



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

**Supplementary volume 1:
literature and
environmental scan**

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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.

Abbreviations

Term	Definition
ACQSH	Australian Commission for Quality and Safety in Healthcare
AHA	Australian Healthcare Associates
ALRC	Australian Law Reform Commission
BPSD	Behavioural and psychological symptoms of dementia
The Charter	the Charter of Aged Care Rights
the Commission	the Aged Care Quality and Safety Commission
COVID-19	Coronavirus disease
DBMAS	Dementia Behaviour Management Advisory Service
the Department	the Australian Government Department of Health
the Joint Committee	the Parliamentary Joint Committee on Human Rights
NDIS	National Disability Insurance Scheme
NDIS Commission	NDIS Quality and Safeguards Commission
NDIS Rules	<i>NDIS (Restrictive Practices and Behaviour Support) Rules 2018</i>
NTCAT	Northern Territory Civil and Administrative Tribunal
OPAN	Older Persons Advocacy Network
PBS	Pharmaceutical Benefits Scheme
PRN	<i>Pro re nata</i> (as required)
provider	Approved residential aged care provider under the <i>Aged Care Act 1997</i>
Quality Indicator Program	National Aged Care Quality Indicator Program
Quality Standards	Aged Care Quality Standards
Restraints Principles	Part 4A of the <i>Quality of Care Principles 2014</i>
the review	Independent review of legislative provisions governing the use of restraint in residential aged care
the Royal Commission	the Royal Commission into Aged Care Quality and Safety
SACAT	South Australian Civil and Administrative Tribunal
SAT	State Administrative Tribunal (WA)
STRC	Short-Term Restorative Care

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1 Introduction

On 1 July 2019, the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (the Restraints Principles) came into effect.

Other reforms taking effect at the same time (directly or indirectly related to the issue of restraint) included:

- The Aged Care Quality Standards (the Quality Standards)
- The Charter of Aged Care Rights (the Charter)
- The National Aged Care Quality Indicator Program (Quality Indicator Program), introducing mandatory reporting requirements for physical restraint.

On 29 November 2019, the *Quality of Care Amendment (Reviewing Restraints Principles) 2019* came into effect. This legislation:

- Clarified that restraint must only be used as a last resort.
- Referred to state and territory legislation regarding responsibilities for obtaining informed consent.
- Required a 12-month review of the Restraint Principles (see the *Review of the Restraints Principles: Final Report* [final report], to which this document is a supplement).

Australian Healthcare Associates (AHA) was engaged by the Australian Government Department of Health (the Department) to undertake the required review of the Restraints Principles (the review).

The purpose of this document is to summarise relevant contextual information that informed the design and conduct of the review, and to support interpretation of

findings and recommendations presented in the final report. It summarises:

- The Australian residential aged care landscape (Chapter 2)
- Australian and international legislation for minimising the use of restraint in residential aged care and other relevant settings (Chapter 3)
- Views and recommendations of relevant inquiries (Chapter 4), including independent inquiries and those conducted by:
 - The Royal Commission into Aged Care Quality and Safety (the Royal Commission)
 - The Parliamentary Joint Committee on Human Rights (the Joint Committee)
 - The Senate Standing Committee on Regulations and Ordinances.
- Other activities and initiatives relevant to minimising the inappropriate use of restraint in residential aged care (Chapter 5), including:
 - Recent developments in aged care policy and legislation
 - Non-regulatory measures and resources.
- Policy settings in Australian states and territories that potentially impact the regulation of restraint in aged care (Chapter 6).
- Issues related to the interface between primary and aged care, and options to enhance this to support reduced use of chemical restraint (Chapter 7)
- The potential impact of COVID-19 on the use of restraints in residential aged care settings (Chapter 8).

2 Setting the scene: residential aged care in Australia

In Australia, residential aged care is available on either a permanent or short-term basis, the latter being provided either for respite or as part of the Short-Term Restorative Care (STRC) Programme.¹

Residential care provides hotel-like services (accommodation, cleaning, meals), personal care (bathing, toileting), clinical care (wound care, medications, nursing), and social care (recreation and emotional support) to people who require a higher level of care than can be provided at home (Australian Government Department of Health 2019a).

It is primarily funded by the Australian Government and accounts for around two-thirds of government expenditure on aged care services in Australia, at around \$13 billion per annum (Australian Government Department of Health 2019a). As of 30 June 2020, there were 845 organisations providing residential aged care in 2,722 homes across Australia (Table 2-1) and 94 operational services providing STRC across the country across all settings (Australian Institute of Health and Welfare 2020).

Table 2-1: Number of operational residential aged care homes and places, as of 30 June 2020

Category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Residential aged care homes	882 (32%)	766 (28%)	473 (17%)	247 (9%)	245 (9%)	72 (3%)	25 (1%)	12 (<1%)	2,722 (100%)
Residential aged care places*	72,269 (33%)	57,704 (27%)	42,072 (19%)	18,509 (9%)	18,338 (8%)	5,111 (2%)	2,583 (1%)	559 (<1%)	217,145 (100%)

Source: *Aged care data snapshot 2020*, published on GEN-agedcaredata.gov.au

* Includes all residential places regardless of stay length (permanent or respite), but not STRC.

¹ The STRC is an early intervention programme that provides a time-limited, goal-oriented, multidisciplinary package of care and services for up to 8 weeks. STRC can be delivered in a community setting (e.g. a person's own home), a residential aged care setting, or a combination of both (Australian Government Department of Health 2020e).

Government-subsidised places are allocated to residential aged care homes through a competitive application process; at 30 June 2020 there were 217,145 places available (Table 2-1). The majority of these (55%) are managed by not-for-profit organisations, with private for-profit organisations responsible for most of the remainder (Table 2-2).

Table 2-2: Number and percentage of ownership types of residential aged care approved providers 2020

Category	Total
Not-for-profit	119,276 (55%)
Religious	50,273 (23%)
Charitable	40,505 (19%)
Community-based	28,421 (13%)
Religious/Charitable	77 (<1%)
Private for-profit	89,439 (41%)
Government	8,430 (4%)
State and territory	7,255 (3%)
Local government	1,175 (<1%)
Total operational residential aged care places	217,145 (100%)

Source: *Aged care data snapshot 2020*, published on GEN-agedcaredata.gov.au

2.1 Population profile

Residents of aged care homes account for around one-fifth of all aged care consumers. In 2019–20, there were 244,363 permanent residents of aged care homes and 66,873 respite residents, for a total occupancy rate² of 88 per cent (Australian Institute of Health and Welfare 2020). Note that the total number of residents exceeds the number of residential care places due to resident turnover in the 12-month period.³

Overall, Australia's ageing population has resulted in an increase in the number of aged care residents over time (e.g. by 15% in the 10 years to 30 June 2019; Australian Government Department of Health 2019b). In 2018–19 the average length of stay in residential aged care was almost 3 years for permanent residents, and almost one month (26 days) for those in respite care (Australian Government Department of Health 2019a).

Australian women tend to live longer than men and are therefore overrepresented in residential aged care, where they outnumber men at a ratio of 2:1. However, men appear to move into residential care sooner and account for a greater proportion of residents in younger age groups (Australian Government Department of Health 2019b). On average, men who become permanent residents of aged care homes do so at age 82.5 and women at 84.8 (unpublished ROACA data).

Aboriginal and Torres Strait Islander Australians and people from culturally and linguistically diverse (CALD) backgrounds are underrepresented in residential care homes. Specifically, Aboriginal and Torres Strait Islander Australians constitute just one per cent of permanent residents (Australian Institute of Health and Welfare 2020) despite representing 3 per cent of the Australian population overall (Australian Institute of Health and Welfare (AIHW) 2019); people from CALD backgrounds account for approximately 1 in 5 aged care residents, but 1 in 4 older Australians (Australian Government Department of Health 2019a).

² Occupancy rate is the total number of days that all people spent in residential aged care over a year, divided by the total number of places that were available over the year (Australian Government Department of Health 2017)

³ For comparison, the number of permanent aged care residents on 30 June 2020 was 183,989.

