was identified as a source of confusion for residents, families and providers. In contrast to widespread support for harmonising aged care more closely with disability legislation, few stakeholders identified the health sector as providing a model to which aged care should aspire (although nursing peak representatives commented that inpatient mental health reforms had resulted improved oversight and regulation, and could provide a benchmark for aged care). Improving the degree to which restraint practices were consistent in residential aged care and healthcare settings was seen as critical given that residents frequently moved between them. One consumer peak organisation also noted that the Restraints Principles speak to the use of restraint in residential aged care specifically, and that this introduced a potential gap in the regulation of restraint in community aged care settings.

A number of provider staff and organisational stakeholders spoke of the challenges associated with different approaches to prescribing of psychotropic medications across sectors. Providers felt that residents were often prescribed these medications in acute or community care, that the reasons for prescribing were poorly documented, and that they were left to manage a problem that was not their creation. Consumer peaks, provider peaks, and representatives of the healthcare sector also spoke about the potential implications of a 'set and forget' mentality. Without clear processes or procedures for review of medications prescribed in other settings, they felt that residents could be left on medications that, though appropriate in the short term, were not intended to be continued long term. Supporting communication and shared record keeping across sectors was perceived to be one option to help address this issue.

Finally, provider peak representatives related concerns about the impact on resident care associated with differences in knowledge, skills, and interpretation of the Restraints Principles across settings. They reported that some staff in aged care homes felt unable to care for people exhibiting more extreme behaviours of concern during acute episodes without using restraint, but that acute services were sometimes reluctant to accept these residents as they believed the behaviour could be managed in the aged care home. Stakeholders also noted that some staff worked across the aged care and acute settings and could bring practices with them, resulting in unintentional non-compliance with the Restraints Principles.

> [The legislation] has led to a lack of certainty around management of people with more extreme behaviours, for example a provider had a resident who had a number of acute episodes and they had to be bounced back and forth between hospital and facility.
>
> *– Provider peak representative*

Discussion

Though the workforce, consumers, behaviours, care settings, and contextual factors differ across sectors, there is general consensus that the approach to regulating restraint should be harmonised to the extent possible. As discussed throughout this report, the disability sector is considered to provide a particularly relevant point of reference (Australian Law Reform Commission 2017, Community Affairs References Committee 2018). Differences between the 2 sectors has been considered to represent unjustifiable inconsistency in the

protection of consumers' rights (Royal Commission into Aged Care Quality and Safety 2019b), 'which may amount to discrimination against older Australians' (Parliamentary Joint Committee on Human Rights 2019, p 54).

As further noted by the Royal Commission into Aged Care Quality and Safety (2019):

> *The National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, made under the *National Disability Insurance Scheme Act 2013* (Cth), set out specific rules for the use of certain restrictive practices by particular providers under the National Disability Insurance Scheme. These include the requirement to engage a 'behaviour support practitioner', whom the National Disability Insurance Scheme Quality and Safeguard Commissioner approves, the development and lodgement of a behaviour support plan, and monthly reporting and oversight by a Senior Practitioner in the Quality and Safeguard Commission. The new Principles for aged care falls [sic] well short of this approach (p 215).

The feedback received through this review therefore echoes findings of previous inquiries and the recommendations of Counsel Assisting in suggesting that restraint legislation in aged care should be informed by the operation of the NDIS Rules (Royal Commission into Aged Care Quality and Safety 2020a). A number of aspects requiring greater legislative alignment have been highlighted in this and previous inquiries, with general opinion favouring the NDIS approach to defining restrictive practices, specifying different obligations for providers according to law in the jurisdiction in which they are registered, legislating the requirement to deliver person-centred care, compelling providers to adopt a positive behaviour support framework, and mandating regular reporting and independent oversight (Parliamentary Joint Committee on Human Rights 2019, Community Affairs References Committee 2018, Royal Commission into Aged Care Quality and Safety 2019b).

Human Rights Watch also reflected that although the Restraints Principles do not regulate prescribing practices, 'other regulatory agencies, namely the National Disability Insurance Scheme, have chosen to regulate the practice of chemical restraint, including these prescribing practices, informed consent, safeguards and the requirement of alternative measures, among others' (Human Rights Watch 2019, p 54).

Of course, it is important to note that the NDIS Rules are by no means a golden ticket to the effective minimisation of restraint. Restraint remains a contentious issue in the disability space (and is a key area of inquiry into the current *Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with a Disability*), and the NDIS itself is relatively new and its impact has not yet been evaluated. However, it is clear that the NDIS Rules are generally considered to provide a good foundation from which to build, particularly given that NDIS participants can and do live in residential aged care facilities. The complexity associated with navigating 2 different yet overlapping pieces of legislation has been a source of concern for many, including NCAT (*VZM* 2020). It is important to note also that on 1 December 2020, residential aged care providers who support NDIS participants will be required to register with the NDIS Commission (this requirement was originally scheduled to come into force on 1 July but was delayed due to COVID-19). Thus, introducing greater consistency between NDIS and aged care legislation will soon become more important, and potential consequences of inconsistencies more evident. As recommended by Counsel Assisting, there should be no inequities for people with a disability who are also in receipt of aged care (Royal Commission into Aged Care Quality and Safety 2020a).