3 Approaches to the regulation of restraint

3.1 Background

A brief literature scan was undertaken to summarise what is known about the role of regulation, approaches and examples, and the effectiveness of legislation regulating the use of restraint in aged care and other relevant settings.⁴

Google and PubMed searches were conducted using broad terms (e.g. restraint/residential aged care/regulation). Relevant articles were sourced and reviewed; key references cited in these articles were also sourced for review if not identified through the primary search.

This chapter summarises relevant evidence and some of the key issues for consideration noted in the identified peer-reviewed and grey literature.

3.2 Findings

3.2.1 The role of regulation

While the question of how best to regulate restraint in the disability and aged care sectors is 'the subject of ongoing debate', there is limited academic literature to inform the topic (Chandler et al. 2017). The need for regulation, however, appears universally agreed. Regulation can:

- Provide certainty in law and therefore in practice by clarifying the legal status of restraint and defining the circumstances in which it may/may not be used
- Set clear and consistent standards

- Protect individuals' right to autonomy, by enshrining a person's 'dignity of risk'
- Limit providers' opportunities to use restraint inappropriately by providing evidence-based criteria for when restraint might be appropriate
- Reduce or prevent abuse of providers' powers by helping to protect vulnerable people in a context of significant power imbalance (McDonald 2003).

The report of the Seclusion and Restraint Project, commissioned by the National Mental Health Commission, similarly noted that a legislative structure can:

- Clarify the role of restraint as a 'last resort' measure
- Set clear and consistent standards
- Clarify the circumstances under which a breach occurs
- Give a legislative structure to policies
- Make the regulatory framework easy to locate.

On the other hand, 'softer' regulatory approaches (e.g. policies, procedures and clinical guidelines) may have different advantages, such as being:

- Comprehensive and specific
- More accessible/understandable
- Potentially more uniform across jurisdictions (e.g. national guidelines)
- Able to give more useful, practical advice
- More flexible and adaptable to local conditions and circumstances, as well as new information/developments (Melbourne Social Equity Institute 2014).

⁴ Note the literature scan was not a systematic review. Information presented here is intended to provide context for the Review of the Restraints Principles, rather than represent a comprehensive summary of available literature.

As noted in Chapter 4, some stakeholders have called for stronger legislation in Australia to support the minimisation of restraint across all sectors, including aged care. However, a sentiment of 'less regulation is better than more' has been expressed by other stakeholders, including the president of the Royal Australian College of General Practitioners (Nespolen 2019).

3.2.2 Regulatory approaches

A number of sources describe, compare, and contrast legal frameworks addressing restraint in aged care in a number of international jurisdictions (Office of the Public Advocate (Qld) 2017, Kaskie et al. 2015, McDonald 2003). Generally, significant variation in these frameworks is noted between countries, and sometimes between states and provinces. In parallel, the prevalence of the use of restraint also varies widely within and between countries, which may in part be attributable to regulatory factors (Feng et al. 2009).

In Canada, for example, there is no federal legislation to regulate the use of restraint in aged care, but there is local legislation in 8 of the 10 Canadian provinces. New Zealand has mandatory national standards that outline the requirements to be met before physical restraint can be used, provide standards for using restraint and seclusion, and disallow the use of medication as chemical restraint (Office of the Public Advocate (Qld) 2017).

Meanwhile, in the US, a review of dementia policies in residential care and assisted living regulations found that in 2013:

- 10 states prohibited the use of chemical restraint, sedatives, and psychotropic medication under any circumstances
- 24 states permitted the use of chemical restraint when certain conditions were met (e.g. with physician authorisation or during an emergency)

- 13 states had no policies in place regulating the use of chemical restraints (Kaskie et al. 2015).

A 2003 comparison of international regulatory frameworks addressing use of restraint concluded there are 2 main contrasting approaches to the regulation of physical restraint in aged care. Facility-focused frameworks target institutional compliance, while patient-focused frameworks 'aim to maximise observance of and respect for the human rights of individuals in health care systems'. The author recommended a 'hybrid approach' in which:

- Authorisation for the use of physical restraint is set out in legislation, subject to stringent conditions and safeguards
- Providers are required to document the circumstances of restraint and the strategies applied before the use of restraint as a last resort
- All instances of restraint are to be reported to an independent monitoring agency with powers of random inspection (McDonald 2003).

In reviewing 'lessons learned' from the Oakden investigation (see Chapter 4), Maker & McSherry (2019) highlighted 3 main mechanisms for regulating the use of restraint:

- Legislation (ideally national)
- Policy documents (guidelines, codes of practice, policies and procedures)
- A body with powers of inspection.

All of these do currently exist in the Australian setting, but with jurisdictional differences and remaining gaps and inadequacies (Maker & McSherry 2019, Royal Commission into Aged Care Quality and Safety 2019b, Office of the Public Advocate (Qld) 2017). Key features and potential gaps in various regulatory approaches addressing restraint in aged care are summarised in Table 3-1.

Table 3-1: Key features and potential gaps in regulatory frameworks

Key features	Potential gaps
<ul style="list-style-type: none"> • Implementation of legislation, standards, regulations and safeguards outlining best practice and requirements • Establishing principles that underpin the regulatory framework • Prohibiting the use of medicines as a form of restraint • A rigorous system of auditing • Penalties for non-compliance with relevant standards • Congruent national and state regulatory frameworks • Encouraging the judiciary to promote older people's freedoms and independence 	<ul style="list-style-type: none"> • An overly bureaucratic approach/focus on minimum standards rather than person-centred focus/upholding human rights • Inappropriate influence by commercial/for-profit aged care sector • Failure to establish and implement minimum resourcing requirements to support the objectives of legislation • Failure to establish 'functional interconnections' between the legislative framework and practice • Auditing criteria that are not sufficiently specific to restraint and aged care • Lack of a consistent data collection and reporting strategy.

Source: Office of the Public Advocate (Qld) 2017

3.2.3 Restraint in national disability legislation

Of direct interest to consideration of restraint in the aged care sector is how these practices are regulated in the disability sector.

Although disability services are regulated by jurisdictional legislation, there is also national legislation that relates to provision of services under the National Disability Insurance Scheme (NDIS). This legislation includes frameworks and rules that explicitly regulate behaviour support and the use of restraint, with a focus on minimising and eliminating these practices within the sector.

The *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (the NDIS Rules), made under the *NDIS Act 2013* (Cth), regulate the use of certain restrictive practices by NDIS providers. These include:

- Seclusion
- Chemical restraint
- Mechanical restraint
- Physical restraint
- Environmental restraint.

The NDIS Rules also include the requirement to engage a 'behaviour support practitioner' approved by the NDIS Quality and Safeguards Commissioner, the development and lodgement of a behaviour support plan, and monthly reporting and oversight by a Senior Practitioner in the NDIS Quality and Safeguards Commission (the NDIS Commission) (Royal Commission into Aged Care Quality and Safety 2019b). NDIS services that develop behaviour support plans or use restrictive practices must abide by the *NDIS Quality and Safeguarding Framework* which, like the legislation, is underpinned by principles of human rights and person-centred care (NDIS Quality and Safeguards Commission n.d.).

Further, under the NDIS Rules, providers must report incidents (and allegations) of the unauthorised use of a restrictive practice in relation to an NDIS participant (NDIS Quality and Safeguards Commission n.d.).

As noted in the Royal Commission's interim report, 'the new Principles for aged care falls [sic] well short of this approach' (Royal Commission into Aged Care Quality and Safety 2019b).

The NDIS Act also contains reference to capacity and decision making, noting that 'people with disability are assumed, so far as is reasonable in the circumstances, to have capacity to determine their own best interests and make decisions that affect their own lives'. Indeed, as Cukalevski (2019) notes, a key objective of the NDIS is to respect the interests of people with disability in exercising choice and control.