As noted by stakeholders in this review, disability is not the only sector with a relationship to aged care, and the importance of considering the impact of residents' transition between settings should not be discounted. In this light it is worth noting Counsel Assisting's recent recommendations to

integrate the currently separate Commissions for Health Care and Aged Care into one unified body, improve the transition between residential and acute care, and improve data and record sharing between the 2 sectors (Royal Commission into Aged Care Quality and Safety 2020a).

Finally, it is important to recognise that the aged care, disability sectors, health, and mental health sectors are in a state of flux. This review was conducted at a specific moment in time; its recommendations for the aged care sector to align with current legislation, practice, and policy should not preclude further review and reform as new learnings come to light. Ongoing communication and collaboration across sectors will be key to ensuring high quality care and harmonising the protection of rights for all Australians.

5 Impact of COVID-19 on restraint in residential aged care

The first 12 months of the Restraints Principles' operation was influenced by a number of factors, including the simultaneous introduction of new Quality Standards and the activities and reports of the Royal Commission. In March 2020, however, the first outbreaks of the COVID-19 pandemic began in aged care homes in Sydney and further sharpened the spotlight on the aged care. Aged care residents were disproportionately affected by the virus and were subject to varying degrees of 'lock down' in an attempt to slow its spread. The response at all levels of the sector has been widely criticised (Royal Commission into Aged Care Quality and Safety 2020b).

Perspectives on the use of restraint in the early months of 2020 are therefore, unavoidably, entangled with those on the impact of COVID-19 on the sector more broadly. A primary defence against the virus – maintaining physical distancing – gave rise to widespread lockdowns of aged care facilities with restrictions on the movement of both residents and visitors. Thus, this review examined the effect of legislation aiming to minimise restraint in the context of several months of widespread seclusion and environmental restraint. We were therefore interested in whether aged care consumers and providers considered the pandemic (and its associated restrictions) to have had a noticeable effect on the use of restraint, and asked specifically about this in consumer consultations and provider surveys (for full details see *Supplementary volume 2*). Other stakeholder groups were not specifically asked about the impact of COVID-19 on the use of restraint, although it was frequently raised as influencing the Restraints Principles' implementation, or in discussions about learnings for the aged care sector more generally.

Overall, there was no consensus view on how the use of restraint had changed during the COVID-19 pandemic, although in some cases it was seen to have affected the implementation of the Restraints Principles. We also heard some examples of good practice and opportunities for the COVID-19 experience to inform future efforts to minimise restraint, as described below. It should be noted that none of the providers or consumers who participated in this review indicated that there had been any COVID-19 cases at the aged care home(s) with which they were associated. This may have had a bearing on their experiences and observations on the use of restraint during the pandemic, and the findings reported here should be interpreted with this in mind.

5.1 Impact of COVID-19 on restraint use

More often than not, families and carers were unsure whether use of restraint changed during the early months of the COVID-19 pandemic. However, a number of respondents did express concern that physical restraint had increased during this time, with residents restricted to their rooms and unable to interact with visitors or each other.

Where provider staff considered that restraint has increased, they were similarly more likely to report that this was in relation to physical restraint (n=37; 9%) than chemical restraint (n=18; 4%). These respondents highlighted that this increase was largely due to the definition of environmental restraint being subsumed

under that of physical restraint in the Restraints Principles; they provided examples related to aged care homes being locked down in response to outbreaks, including limited visitor access and enforcement of 'stay at home' directives.

However, the majority (70–73%) of provider staff who completed the survey did not perceive there to have been any change in the prevalence of restraint use during the early months of COVID-19; only a small number of survey responses indicated that the use of either chemical (n=23; 5%) or physical (n=17; 4%) restraint had reduced in this period.

A number of organisational stakeholders including consumer advocates and peak bodies, and a nursing peak, felt the use of restraint had increased during COVID-19. They noted that the lack of external visitors meant that providers could potentially engage in undesirable practices unchecked, and were particularly concerned about the potential for increased use of chemical restraint.

These stakeholders were careful to point out that these views were based on anecdotal reports and observations, with one individual stating 'we don't have enough data to prove all this'. Nonetheless, they perceived a number of factors that may contribute to an increase in the use of chemical restraint, including the challenges associated with ensuring residents maintained safe physical distancing, and in providing a sufficiently stimulating environment to prevent the need for restraint without visitors and the usual program of activities.

These sentiments were echoed by provider staff, who were unsure how, without using restraint, they would ensure that residents with COVID-19 who were prone to wandering complied with isolation rules.

Provider staff also noted that the COVID-19 restrictions themselves (including staff wearing protective equipment, visitor restrictions, and changing from an open to a locked environment) could be confronting and confusing for residents, especially those with dementia. This confusion could, in turn, be expressed as a change in behaviour that staff felt unable to manage without the use of restraint.

Several consumer advocates and peak bodies also shared the view that visitor restrictions introduced a degree of uncertainty about what was happening within aged care homes in relation to restraint. They noted that these restrictions made it difficult to both judge whether restraint use had changed during COVID-19, and to determine the degree to which providers were complying with the Restraints Principles.

5.2 COVID-19 and the implementation of the Restraints Principles

Providers, consumer peaks and advocates, and a nursing peak body noted that COVID-19 had been 'all-consuming', making it difficult to focus on or progress other projects. As such, there was a sense that there had been limited opportunity for extensive promotion of, and engagement with, the Restraints Principles. For example, consumer advocates noted that prior to COVID-19 they had been delivering education to providers but this was now on hold; providers similarly noted that face-to-face training opportunities were limited as was face-to-face access to specialist support such as DBMAS.

A consumer peak also expressed concerns about a lack of visibility of broader activities designed to support the implementation of the Restraints Principles; in particular, this representative was unclear if the second phase of the awareness-raising campaign targeting high prescribers had gone ahead (*Supplementary volume 1*).

Some participants also commented on the impact of COVID-19 on providers' adherence with particular aspects of the Restraints Principles by, for example, reducing opportunities to engage families in discussions about restraint and to obtain written consent.

> There's a lot of fatigue in relation to COVID; it's so relentless, so much to do, so much change on a daily basis. Even families of residents – stress levels are higher because of restrictions on visiting, so when we try to engage them in conversation about restrictive practices, those conversations are harder to have.
>
> *– Provider focus group participant*

Anecdotally, some organisational stakeholders felt that providers' handling of the immediate threat of COVID-19 was indicative of the likely weight they gave to managing the less acute problem of restraint, and to complying with the Restraints Principles. As one consumer peak noted 'if families aren't advised their family member has been sent off to hospital or they've tested positive to COVID, how on earth are we going to expect the aged care sector to communicate about a change in medication, that they're seeing as not a problem'.

Consumer advocates felt that the pandemic showed the need for better training and better communication to ensure transparent care and adherence to policies and procedures.

Some stakeholders also suggested that COVID-19 raised questions about the Commission's oversight of the sector, and providers' ability to assess their own performance, which translated to the regulation of restraint.

For several stakeholders, COVID-19 was also perceived to compound and highlight the resourcing challenges that were identified as a significant barrier to the implementation of the Restraints Principles (see Sections 4.1 and 4.8). They noted that a lack of sufficiently trained staff left providers unable to effectively manage both COVID-19 outbreaks and provide quality care for residents while also complying with their responsibilities under the Restraints Principles.

As noted above, provider staff felt that this was particularly challenging where residents with dementia were concerned, and argued that in some cases, chemical restraint might represent the 'least restrictive' option to ensure the safety of residents and staff.

> What we are seeing at the moment for example with COVID is that the kind of care and knowledge that are needed … [are] lacking in the aged care workforce.
>
> *– Nursing peak representative*

> When it comes to the Restraints Principles and restrictions on environmental restraint, it's very challenging. All of the interventions they want you to do before you resort to chemical [restraint], it takes up so much staffing time and there is no funding for it. When they talk on the news about how disgusting it was that a dementia patient was allowed to walk in to a COVID room, realistically we can't use restraint; you are looking at one-on-one nursing to deal with this kind of stuff.
>
> *– Provider focus group participant*

5.3 Good practice examples and lessons for the future

Despite the challenges noted above, participants in this review identified a number of silver linings in relation to COVID-19 and future efforts to minimise restraint in residential aged care. We heard numerous examples of good practice, including from several consumers who indicated they were happy with the way their aged care home handled COVID-19. They cited 2 key elements of successful COVID-19 management, both of which are relevant to restraint practices and were also identified by other stakeholders. First, consumers applauded aged care homes who committed to providing regular opportunities for virtual social connection (e.g. through Facetime). A consumer peak similarly noted that, after early complaints, many aged care homes attempted to implement COVID-19 protocols in a more thoughtful, consumer-centred way, to allow continued social connection. This demonstrates a flexibility in considering and implementing alternative approaches that may inform future thinking around restraint alternatives.