The NDIS Commission began regulating disability providers operating in South Australia and New South Wales from July 2018; in Victoria, Queensland, Tasmania, Australian Capital Territory and Northern Territory from July 2019 and will start regulating those in Western Australia from 1 December 2020 (NDIS Quality and Safeguards Commission n.d.).

Evidence collated through the mandated national reporting system indicates that despite the relatively stronger regulatory environment, restraint practices are still prevalent in the disability sector. In the 6 months between 1 July and 31 December 2019, the NDIS Commission was notified of over 65,000 incidents of unauthorised restraint, affecting over 2,000 consumers (in other words, an average of 27 incidents per person) (NDIS Quality and Safeguards Commission 2020a). The majority of reported incidents related to chemical restraint. Consumer groups and others have criticised the NDIS Commission for taking action against providers in only a handful of incidents; however, in many cases restraint was reported despite its use complying with relevant state or territory law (Henriques-Gomes 2020, NDIS Quality and Safeguards Commission 2020a).

The NDIS Commission also notes that the large increase in reports of unauthorised

use of restrictive practices (from 2018–19 to 2019–20) relates to:

- Increased coverage, with 5 new jurisdictions coming under the NDIS Commission's remit from 1 July 2019
- Increasing reporting compliance by NDIS providers
- The requirement to report individual instances of unauthorised restrictive practices in jurisdictions where no authorisation mechanism exists (NDIS Quality and Safeguards Commission 2020b).

However, like other sectors, the disability sector also faces the challenge of providers needing to simultaneously interpret rules and regulations at both national and state and territory levels. For example, the use of a regulated restrictive practice 'may also require authorisation or consent under the relevant state or territory legislative and policy frameworks' (NDIS Quality and Safeguards Commission n.d.).

Currently, residential aged care providers, which are also registered NDIS providers in states and territories where the NDIS Commission operates, must comply with both NDIS and aged care regulations. Within the NDIS regulations, as noted above, this includes behaviour support requirements (where applicable) and reporting of restrictive practices to the NDIS Commission.

From 1 December 2020, all residential aged care providers supporting NDIS participants will need to be registered with the NDIS Commission and meet the requirements of the NDIS Act and NDIS provider registration and practice standards rules (Aged & Community Services Australia 2020). An online hub and telephone support line has been developed specifically to support residential aged care homes in meeting this requirement.

It is also relevant to note that the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability is currently examining the issue of restraint in the disability sector. In an issues paper relating specifically to restrictive practices (released on 26 May 2020), restrictive practices (both physical and chemical) are highlighted in the definition of violence and abuse. Public responses to the issues paper were invited up until 2 October 2020 (although later comments can be provided via the general submissions process), and questions specifically related to regulation of restraint have been posed (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability 2020).

Over 4 days from 22 September 2020, public hearing 6 of the disability Royal Commission explored psychotropic medication, behaviour support and behaviours of concern. In his opening statement, the Chair referenced overuse of psychotropic medications and the 'blurred' distinction between use of these medications as medical treatment and as chemical restraint.

3.2.4 Restraint in national health care regulation

Under the *National Health Reform Act 2011* (Cth), the Australian Commission on Safety and Quality in Health Care is responsible for developing standards relating to health care safety and quality and for coordinating the Australian Health Service Safety and Quality Accreditation Scheme.

The National Safety and Quality Health Service Standards govern the delivery of care in hospitals, day procedure services and public dental services across Australia. They provide nationally consistent expectations regarding the level of care consumers can expect from health service organisations.

Specifically, under the 'comprehensive care' Standard, 'minimising patient harm' includes articulated 'actions' relating to the minimisation of restraint (action 5.35) and seclusion (5.36), as well as preventing falls and harm from falls (5.25), preventing delirium and managing cognitive impairment (5.29) and predicting, preventing and managing aggression and violence (5.34).

The actions relating to seclusion and restraint state that where these practices are clinically necessary to prevent harm, the health service organisation has systems that:

- Minimise and, where possible, eliminate their use
- Govern their use in accordance with legislation
- Report their use to the governing body (Australian Commission on Safety and Quality in Health Care 2019).

3.2.5 The effectiveness of regulation

Determining the effectiveness of regulation (and, in particular, of regulation on its own) is unclear. In some instances, evidence of effectiveness may be significantly hampered by a lack of national data collection. Conversely, the introduction of increased scrutiny and mandatory reporting may lead to an apparent increase in restraint (Office of the Public Advocate (Qld) 2017).

In the US 'there is general consensus in the literature that the use of restraint in nursing homes has decreased since the introduction of legislation' (Office of the Public Advocate (Qld) 2017). Castle et al. (1997) found overall reductions in the use of restraints following legislative change, but that some types of residential homes may be more willing or able to effect change. Staffing levels, average occupancy, competitiveness of the local market, presence of a dementia-specific unit, and funding policies were significantly associated with the use of restraints.

By contrast, a Canadian study found that the introduction of legislation had little or no effect on the use of restraint in aged care – although the reasons for this could be many, including a baseline of good practice (Ralphs-Thibodeau 2007).

There may be some benefits of regulation other than reducing the incidence of restraint, at least in the short term. For example, the explicit inclusion of restrictive practices provisions in Queensland's *Disability Services Act 2006* (along with related initiatives) is noted to have improved transparency, consistency and accountability in the disability sector. On that basis, the Office of the Public Advocate in that state has recommended a similar provision be considered in the aged care sector (Office of the Public Advocate (Qld) 2017).

Ultimately, it is broadly acknowledged that legislation and policy alone are necessary, but insufficient, to uphold the rights of individuals and/or to change entrenched practices, and that non-regulatory measures are important drivers of reform (Maker & McSherry 2019, McDonald 2003, Schulmann et al. 2017).

In this context, it is worth noting that the Royal Commission identified several focus areas for non-regulatory initiatives in its interim report (see Chapter 4), and that a number of relevant resources and initiatives have already been implemented to support the minimisation of restraint in aged care, as highlighted in section 5.5.

4 Key inquiries and reviews

There is a long history of concern about the use of restraint in residential aged care.

Along with concerns about the human rights of those subjected to restraint and seclusion (Human Rights Watch 2019, Alzheimers Australia 2016), the safety and efficacy of these practices has been questioned in a number of studies and reports (Royal Commission into Aged Care Quality and Safety 2019a, Melbourne Social Equity Institute 2014), and the economic costs of restraint and seclusion (and conversely cost benefits of minimisation or elimination of these practices) have been described. These include, for example, the personal costs to the person subjected to these practices, organisational costs associated with staff turnover and legal proceedings, and the opportunity cost of treatment not received when an individual is instead restrained or isolated (Chan et al. 2012).

However, to understand the development of the Restraints Principles it is sufficient to look only as far back as 2017. That year saw the release of 3 landmark reports: 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 Carnell–Paterson review).

These reports prompted a series of events, including aged care reforms and refinement of the draft Quality Standards as well as the development of the Restraints Principles, their subsequent amendment, and implementation of a range of supporting non-regulatory measures (see section 5.5).

This chapter provides an overview of key inquiries and reviews addressing restraint in residential aged care, presented in chronological order of publication from April 2017 to present.

Note that the scope of inquiry has typically included but not been limited to the use of restraint or the Restraints Principles themselves; for simplicity, only views and recommendations relevant to restraint are included here.

The Oakden Report

10 April 2017 (Groves et al. 2017)

Overview: Investigation launched by the South Australian Government’s Chief Psychiatrist in response to concerns from the CEO of Northern Adelaide Local Health Network about care being delivered at the Oakden Older Persons Mental Health Service. Activities included site visits, staff interviews, consultation with families and carers (in person and via written submissions), and review of clinical files.

Viewpoint: The authors considered the use of restraint at Oakden to be contrary to all SA Health policies and national standards. They found that staff were insufficiently trained in alternatives to restraint and in the relevant legislation, and that documentation was poor and not used to inform quality improvement.