Secondly, consumers valued a proactive approach to COVID-19 management and information sharing, reiterating the importance of proactive communication in relation to restraint (see also Section 4.3). Several providers also reported implementing proactive strategies to preserve the wellbeing of residents and mitigate against the potential use of restraint. Their approach in this respect was to identify and provide additional support to residents who were more vulnerable to the impacts of social isolation or changes to routine.

> [We took a] proactive approach from the start. We focused specifically on those people who we thought – in a COVID outbreak – would cause distress to themselves and others. Those are the people with cognitive impairment, dementia and those people who have unresponsive behaviours, like wandering; we tried to get an understanding of how staff would manage and support them if they had to be isolated.
>
> *– Provider focus group participant*

Stakeholders further commented on the importance of a proactive approach at an organisational level. For example, a representative of one aged care provider noted that the experience of other organisations had prompted theirs to proactively reach out to all its constituent homes and discuss pandemic preparedness. A consumer peak also highlighted Hammond Care's submission to the Royal Commission in providing an 'exemplary' model of proactively taking responsibility for developing and implementing policies to get ahead of the issue.

Finally, it is clear that the lessons of COVID-19 build on the momentum of aged care inquiries and policy and practice change, and a number of stakeholders expressed cautious optimism that the COVID-19 experience may contribute to more effective implementation of the Restraints Principles in future. One consumer peak, for instance, noted that the pandemic highlighted the need to communicate with consumers in a way that is appropriate and engaging, so that they understand the message being conveyed (see Section 4.3). There was also a sense from providers and medical peaks that COVID-19 served to reinforce the importance of building sector capacity to deliver behavioural interventions (including upskilling front-line staff and increasing

access to allied health involvement). Finally, consumer advocates and medical peaks indicated that this experience demonstrated that aged care providers can implement practice changes quickly and across the nation, and that there is no reason to suggest that such reform is not also possible in the case of restraint.

Appendix A Legislation

Residential aged care providers have specific responsibilities that relate to the use of physical and chemical restraint. These responsibilities are contained in Part 4A of the *Quality of Care Principles 2014*.[13] Part 4A is provided below, following relevant definitions.

A.1 Definitions

The terms 'restraint', 'physical restraint' and 'chemical restraint' are defined in Part 1, Section 4 of the Principles as follows:

> ***restraint*** means any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement.
>
> ***chemical restraint*** means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
>
> ***physical restraint*** means any restraint other than:
>
> (a) chemical restraint; or
>
> (b) the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

The term 'representative' is defined in Part 1, Section 5 of the Principles as follows:

> (1) ***Representative***, of a consumer, means:
>
> (a) a person nominated by the consumer as a person to be told about matters affecting the consumer; or
>
> (b) a person:
>
> (i) who nominates themselves as a person to be told about matters affecting a consumer; and
>
> (ii) who the relevant organisation is satisfied has a connection with the consumer and is concerned for the safety, health and well-being of the consumer.
>
> (2) Without limiting subparagraph (1)(b)(ii), a person has a connection with a consumer if:
>
> (a) the person is a partner, close relation or other relative of the consumer; or
>
> (b) the person holds an enduring power of attorney given by the consumer; or
>
> (c) the person has been appointed by a State or Territory guardianship board (however described) to deal with the consumer's affairs; or
>
> (d) the person represents the consumer in dealings with the organisation.
>
> (3) Nothing in this section is intended to affect the powers of a substitute decision-maker appointed for a person under a law of a State or Territory.

[13] https://www.legislation.gov.au/Details/F2020C00096

Part 4A—Physical or chemical restraint to be used only as a last resort

15D Purpose of this Part

For the purposes of paragraph 54-1(1)(h) of the Act, this Part specifies other responsibilities of an approved provider in relation to the quality of the aged care the approved provider provides that is:

(a) residential care; or

(b) flexible care in the form of short-term restorative care provided in a residential care setting.

15E State and Territory laws continue to apply

This Part does not affect the operation of any law of a State or Territory in relation to restraint.

15F Physical restraint to be used only as a last resort

(1) An approved provider must not use a physical restraint in relation to a consumer unless, in relation to that use of the restraint:

(a) an approved health practitioner who has day-to-day knowledge of the consumer has:

(i) assessed the consumer as posing a risk of harm to the consumer or any other person, and as requiring the restraint; and

(ii) documented the assessment, unless the use of the restraint is necessary in an emergency; and

(b) alternatives to restraint have been used for the consumer to the extent possible; and

(c) the alternatives to restraint that have been considered or used have been documented, unless the use of the restraint is necessary in an emergency; and

(d) the restraint is the least restrictive form of restraint possible; and

(e) the approved provider has the informed consent of the consumer or the consumer's representative to the use of the restraint, unless the use of the restraint is necessary in an emergency.

(2) If an approved provider uses a physical restraint in relation to a consumer, the approved provider must:

(a) if the restraint is used in an emergency—document the matters mentioned in subparagraph (1)(a)(ii) and paragraph (1)(c) as soon as practicable after the restraint starts to be used; and

(b) if the restraint is used without the consent mentioned in paragraph (1)(e)—inform the consumer's representative as soon as practicable after the restraint starts to be used; and

(c) ensure the care and services plan documented for the consumer in accordance with the Aged Care Quality Standards set out in Schedule 2 identifies the following:

(i) the consumer's behaviours that are relevant to the need for the restraint;

(ii) the alternatives to restraint that have been used (if any);

(iii) the reasons the restraint is necessary;

(iv) the care to be provided to the consumer in relation to the consumer's behaviour; and

(d) use the restraint for the minimum time necessary; and

(e) while the consumer is subject to the restraint:

(i) regularly monitor the consumer for signs of distress or harm; and

(ii) regularly monitor and review the necessity for the restraint.

15G Chemical restraint to be used only as a last resort

(1) An approved provider must not use a chemical restraint in relation to a consumer unless:

(a) a medical practitioner or nurse practitioner has assessed the consumer as requiring the restraint and has prescribed the medication the use of which is, or is involved in, the restraint; and

(b) the practitioner's decision to use the restraint has been recorded in the care and services plan documented for the consumer in accordance with the Aged Care Quality Standards set out in Schedule 2; and

(c) the consumer's representative is informed before the restraint is used if it is practicable to do so.

Note 1: Codes of appropriate professional practice for medical practitioners and nurse practitioners provide for the practitioners to obtain informed consent before prescribing medications. Those codes are approved under the Health Practitioner Regulation National Law and are:

(a) for medical practitioners—Good medical practice: a code of conduct for doctors in Australia (which in 2019 could be viewed on the website of the Medical Board of Australia (https://www.medicalboard.gov.au)); and

(b) for nurse practitioners—Code of conduct for nurses (which in 2019 could be viewed on the website of the Nursing and Midwifery Board of Australia (https://www.nursingmidwiferyboard.gov.au)).

Note 2: State and Territory legislation deals with who can consent to the prescribing of medication for a consumer who cannot consent because of any physical or mental incapacity.

(2) If an approved provider uses a chemical restraint in relation to a consumer, the approved provider must:

(a) if the consumer's representative has not been informed of the use of the restraint—inform the consumer's representative as soon as practicable after the restraint starts to be used; and

(b) ensure the care and services plan documented for the consumer in accordance with the Aged Care Quality Standards set out in Schedule 2 identifies the following:

(i) the consumer's behaviours that are relevant to the need for the restraint;

(ii) the alternatives to restraint that have been used (if any);

(iii) the reasons the restraint is necessary (if known by the approved provider);

(iv) the information (if any) provided to the practitioner that informed the decision to prescribe the medication; and

(c) while the consumer is subject to the restraint—regularly monitor the consumer for signs of distress or harm and provide information to the practitioner regarding use of the restraint.

15H Review of this Part

(1) The Minister must ensure that there is a review of the operation of this Part (except this section).

(2) Without limiting subsection (1), the review must consider the effectiveness of this Part in minimising the use of physical restraints and chemical restraints by approved providers in relation to consumers in the period 1 July 2019 to 30 June 2020.

(3) The review must make provision for consultation.

(4) The review must be completed by 31 December 2020.

(5) The Minister must ensure that a written report of the review is prepared.

(6) The Minister must ensure that a copy of the report is:

(a) published on the internet; and

(b) tabled in each House of the Parliament within 15 sitting days of that House after the report is given to the Minister.

15J Repeal of this Part and associated definitions on 1 July 2021

(1) This Part is repealed at the start of 1 July 2021.

(2) The following definitions in section 4 are repealed at the start of 1 July 2021:

(a) approved health practitioner;

(b) chemical restraint;

(c) physical restraint;

(d) restraint.

Appendix B List of organisational stakeholders consulted for the review

Group	Representatives
Aged Care Quality and Safety Commission	Executives Quality assessors and complaints officers
Advocates from National Aged Care Advocacy Program providers	Advocare (WA) Aged and Disability Advocacy Australia (Qld) Aged Rights Advocacy Service (SA) CatholicCare (NT) Elder Rights Advocacy (Vic) Seniors Rights Services (NSW)
Allied health industry representatives	Allied Health Professions Australia Australian Music Therapy Association Australian Psychological Society Australian Physiotherapy Association Dietitians Association of Australia Diversional and Recreational Therapy Australia Occupational Therapy Australia Speech Pathology Australia Other individuals (not representing one of the above organisations)
Consumer peak bodies and representatives	Carers Australia COTA Australia Dementia Australia Older Persons Advocacy Network Older Person's Reference Group Partners in Culturally Appropriate Care
Dementia support service representatives	Dementia Behaviour Management Advisory Service (DBMAS) Severe Behaviour Response Teams (SBRT)
Medical representatives	Australian Medical Association Royal Australian College of General Practitioners Royal Australian and New Zealand College of Psychiatrists: Faculty of Psychiatry of Old Age Australian and New Zealand Society for Geriatric Medicine Other (not representing one of the above groups)
Nursing peak bodies	Australian College of Nursing Australian College of Nurse Practitioners Australian Nursing and Midwifery Federation