Key recommendations: The Local Health Network should develop and implement an Action Plan based on the principles and strategies of trauma-informed care. The Action Plan should:

- Be introduced as soon as possible, and ensure compliance with the SA Health *Restraint and Seclusion Reduction Policy Directive* and *Restraint and Seclusion in Mental Health Services Policy Guideline*

- Ensure all staff are aware of the legislative basis for restrictive practices
- Feature targets to markedly reduced rates of restrictive practice, with milestones along the path
- Enlist the assistance of experts from a range of disciplines that can help rebuild a new approach to the management of severe and persistent challenging behaviours of residents with dementia
- Be externally peer reviewed by those who operate similar services where restrictive practices are either rare or have been eliminated
- Include an expectation that the Chief Psychiatrist and their staff will conduct unannounced inspections.

Response: The SA Health Department established the Response Plan Oversight Committee to oversee the implementation of recommendations made in the Oakden report (SA Health 2018).

Elder Abuse—A National Legal Response

14 June 2017 (Australian Law Reform Commission (ALRC) 2017)

Overview: Examined laws and frameworks designed to safeguard older people from abuse by formal and informal carers, and the relationship between laws at the Commonwealth and state and territory level. The ALRC conducted a desktop review and 117 stakeholder consultations, and received 458 submissions from individuals and organisations.

Viewpoint: The ALRC considered that in some circumstances the use of restraint constitutes elder abuse, and is potentially a civil or criminal offence. Submissions to the ALRC were consistent in the view that restraint should be reduced or eliminated, but opinions varied on whether this is best achieved through legislation or non-regulatory measures.

There was also general agreement in submissions that restraint practices be used only when necessary. Suggested safeguards included that restraint should only ever be used after assessment by a qualified medical professional, with informed consent, and after systematic consideration or attempt of all alternatives.

The ALRC noted that it does not condone the use of restraint but is of the view that it should only be used to prevent *serious* physical harm (although the report does not discuss how this should be defined).

Key recommendations: Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive option and used only:

- As a last resort, after alternative strategies have been considered, to prevent serious physical harm
- To the extent necessary and proportionate to the risk of harm
- With the approval of a person authorised by statute to make this decision
- As prescribed by a person's behaviour support plan
- When subject to regular review.

The ALRC also recommended that the Australian Government consider further safeguards in relation to the use of restraints in residential aged care, including:

- Establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices
- Requiring aged care providers to record and report the use of restrictive practices in residential aged care
- Enhancing consistency in the way restrictive practices are regulated in aged care and the NDIS.

Response: The Australian Government's response (Australian Government n.d.) included the 'More Choices for a Longer Life – protecting older Australians' budget measure (allocated \$22.0 million over 5 years from 2017–18) and the development of a national plan (2019–2023) to address elder abuse (Council of Attorneys-General 2019, Ramesh 2018).

Review of National Aged Care Quality Regulatory Processes

25 October 2017 (Carnell and Paterson 2017)

Overview: Examined why Commonwealth regulatory processes did not detect failures at Oakden. The review was informed by literature review, environmental scan, and consultation including more than 400 submissions and over 40 interviews.

Viewpoint: Carnell and Paterson found that at the time of their review, the use of restraint in aged care was not explicitly regulated. Their view was that restraint escalates rather than calms behaviour, and that the goal should be elimination of the use of restraint altogether. They further considered that there should be a focus on responsive, flexible, and individualised care.

Key recommendations: The Carnell–Paterson review concurred with the ALRC recommendations that any restraints used should be the least restrictive and used only:

- As a last resort, after alternative strategies have been considered, to prevent serious physical harm
- To the extent necessary and proportionate to the risk of harm
- With the approval of a person authorised by statute to make this decision
- As prescribed by a person's behaviour support plan
- When subject to regular review.

The Carnell–Paterson review also supported the ALRC recommendation that approved providers must record and report the use of restrictive practices in residential aged care, specifying that reports should be submitted to the Aged Care Commission. Establishing this agency was also a recommendation of this review, and it is now the Aged Care Quality and Safety Commission (the Commission). Carnell and Paterson also recommended that:

- Accreditation assessments should include review of the use of psychotropic agents
- The use of antipsychotic medications should be approved by the Commission's chief clinical advisor.

Response: The Australian Government's response to the review included:

- Introducing unannounced audits for residential aged care services applying for re-accreditation
- Establishing the Commission
- Developing options for a Serious Incident Response Scheme (Australian Government Department of Health 2020a).

Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia

24 October 2018 (Parliament of the Commonwealth of Australia 2018)

Overview: Conducted by the House of Representatives Standing Committee on Health, Aged Care and Sport, this inquiry examined the incidence, reporting, and response to mistreatment of aged care residents, as well as the effectiveness of regulatory bodies, and the adequacy of consumer protection arrangements. The inquiry received 123 public and invited submissions, 33 exhibits, and held 7 public hearings.

Viewpoint: GPs reported observing a range of inappropriate practices related to restraint in aged care, such as pressure to prescribe antipsychotics inappropriately. Submissions highlighted concerns around the lack of legislation restricting the use of restraint, or mandating appropriate staff training and use of relevant resources (e.g. the Department's Decision-Making Tool; see Information and resources in section 5.5). There was a view that improved education and implementation of new service models had begun to change the use of chemical restraint, at least in Queensland.

Key recommendations: That the Australian Government amend the *Aged Care Act 1997* (Cth) to legislate that:

- The use of restraint in residential aged care homes be limited to the 'least restrictive' and applied only as a last resort
- Providers record any use of restraint, with records to be collected by the Department of Health
- Restraint only be used after a medical professional has prescribed/recommended such use
- The legal guardian and/or family member be immediately advised of the use of restraint.

Response: The Australian Government's response provided in principle support for the recommendations above, noting the introduction of the Restraints Principles and strengthening of providers' obligations (under the Quality Standards) relating to clinical care, including medication management (Australian Government 2019).

Prevention of physical restraint use among nursing home residents in Australia: The top three recommendations from experts and stakeholders

March 2019 (Bellenger et al. 2019).

Overview: A stakeholder consultation process undertaken in Australia in 2016 resulted in a set of 15 consensus-based recommendations to support the minimisation of physical restraint in residential aged care homes.

Viewpoint: The authors note increasing support for the minimisation and elimination of physical restraint, but wide variation across Australia in terms of practice and governance.

Key recommendations: Stakeholders ranked the following recommendations as the 3 most important:

- That a single definition of physical restraint be legislated to ensure common understanding and universal application
- That physical restraint act as a trigger for mandatory referral to a specialist aged care team to review the resident's care plan and identify strategies to minimise or eliminate the use of restraint
- To ensure that residential aged care staff profiles and competencies are appropriate to meet the needs of residents with dementia.

Other recommendations included that informed consent be obtained and documented prior to the use of restraint if its use was unavoidable, and that a systematic, national approach to reporting, monitoring and investigating the use of physical restraint be adopted.

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

3 April 2019 (Senate Community Affairs References Committee 2018)

Overview: Inquiry by the Senate Standing Committee on Community Affairs, launched in June 2017 in response to the Oakden report. An interim report was released in February 2018, which presented findings of public and confidential hearings; this report reiterated those findings and presented findings of an additional hearing plus regulatory developments.

Viewpoint: The committee noted a fundamental differing of opinion across stakeholders as to whether providers are health care services, or accommodation services in which residents may choose to receive health care. They noted a need for more explicit guidance on where the line is between personal and clinical care, and who is responsible for delivery and standards of care. They found that work to date had not adequately reduced the use of restraint.

The committee viewed the shift towards person-centred care in the (then forthcoming) Quality Standards as a positive step and one that should be accompanied by a change to person-centred regulation. They felt there was a lack of clarity on the extent to which prior reviews and expert opinion have been taken into account in the recent reforms.

They raised concerns that there was no indication of how assessors would review provider processes against best practice guidelines for medication management, or how chemical restraint would be benchmarked. The committee also raised concerns about the relaxing of requirements for clinical governance in the new Quality Standards, and were of the view that oversight of restrictive practice in aged care should not be any less strict than that applied in other contexts (e.g. mental health, disability).