Group	Representatives
Pharmacy representatives	Australian Association of Consultant Pharmacy Pharmacy Guild of Australia Pharmaceutical Society of Australia Other (not representing one of the above groups)
Providers	Allambie Heights Residential Aged Care facility (NSW) Alexander Aged Care Facility (Vic) Ashfield Baptist Homes (NSW) Benevolent Living (Qld) Cranbrook Care (NSW) Della Dale Aged Care (Vic) Feros Care (NSW) Helping Hand (SA) Lutheran Services Qld (Qld) Marco Polo Aged Care Services (NSW) Murrumbidgee Local Health District (NSW) Omeo District Health (Vic) Pathways Aged Care (NSW) Parkview Nursing Home (Vic) Strathalbyn & District Aged Care Facility (SA) Warramunda Village (Vic) Western District Health Service (Vic)
Provider peak bodies	Aged Care Guild Aged Care Industry Association Aged & Community Services Australia Leading Age Services Australia
Public guardians/advocates and civil and administrative tribunals	Australian Guardianship and Administrative Council Northern Territory Office of the Public Guardian Public Trustee and Guardian (ACT) Queensland Civil and Administrative Tribunal Queensland Office of the Public Guardian South Australian Office of the Public Advocate Victorian Office of the Public Advocate Western Australian Office of the Public Advocate
Other key stakeholders and Advisory Group members	Australian Commission on Quality and Safety in Healthcare NDIS Quality and Safeguard Commission Department of Social Services
Other individuals and organisations	Experts, Monash University Medication management service provider Written submissions

References

ACCEPD (2013) *Capacity & dementia. A guide for South Australian Health Care Professionals: Mini-legal kit Series 1.6*, ACCEPD, accessed 26 November 2020. http://capacityaustralia.org.au/wp-content/uploads/2013/10/122018-AUST-CENTRE-OF-CEP__-DISABILITIES-ACCEPD-SA-Legal-Kit-8pp-2.pdf

ACT Government (2020) *Informed consent*, ACT Government Health website, accessed 26 November 2020. https://health.act.gov.au/about-our-health-system/consumer-involvement/informed-consent

ACT Government (n.d.) *ACT senior practitioner fact sheet*, ACT Government, accessed 8 November 2020. https://www.communityservices.act.gov.au/quality-complaints-and-regulation/office-of-the-senior-practitioner/act-senior-practitioner-fact-sheet

Aged Care Quality and Safety Commission (2019) *Guidance and resources for providers to support the new aged care quality standards*, ACQSC, Australian Government, accessed 15 November 2020. https://www.agedcarequality.gov.au/resources/guidance-and-resources-aged-care-quality-standards-providers

Aged Care Quality and Safety Commission (2020a*) Psychotropic medications used in Australia – information for aged care*, ACQSC, Australian Government, accessed 15 November 2020. https://www.agedcarequality.gov.au/resources/psychotropic-medications-used-australia-information-aged-care

Aged Care Quality and Safety Commission (2020b) *Minimising the use of restraints, ACQSC, Australian Government*, accessed 12 November 2020. https://www.agedcarequality.gov.au/resources/minimising-use-restraints

Aged Care Quality and Safety Commission (2020c) Better use of medication in aged care project updates, ACQSC, Australian Government, accessed 12 November. https://www.agedcarequality.gov.au/providers/better-use-medication-aged-care-project/better-use-medication-aged-care-project-updates

Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care: Australia's Aged Care Workforce Strategy*, report to the Department of Health, Australian Government, accessed 12 November. https://www.health.gov.au/resources/publications/a-matter-of-care-australias-aged-care-workforce-strategy

Alzheimers Australia (2016), *Submission to the Australian Law Reform Commission (ALRC) – response to the ALRC issues paper: elder abuse* [public submission No. 80], ALRC website, accessed 18 November 2020. https://www.alrc.gov.au/inquiry/elder-abuse-2/elder-abuse-submissions/

Australian Law Reform Commission (2014) The use of restrictive practices in Australia, ALRC, Australian Government, accessed 1 May 2020. https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/8-restrictive-practices-2/the-use-of-restrictive-practices-in-australia

Australian Commission on Safety and Quality in Health Care (2020) *Fact sheet for clinicians. Informed consent in health care*, Australian Government, accessed 26 November 2020. https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf

Australian Law Reform Commission (2017) *Elder Abuse - A National Legal Response*, ALRC, Australian Government, accessed 12 November 2020. https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131

Australian Medical Association (2015) *Restraint in the Care of People in Residential Aged Care Facilities*, accessed 16 November 2020. https://ama.com.au/position-statement/restraint-care-people-residential-aged-care-facilities-2015

Belcher J, Warwar S and Mak J (2020) *Formative research: Psychotropic medicines in older*

people (community and aged care), NPS Medicinewise, Sydney.

Carnell K and Paterson R (2017) *Review of national aged care quality regulatory processes*, report to the Minister for Aged Care, Australian Government, accessed 18 November 2020. https://www.health.gov.au/resources/publications/review-of-national-aged-care-quality-regulatory-processes-report

Dementia Australia (2020) *Key facts and statistics*, Dementia Australia website, accessed 10 November 2020. https://www.dementia.org.au/statistics

Department of Health (2017) *Aged care diversity framework*, Department of Health, Australian Government, accessed 5 November 2020. https://www.health.gov.au/resources/publications/aged-care-diversity-framework

Department of Health (2018) *Psychological treatment services for people with mental illness in residential aged care facilities*, Department of Health, Australian Government, accessed 5 November 2020. https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

Department of Health (2019a) *Report on the outcome of public consultation on the Serious Incident Response Scheme for Commonwealth funded residential aged care*, Department of Health, Australian Government, accessed 5 November 2020. https://www.health.gov.au/resources/publications/report-on-the-outcome-of-public-consultation-on-the-serious-incident-response-scheme

Department of Health (2019b) *Revised risperidone PBS Listings for use as indicated for behavioural and psychological symptoms of dementia*, Department of Health, Australian Government, accessed 12 November 2020. https://www.pbs.gov.au/pbs/news/2019/11/Revised-risperidone-PBS-listings-for-behavioural-and-psychological-symptoms-of-dementia-from-1-Janua

Department of Health (2020a) *Aged Care – funding for dementia care and support*, Department of Health, Australian Government, accessed 27 October 2020. https://www.health.gov.au/resources/publications/budget-2020-21-aged-care-funding-for-dementia-care-and-support

Department of Health (2020b) *National Aged Care Mandatory Quality Indicator Program*, Department of Health website, accessed 21 October 2020. https://www.health.gov.au/initiatives-and-programs/national-aged-care-mandatory-quality-indicator-program

Department of Health (2020c) *Initiatives to minimise inappropriate use of restraint*, Department of Health website, accessed 22 June 2020. https://www.health.gov.au/initiatives-and-programs/minimising-inappropriate-use-of-restraint-in-aged-care#initiatives-to-minimise-inappropriate-use-of-restraint

Department of Health (2020d) *Six steps for safe prescribing of antipsychotics and benzodiazepines in residential aged care*, Department of Health, Australian Government, accessed 30 October 2020. https://www.health.gov.au/resources/publications/six-steps-for-safe-prescribing-of-antipsychotics-and-benzodiazepines-in-residential-aged-care

Department of Health (2020e) *3 simple checks to support your residents*, Department of Health, Australian Government, accessed 23 July 2020. https://www.health.gov.au/resources/publications/three-simple-checks-to-support-your-residents-for-personal-care-workers-in-residential-aged-care

Department of Health (2020f) *Minimising inappropriate use of restraint in aged care*, Department of Health website, accessed 9 November 2020. https://www.health.gov.au/initiatives-and-programs/minimising-inappropriate-use-of-restraint-in-aged-care

Department of Health (6 October 2020) *Budget 2020-21: Record health and aged care investment under Australia's COVID-19 pandemic plan* [media release], Department of Health, Australian Government, accessed 29 October 2020. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/budget-2020-21-record-health-and-aged-care-investment-under-australias-covid-19-pandemic-plan

Department of Health and Ageing (2012) *Decision-making tool: Supporting a restraint free environment in residential aged care*, Department of Health and Ageing, Australian Government, accessed 12 October 2020.

https://www.agedcarequality.gov.au/media/87628

Disalvo D, Luckett T, Bennett A, Davidson P and Agar M (2019) 'Pharmacists' perspectives on medication reviews for long-term care residents with advanced dementia: a qualitative study', *International Journal of Clinical Pharmacy*, 41(4):950–962, doi: 10.1007/s11096-019-00821-7

Duckett S, Swerissen H and Stobart A (2020) *Rethinking aged care: emphasising the rights of older Australians*, Grattan Institute, Melbourne, accessed 12 November 2020. https://grattan.edu.au/report/rethinking-aged-care/

Empowered Project (2020) *Consent for Psychotropic use in dementia: a guide for prescribers across Australia*, Empowered website, accessed 26 November 2020. https://empoweredproject.org.au/consent-for-psychotropic-use-in-dementia-a-guide-for-prescribers-across-australia/

Groves A, Thompson D, McKellar D and Procter NG (2017) *The Oakden report*, SA Health, Government of South Australia.