Key recommendations:

- The Australian Government should act urgently to ensure the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector is extended to the aged care sector.
- The Australian Government should urgently investigate changes to ensure that the use of antipsychotic medications in residential aged care homes are approved by the chief clinical advisor of the Commission.

Response: The Australian Government noted the recommendations highlighted above, referring to the introduction of the Restraints Principles and non-regulatory supports, and noting the need for individualised clinical decision-making regarding the use of antipsychotic medications (Australian Government 2020a).

Background paper 4: Restrictive practices in residential aged care in Australia

3 May 2019 (Royal Commission into Aged Care Quality and Safety 2019a)

Overview: One of 8 background papers developed by the Royal Commission, comprising a review of academic literature, clinical guidelines, government standards, FDA news, and coronial inquiries. The paper examined definitions and consequences of restraint and the current state of play in Australia (including prevalence of restraint, regulation, legal frameworks).

Viewpoint: The paper found that restraint (and ways to reduce or avoid it) is an issue of significant public interest. It identified differing opinions on whether restraint is ever justified but concluded that the available evidence suggested that restraint can cause harm. Reliable data on the prevalence of restraint was found to be lacking, and determining prevalence to be made more challenging due to inconsistencies in the way restraint has been defined. The Royal Commission noted the 'patchwork' of federal, state and territory laws and non-regulatory policies and guidance that govern the use of restraint.

Key recommendations: Further inquiry is required into the nature and extent of restraint, how to deliver alternatives, and the systemic factors (legal and other frameworks) required to ensure safety and quality of services.

“Fading Away”: How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia

15 October 2019 (Human Rights Watch 2019)

Overview: Explored human rights concerns associated with chemical restraints in aged care, including obstacles to effective regulation and enforcement of older people’s rights. Eighty-nine interviews were conducted between April 2018 and August 2019 with families, health professionals, advocates, and government officials in Queensland, Victoria, New South Wales and the ACT.

Viewpoint: The Human Rights Watch considered the Restraints Principles (as legislated in July 2019) to be flawed because they do not prohibit chemical restraint, guarantee the right to informed consent, or provide for a complaint mechanism when a person has been chemically restrained. They considered the current complaints system improved, but still difficult to navigate and unclear in its authority to address complaints relating to chemical restraint. The authors were of the view, however, that improved complaint mechanisms would not replace the need for strengthened and enforced regulations. They also considered the Quality Standards insufficient because they do not mandate the reporting of the use of chemical restraint, and highlighted the need to address broader systemic issues of undertraining and understaffing at aged care homes.

Key recommendations: Parliament should enact legislation to eliminate the use of chemical restraint, specifying:

- Mandatory training for all aged care providers in dementia and dementia care, and in alternative methods to de-escalate unwanted behaviour

- Minimum staffing levels to provide support to older people
- Adequate enforcement mechanisms to protect older people’s rights.

Review of the Restraints Principles and their limitations

20 October 2019 (Peisah et al. 2019)

Overview: Examined the meaning of the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* and accompanying explanatory statement, and their role in improving practice. The project was led by Capacity Australia, funded by the Australian Government through the Dementia and Aged Care Services Grant.

Viewpoint: The authors considered the Restraints Principles a positive step forward in reducing restraint, but felt that more work was required to bring the requirements for chemical restraint up to the same level of rigour as those for physical restraint. In particular, they considered the definition of chemical restraint too vague and open to interpretation, rendering the legislation potentially ineffective. They also viewed the conditions for restraint use as insufficient, noting that providers were not explicitly required to try alternative strategies, and could meet their obligations by simply documenting that none had been attempted. Finally, the authors expressed concern about the different consent requirements for physical and chemical restraint.

Recommendations: Strategies to improve practice around chemical restraint and consent are required beyond the Restraints Principles.

Royal Commission interim report

31 October 2019 (Royal Commission into Aged Care Quality and Safety 2019b)

Overview: Presented findings primarily from hearings conducted between February and July 2019, with evidence collected up to September 2019 included where possible. The report summarised evidence on the use of restraint, the reasons for it, and presented directions for reform.

Viewpoint: The Royal Commission considered that restraint is not effective in managing behaviour and can cause harm. It noted that the drivers behind restraint use are multifaceted and include a focus on addressing symptoms rather than their underlying cause, insufficient training and knowledge across professional groups (care workers, health professionals), staffing and workload pressures, and insufficient rules and regulation. The Royal Commission's view was that previous recommendations for reform have not been fully implemented, and that the Restraints Principles fall short of regulation in the disability sector.

Key recommendations:

Recommendations will be made in the final report; however, suggested directions in the interim report included:

- Improved training in dementia and its management for aged care staff and GPs
- Better support for regular and targeted reviews of aged care residents taking psychotropic medications, through the Residential Medication Management Review service
- Better monitoring and enforcement of authority requirements under the PBS
- Mandatory collection and public availability of data on the use of restraint

- Increased implementation of dementia-friendly design principles
- A consistent approach to restraint regulation across sectors.

Response: The Australian Government responded to the interim report by announcing a \$537 million funding package, including:

- \$25.5 million to improve medication management programs to reduce chemical restraint in aged care, and new restrictions and education for prescribers
- \$10 million (2019-20) for additional dementia training and support for the aged care sector (Prime Minister of Australia 2019).

Report on the outcome of public consultation on the Serious Incident Response Scheme for Commonwealth funded residential aged care

November 2019 (Australian Government Department of Health 2019c)

Overview: Public comment on the Serious Incident Response Scheme was held from 30 August to 11 October 2019. Forty-five stakeholders responded to the online consultation paper, representing carers, consumer advocacy organisations, aged care providers, health professionals, assessment teams, and government. The SIRS in residential aged care will be implemented from early 2021.

Viewpoint: Stakeholders noted a number of issues relating to restraint and the Restraints Principles, including:

- Concerns over the adequacy of the Restraints Principles amendment in protecting aged care consumers from the misuse of restraint
- The need for consistent definitions and understandings of restraint (e.g.

between aged care and disability sectors)

- Confusion around requirements within the Restraints Principles (e.g. circumstances under which restraint is 'non-compliant', ambiguity of the terms 'as soon as practicable', 'minimum time necessary' and 'regularly monitor')
- Confusion around the overlap in regulating the use of restraint between the Serious Incident Response Scheme and the Restraints Principles
- A lack of guidance regarding the inappropriate use of restraint
- The likelihood of providers self-reporting inappropriate use of physical and chemical restraint.

Parliamentary Joint Committee on Human Rights inquiry report

13 November 2019 (Parliamentary Joint Committee on Human Rights 2019)

Overview: Inquiry launched in July 2019 after the Parliamentary Joint Committee on Human Rights received letters from the Human Rights Watch and Office of the Public Advocate (Victoria), expressing human rights concerns about the Restraints Principles. The inquiry was conducted as part of the Joint Committee's function of examining legislative instruments for compatibility with human rights, and involved a one-day public hearing and request for additional information from the Department.

Viewpoint: The Joint Committee supported the intention behind the Restraints Principles but held 3 key concerns: first, that the Restraints Principles created confusion regarding roles and responsibilities of providers and consumers' representatives, especially in relation to consent. Second, that there was confusion around legal obligations that might inadvertently increase the likelihood of restraint being used without consent.

And finally, that there was no requirement within the Restraints Principles that all reasonable steps be taken to eliminate the need for restraint.

The report also presented the views of dissenting Joint Committee members, who recommended that the Restraints Principles be disallowed, citing serious concerns about the potential to encourage rather than reduce use of restraint, lack of clarity around informed consent, inconsistency with the NDIS regulations and human rights obligations.

Recommendations: The Joint Committee recommended that at a minimum:

- The Restraints Principles be amended to clarify that other laws prohibit the use of both physical and chemical restraint without prior informed consent
- Detailed amendments be made to the explanatory statement accompanying the Restraints Principles to clarify the legislation's relationship to state and territory laws, especially regarding the authorisation of substitute decision making, and prescriber obligations to exhaust alternative options and obtain informed consent.

The Joint Committee also recommended that extensive consultation with relevant stakeholders be undertaken to work towards better regulation of the use of restraints in residential aged care homes, including:

- An explicit requirement to exhaust alternatives to the use of restraint, including preventative measures, such that restraint be used only as a last resort (noting the approach taken by the NDIS Rules)
- Obligations to obtain or confirm informed consent prior to the administration of chemical restraint
- Improved oversight of restraint use
- Mandatory reporting requirements for the use of all types of restraint.

Government response to the Parliamentary Joint Committee on Human Rights inquiry report

4 March 2020 (Australian Government 2020b)

Overview: The Australian Government provided in principle support for the Joint Committee's recommendations. The response described the revisions in the *Quality of Care Amendment (Reviewing Restraints Principles) 2019*. It also highlighted the program of work underway to minimise the use of restraints through non-regulatory measures, and additional budget measures in progress, including the development and piloting of quality indicators relating to chemical restraint.

The government also noted the recommendation made by dissenting members of the Joint Committee, but put forward the amendment as a more timely solution than disallowance of the Restraints Principles. The response provided in principle support for the recommendation to introduce new legislation and conduct widespread consultation. The amendment was proposed to fit this brief, with the 12-month review required to include consultations expected to consider concerns raised by dissenting members.

Senate review of the Restraints Principles

The *Legislation Act 2003* (Cth) provides for the disallowance of all delegated legislative instruments (i.e. those made by someone other than Parliament such as the Governor-General or a minister). All legislative instruments are subject to disallowance unless exempted by law. Motions must be filed within 15 sitting days after tabling. If the motion is agreed to, the legislation is disallowed and is effectively repealed. If the legislation repealed an earlier piece of legislation (in full or in part), that part of the earlier legislation is revived. The Senate Standing Committee's role is to ensure that each legislative instrument referred to it complies with the committee's non-partisan scrutiny principles, which relate to statutory requirements, the protection of individual rights and liberties, and parliamentary oversight. The Restraints Principles, as a delegated legislative instrument, were subject to the Legislation Act and were referred to Senate Standing Committee on Regulations and Ordinances in July 2019.

Table 4-1 summarises the process, culminating in the withdrawal of a motion to disallow the legislation in light of the November 2019 amendment.

Table 4-1: Overview of Senate Standing Committee's review of the Restraints Principles

Date	Summary
2 July 2019	<i>Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019</i> tabled in the Senate.
16 July 2019	The Committee lodged a notice of motion to disallow, to provide time for the minister's advice to be considered.
24 July 2019	The Committee noted in Delegated legislation monitor 3 ongoing correspondence with the Minister to resolve concerns that the Restraints Principles (a) trespass on personal rights and liberties, and (b) involve significant matters more appropriate for primary rather than delegated legislation (Senate Standing Committee on Regulations and Ordinances 2019).
16 October 2019	Delegated legislation monitor 7 outlined correspondence between the Committee and the Minister on the issue of whether the Restraints Principles should be set out in primary legislation, given the inclusion of significant matters that may affect personal rights and liberties of aged care consumers. The Committee's view was that neither consistency with existing regulatory measures nor administrative efficiency were sufficient justification for the Restraints Principles to be included in delegated legislation. It also considered that review of the Restraints Principles by the Parliamentary Joint Committee on Human Rights and Royal Commission did not constitute sufficient scrutiny to enact the Restraints Principles in Parliament. The Committee therefore referred the Restraints Principles to the Senate (Senate Standing Committee on Regulations and Ordinances 2019).
27 November 2019	In Delegated legislation monitor 9 the Committee described a private briefing held on 12 November between itself, the Minister, and senior officers within the Department of Health. In the meeting the Minister briefed the Committee on forthcoming amendments to the Restraints Principles to provide for a review of operations after 12 months. The Committee viewed this amendment as complying with its scrutiny principles and resolved to withdraw the notice of motion to disallow (Senate Standing Committee on Regulations and Ordinances 2019).
28 November 2019	Notice of motion to disallow withdrawn.

5 Relevant national aged care legislation and initiatives

5.1 The Aged Care Quality Standards

The current Quality Standards came into effect on 1 July 2019, and provide a framework of core requirements for quality and safety that apply across all Australian Government-funded aged care settings (Aged Care Quality and Safety Commission 2019).

Providers' compliance with the 8 Quality Standards is determined by performance assessments, in which Commission-registered quality assessors:

- Review relevant information (e.g. provider self-assessment data, outcomes of previous assessments, complaints received, referrals from other regulatory bodies, and information provided by consumers and their representatives)
- Obtain and evaluate evidence through observations, interviews and documented evidence of the quality of care and services.

Following each performance assessment, a delegate of the Commissioner considers the assessment team's report, the provider's response and other relevant information, and develops a performance report. The report details the delegate's assessment of the provider's performance against the Quality Standards (met or not met).

Commission assessors also conduct unannounced site audits between the submission of an application for re-accreditation and the expiry of the service's period of accreditation.

Six of the 8 Quality Standards include requirements directly or indirectly relevant to the use of restraint. The intent behind these requirements is summarised below, along with example actions that could be taken and evidence that could be collected by providers to implement and comply with each one. This information has been gathered from:

- *Guidance and Resources for Providers to support the Aged Care Quality Standards* (Aged Care Quality and Safety Commission 2019)
- *Regulatory Bulletin RB 2019-08 Regulation of physical and chemical restraint* (Aged Care Quality and Safety Commission 2020a).

5.1.1 Standard 1: Consumer dignity and choice

Relevant requirement(s): 1 (3) (d) Each consumer is supported to take risks to enable them to live the best life they can.

Intent of this requirement: All adults have an equal right to make decisions about things that affect their lives and to continue to make those decisions as they get older. Making decisions in everyday life involves risks. This requirement is about how the organisation respects a consumer's wishes and preferences relating to the risks they choose to take.

Dignity of risk supports a consumer's independence and self-determination to make their own choices, including to take some risks in life. If consumer choices are possibly harmful to them, organisations are expected to help the consumer understand the risk and how it could be managed to help them live the way they choose.

Organisations have other responsibilities under law to manage risks to the health and safety of the workforce and others in the service environment. In meeting these obligations, the organisation is expected to show how they involve consumers and look for solutions that are the least restrictive of their choice and independence.

Examples of actions and evidence:

- Consumers say they are an active partner in decisions that involve risk and problem-solving solutions to reduce risk where possible.
- The workforce can describe how they use problem-solving solutions to minimise risk and tailor solutions to help the consumer live the life they choose.
- If a consumer's choices and preferences are restricted, there are policies and procedures that make sure these restrictions are limited and tailored and proportionate to the risk.

5.1.2 Standard 2: Ongoing assessment and planning with consumers

Relevant requirement(s): 2 (3) (a)

Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services.

Intent of this requirement: Assessment and planning processes are expected to support organisations to deliver safe and effective care and services. Relevant risks to a consumer's safety, health and wellbeing are to be assessed, discussed with the consumer, and included in planning a consumer's care.

Where consumers have lost their decision-making capacity and have an advance care directive in place, health professionals have obligations to access and enact the

advance care directive. It should be available at the point of care and shared across service providers. Where a consumer has requested care or services that may pose a risk to their safety, health or wellbeing, such as the use of a physical restraint for comfort, organisations are expected to discuss the risks and alternative solutions with the consumer, so the consumer can make an informed decision about their care and services. Arrangements to protect consumers require assessment, documentation in care and services plans, informed consent and regular monitoring and review. When 2 or more organisations share the care and services for a consumer, or where there are integrated care and services, arrangements need to be in place to share and combine relevant information. This includes information about any risks to the consumer's safety, health and wellbeing.

Examples of actions and evidence:

- Where physical or chemical restraint is in use, consumers or their representatives say they have given informed consent, consistent with state and territory law.
- Consumers describe how the workforce took a problem-solving approach to managing or minimising risk or meeting their needs, goals and preferences where a solution wasn't obvious.
- The workforce can describe how they assess risk, and how they work together with consumers to minimise risk.
- The workforce can describe how consumers, and others who contribute more broadly to care and services (such as medical professionals), work together to deliver a tailored care and services plan, and monitor and review the plan as needed.