Human Rights Watch (2019) *'Fading away': how aged care facilities in Australia chemically restrain older people with dementia*, Human Rights Watch, accessed 12 October 2020. https://www.hrw.org/report/2019/10/15/fading-away/how-aged-care-facilities-australia-chemically-restrain-older-people

Melbourne Social Equity Institute (2014) *Seclusion and Restraint Project: Report*, Prepared for the National Mental Health Commission by Melbourne Social Equity Institute, University of Melbourne, Melbourne.

NDIS Quality and Safeguards Commission (n.d.) Behaviour support, NDIS Commission website, accessed 8 November 2020. https://www.ndiscommission.gov.au/providers/behaviour-support

NDIS Quality and Safeguards Commission (2018) *NDIS Practice Standards and Quality Indicators*.

NSW Civil and Administrative Tribunal (2019) *Restrictive practices and guardianship*, NCAT, NSW Government.

Parliament of Australia (2018) *Report on the inquiry into the quality of care in residential aged care facilities in Australia*, House of Representatives Standing Committee on Health, Aged Care and Sport, Australian Government, accessed 8 November 2020. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/AgedCareFacilities/Report

Parliamentary Joint Committee on Human Rights (2019) *Quality of Care Amendment (Minimising the Use of Restraints) Principles Inquiry Report*, Parliamentary Joint Committee on Human Rights, Australian Government, accessed 15 November 2020. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment/Report

Peisah C, Jessop T and Breen J (2019) 'A missed opportunity to improve practice around the use of restraints and consent in residential aged care: limitations of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019', *Australasian Journal on Ageing* 39(3):292–296, doi: 10.1111/ajag.12757.

Peisah C and Skladzien E (2014) *The use of restraints and psychotropic medications in people with dementia*, report for Alzheimer's Australia.

Royal Commission into Aged Care Quality and Safety (2019a) *Restrictive practices in residential aged care in Australia – background paper 4*, Office of the Royal Commission, Australian Government, accessed 8 November 2020. https://agedcare.royalcommission.gov.au/publications/background-paper-4-restrictive-practices-residential-aged-care-australia

Royal Commission into Aged Care Quality and Safety (2019b) *Interim Report: Neglect, Vol. 1*, Royal Commission into Aged Care Quality and Safety, Australian Government, accessed 8 November 2020. https://agedcare.royalcommission.gov.au/publications/interim-report-volume-1

Royal Commission into Aged Care Quality and Safety (2019c) *Interim Report: Neglect, Vol. 2*, Royal Commission into Aged Care Quality and Safety, Australian Government, accessed 8 November 2020. https://agedcare.royalcommission.gov.au/publications/interim-report-volume-2

Royal Commission into Aged Care Quality and Safety (2020a), *Aged care and COVID-19: A special report*, Royal Commission into Aged Care Quality and Safety, Australian Government, accessed 30 October 2020. https://agedcare.royalcommission.gov.au/publications/aged-care-and-covid-19-special-report

Royal Commission into Aged Care Quality and Safety (2020b) *Counsel Assisting's final submissions: proposed recommendations*, Royal Commission into Aged Care Quality and Safety, Australian Government, accessed 29 October 2020. https://agedcare.royalcommission.gov.au/media/29098

Senate Community Affairs Reference Committee (2017) *Future of Australia's aged care sector workforce*, C (ed.), Parliament of Australia, accessed 12 November 2020. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report

Senate Community Affairs References Committee (2018) *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised*, Parliament of Australia, accessed 18 November 2020. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality/Interim report

The Royal Australian & New Zealand College of Psychiatrists (2013) *Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): A handbook for NSW health clinicians*, NSW Ministry of Health, NSW Government, accessed 12 November 2020. https://www.health.nsw.gov.au/mentalhealth/resources/Pages/assessment-mgmt-people-bpsd.aspx

Westbury JL, Gee P, Ling T, Brown DT, Franks KH, Bindoff I, Bindoff A and Peterson GM (2018) 'RedUSe: Reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities', *Medical Journal of Australia*, 208(9):398–403. doi: 10.5694/mja17.00857

Legislation

Aged Care Act 1997

National Disability Insurance Scheme Act 2013

National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018

Quality of Care Principles 2014

Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019: Explanatory statement

Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019

Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019: Explanatory statement

Legal cases

VZM (2020) NSWCATGD 25 [NSW Civil and Administrative Tribunal decision]

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Suggested citation: Australian Healthcare Associates, 2020, Independent review of legislative provisions governing the use of restraint in residential aged care - Final report, Australian Government Department of Health, Canberra.

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