5.1.3 Standard 3: Personal care and clinical care

Relevant requirement(s): 3 (3) (b)

Effective management of high-impact or high-prevalence risks associated with the care of each consumer.

Intent of this requirement:

Organisations need to deliver personal or clinical care and manage risk in a way that balances the consumer's rights and preferences with their safety and the safety of others. This includes managing challenging behaviours in ways that involve the consumer and respects their rights, dignity and independence. This means organisations can manage risk and provide personal and clinical care in the least restrictive way and least restrictive service environment, while keeping consumers, the workforce and others safe.

Dementia affects many consumers receiving care and services. There are some gaps between what generally happens now and what is best practice care for consumers living with dementia. Although antipsychotic medicines may be appropriate for adults with severe mental health issues or long-term mental illness, there is concern that these medicines are being prescribed inappropriately in people aged 65 years and over for their sedative effects – that is, as a form of chemical restraint for people with psychological and behavioural symptoms of dementia or delirium.

Minimising restrictive practices: These interventions have high potential for harm and are practices that organisations can avoid with positive changes in how they assess, plan and deliver personal and clinical care for consumers. If an organisation uses restrictive practices such as physical or chemical restraint, these are expected to be consistent with best practice and used as a last resort, for as short a time as possible and comply with relevant legislation.

Examples of actions and evidence:

- Consumers say their care is safe and right for them.
- Consumers say members of the workforce explain risks to their wellbeing and they get to have input into the steps to reduce the risks.
- Members of the workforce can describe how they identify, assess and manage high-impact or high-prevalence risks to the safety, health and wellbeing of each consumer when delivering personal or clinical care.
- The workforce can describe how they get information or advice on best practice to manage high-impact or high-prevalence risks.
- The workforce can describe how the organisation supports them to identify and manage the high-impact or high-prevalence risks to the safety, health and wellbeing for each consumer.

5.1.4 Standard 5: Organisation's service environment

Relevant requirement(s): 5 (3) (b) The service environment: (i) is safe, clean, well maintained and comfortable; and (ii) enables consumers to move freely, both indoors and outdoors.

Intent of this requirement: The service environment is expected to promote the free movement of consumers (including to access outdoor areas). It may be important that the service environment is secure or access to certain areas are restricted to help create a safe service environment for consumers. Arrangements to protect consumers require assessment, documentation in care and services plans, informed consent from the consumer and regular monitoring and review, in line with best practice and legislation.

Examples of actions and evidence:

- Consumers say they can move freely within the service environment and access the parts of the service they use independently, including the outdoor environment.
- Evidence that any restriction in place at the service environment which impacts a consumer is based on the least restrictive option. The basis for any restriction is also up-to-date, evidence-based, transparent and able to be reviewed.

5.1.5 Standard 7: Human resources

Relevant requirement(s): 3 (d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards.

Intent of this requirement: This requirement is about support for the workforce to deliver outcomes for consumers in line with the Quality Standards. Meeting this requirement will support the workforce in their day-to-day practice, reduce risks and improve care. Members of the workforce should receive the ongoing support, training, professional development, supervision and feedback they need to carry out their role and responsibilities.

Examples of actions and evidence:

- Consumers say they have confidence in the ability of members of the workforce who deliver their care and services.
- The workforce can describe the training, support, professional development and supervision for them to be able to carry out their role.
- Management of the organisation can describe how they work out what training will be needed for the workforce in line with new or changing needs of their consumers.
- The organisation can provide evidence of induction and other training and development programs for all members of the workforce relevant to the Quality Standards.

5.1.6 Standard 8: Organisational governance

Relevant requirement(s): 8 (3) (e)

Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship, (ii) **minimising the use of restraint** and (iii) open disclosure

Intent of this requirement: Clinical governance is the set of relationships and responsibilities between the organisation's governing body, executive, clinicians, consumers and others to achieve good clinical results. It puts systems in place for delivering safe, quality clinical care and for continuously improving services. Clinical governance usually includes involving consumers and clinicians, clinical review, training, risk management, use of information and workforce management. This requirement describes the clinical governance and safety and quality systems that are required to maintain and improve the reliability, safety and quality of clinical care, and to improve outcomes for consumers where organisations provide clinical care.

Minimising the use of restraint: 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. Where restraint is clinically necessary to prevent harm, the organisation should have systems to manage how restraints are used. This is in accordance with legislation and the organisation's policies on reporting the use of restraints.

Examples of actions and evidence:

- Consumers say members of the workforce discuss their clinical care with them, including risks and benefits of any clinical treatment and the appropriate use of medication.
- The workforce say open disclosure is part of the organisation's practice when

a negative event happens. They can also describe the open disclosure process.

- Records that show use of restraint is always as a last resort, the application of restraint is documented and the safety and wellbeing of the consumer is monitored.
- Evidence of appropriate authorisation and consent for the use of restraints in compliance with legislation.

5.2 National Aged Care Mandatory Quality Indicator Program

Both in Australia and internationally, quality indicators are utilised to ensure and improve quality of care for people living in residential aged care (and many other) settings.

A recent report for the Royal Commission noted that 'while there is considerable heterogeneity between indicators measured internationally, several are consistently used, highlighting their importance and agreed value'. The use of physical restraints and the use of antipsychotic medications are 2 such indicators (Caughey et al. 2020).

The Quality Indicator Program was made compulsory across Australia from 1 July 2019, requiring all Commonwealth-subsidised residential aged care homes to report quarterly on 3 critical clinical areas – pressure injuries, use of physical restraint, and unplanned weight loss.

The Quality Indicator Program currently requires aged care homes to carry out observation assessments on 3 days every 3 months, counting all observations of 2 categories of physical restraint use: **intent to restrain** and **physical restraint devices**.

The Department has undertaken an extensive process to expand the Quality Indicator Program, including a national and international evidence-based literature review, national face-to-face and written consultations, expert consultation, and a national pilot in residential aged care services. From 1 July 2021, the Quality Indicator Program will therefore include updates to the current quality indicators, as well as 2 new indicators related to falls and major injury and medication management (see Figure 5-1).

The Quality Indicator Program definition of physical restraint aligns with the *Quality of*

Care Principles 2014, with restraint defined as any practice, device or action that interferes with a care recipient's ability to make a decision or restricts a care recipient's free movement.

The updated physical restraint quality indicator will measure the percentage of people in the service who have been physically restrained, and requires aged care homes to perform a single 3-day record review for every resident, every quarter. Based on sector feedback, this additional reporting includes residents restrained exclusively through the use of a secure area.

Figure 5-1: New and updated Quality Indicator Program quality indicators from 1 July 2021

New quality indicators

Falls and major injury

- Percentage of care recipients who experienced one or more falls
- Percentage of care recipients who experienced one or more falls resulting in major injury

Medication management

- Percentage of care recipients who were prescribed 9 or more medications
- Percentage of care recipients who received antipsychotic medications

Updated quality indicators

Pressure injuries

- Percentage of care recipients with one or more pressure injuries, reported against 6 pressure injury stages

Physical restraint

- Percentage of care recipients who were physically restrained

Unplanned weight loss

- Percentage of care recipients who experienced significant unplanned weight loss (5 per cent or more)
- Percentage of care recipients who experienced consecutive unplanned weight loss

5.3 Resources supporting the implementation of the Restraints Principles

A number of resources have been developed by the Commission to communicate the Restraints Principles to residential aged care providers, and support their implementation. Note that new resources continue to be developed so the list below should not be considered exhaustive, however at the time of writing, available resources include:

Regulatory Bulletin RB 2019-08 – Regulation of physical and chemical restraint

- Includes a summary of the Restraints Principles, Quality Standards, and FAQs
- Informs residential aged care providers of the requirements to be met before and during the use of restraint

Scenarios involving physical and/or chemical restraint

- Fifteen vignettes illustrating scenarios that constitute physical and/or chemical restraint, as well as scenarios that do not. Each vignette is accompanied by a brief explanation of why the scenario is or is not considered restraint and where relevant, the provider's responsibilities to the Restraints Principles and relevant jurisdictional legislation
- Designed to help care providers understand issues and responsibilities around minimising the use of restraint

Self-assessment tool for recording information on consumers receiving psychotropic medications

- This tool prompts providers to consider and record 9 key factors relevant to use of psychotropic medication, including the non-pharmacological strategies employed and timely discussion with the individual's representative
- Designed to help providers record how use of chemical restraint is managed

Stickers for PRN psychotropic medication

- Formatted sticker templates to facilitate accurate recording of PRN (*pro re nata* – as required) medication, including who it was administered by and when, reasons for use, non-pharmacological strategies tried, and outcome
- Designed to help providers record each use of chemical restraint
- An accompanying guide has also been developed, highlighting the importance of recording PRN medication use and describing how the stickers can assist.

Perimeter restraint self-assessment tool

- Prompts aged care staff to consider the environment and residents' own health and functioning to determine whether each individual is subject to restraint
- Outlines different actions that may be required for residents being restrained, according to whether or not the restraint is necessary (to prevent harm to the resident or someone else) or not.

Other Commission documents also assist providers in a more general sense – for example, the *Guidance and resources for providers to support the new aged care Quality Standards* addressing the 8 Quality Standards (see section 5.1).

5.3.1 Consumer information

In partnership with the Older Persons Advocacy Network (OPAN), the Commission has developed resources to support older people (and their families, carers and representatives) to understand chemical restraint and their rights. These resources include a brochure, a booklet and an interactive webinar series covering:

- What chemical restraint is, why it is used and how to prevent its use
- Medication management and appropriate pharmacological uses of medication (particularly antipsychotics and sedative medications)
- Understanding and using informed consent
- Alternative approaches to chemical restraint
- Current protections
- Where to go for help and support.

5.4 PBS changes

5.4.1 Revised PBS listing for risperidone

On 1 January 2020, changes to the PBS came into effect that aim to reduce inappropriate prescribing of risperidone – the only antipsychotic currently listed on the PBS for dementia. To encourage reduction or cessation of its long-term use, risperidone can only be prescribed initially for a 12-week course. After this period, prescribers must request approval for continued treatment from the Department of Human Services. Repeat prescriptions should not be sought for people who have not responded after 12 weeks.

5.4.2 Data capture and monitoring

Legislative amendments were made in October 2019 to ensure all prescriptions dispensed to residential aged care service consumers are identified as such. Changes to the PBS claiming and payments system to support this mandatory data capture took effect in July 2020.

5.5 Other measures to minimise the use of restraint

The legislative reforms that are the focus of this review are one piece of the puzzle in minimising the use of restraint in residential aged care. As highlighted in Chapter 4, changing practice on the ground ultimately requires a multi-pronged approach. To this end, there is an extensive program of non-regulatory work being undertaken alongside the regulatory and compliance measures, by Australian Government bodies and others, to support the implementation of the Restraints Principles in practice (including those measures set out in Sections 5.3 and **Error! Reference source not found.**). The effectiveness of legislative elements in reducing the use of restraint must therefore be considered in light of the broader context into which they were introduced. A summary of key non-regulatory activities is provided below. Note that to date these activities have focused primarily on chemical restraint, and that new resources continue to be released so the list below should not be considered exhaustive.⁵

⁵ It is also worth noting the wide array of resources available that, while not specific to the Restraints Principles, support behaviours that are consistent with them. These include for example clinical practice guidelines (e.g. Royal Australian College of General Practitioners 2019), and health professional newsletters (e.g. Meditrax 2019).

Dementia Behaviour Management Advisory Service (DBMAS)

Organisation: Dementia Support Australia

Aim: To reduce inappropriate prescribing of psychotropics

Overview: Provides 24/7 access to expertise, advice and short-term case management interventions

Target audience: Staff and carers in community, residential aged care, acute and primary care settings

Status: Ongoing

Relevance to the Restraints Principles:

Assessment: Yes

Alternatives: Yes

Consent: No

Prescribing: No

Documentation: No

Monitoring: No

Severe Behaviour Response Teams

Organisation: Dementia Support Australia

Aim: To reduce inappropriate prescribing of psychotropics

Overview: A 24/7 mobile service for people with dementia who are experiencing severe behaviours or psychological symptoms of dementia

Target audience: Commonwealth-funded approved residential care homes, multi-purpose services, or flexibly funded services

Status: Ongoing

Relevance to the Restraints Principles:

Assessment: Yes

Alternatives: Yes

Consent: No

Prescribing: No

Documentation: Yes

Psychotropic Medicines in Aged Care Program

Organisation: NPS MedicineWise

Aim: To improve the management of behavioural and psychological symptoms of dementia in those aged ≥ 65

Overview: This program delivers multifaceted interventions through a multidisciplinary approach. The interventions include a range of continuing professional development activities through a CPD-accredited program

Target audience: Health professionals in the aged care sector

Status: Rollout delayed: first webinar scheduled 29 October

Relevance to the Restraints Principles:

Assessment: No

Alternatives: Yes

Consent: No

Prescribing: Yes

Documentation: No

Dementia Training Program

Organisation: Dementia Training Australia

Aim: To improve the wellbeing of people living with dementia and the staff delivering their care

Overview: A consortium (involving 4 universities and Dementia Australia) funded by the Australian Government to provide nationwide education and training regarding the care of people living with dementia. Services include:

- Accredited dementia care vocational-level training courses (free to eligible workers)
- Online training portal for web-based training
- Tailored onsite training for aged care providers, including a dementia skills and environment audit and tailored training package

Target audience: Individuals and organisations caring for people with dementia

Status: Established October 2016 and ongoing

Relevance to the Restraints Principles:

Assessment: Yes

Alternatives: Yes

Consent: No

Prescribing: Yes

Documentation: Yes

Aged Care Quality and Safety Commission online learning (Alis)

Organisation: The Commission

Aim: To complement the delivery of the Commission's face-to-face education programs

Overview: The program provides interactive education to help providers understand the intent and application of the Quality Standards, understand key concepts, and support them in preparing for assessment against the Quality Standards. Alis includes learning modules regarding:

- Minimising the use of restraint
- Dignity of risk
- Improving quality of life
- Optimising independence
- Partnership
- Wellbeing

Target audience: Staff of aged care providers assessed against the Quality Standards

Status: All Commonwealth-funded aged care service providers that are assessed against the Quality Standards have been offered a number of free registrations so they can evaluate the benefits of Alis.

These finite free registrations are available until the end of March 2021, with an option to purchase more registrations to support ongoing professional development.

Relevance to the Restraints Principles:

The program includes a module on minimising the use of restraint.

Targeted prescriber outreach

Organisation: The Department

Aim: To reduce inappropriate prescribing of psychotropics

Overview: A two-stage campaign in which an initial awareness-raising letter was sent to 28,000 prescribers, advising them of best practice for managing behavioural and psychological symptoms of dementia (the *Six steps for safe prescribing fact sheet* was included – see below). A second letter will be sent to a smaller group of high prescribers to prompt reflection on their prescribing rates relative to the average.

Target audience: Prescribers (primarily GPs)

Status: In progress. First letter sent in December 2019; second expected in 2021.

Relevance to the Restraints Principles:

Assessment:	Yes
Alternatives:	Yes
Consent:	No
Prescribing:	Yes
Documentation:	No
Monitoring:	Yes

Information and resources

Beyond information on their respective websites, a number of information resources have been developed by the Department, the Commission and others to support the Restraints Principles and the minimisation of restraint more generally.

Psychotropic medications used in Australia: Information for aged care

Organisation: The Commission

Aim: To increase knowledge of the main classes of psychotropic medications and their role in dementia care

Overview: Brief information booklet outlining different psychotropics, the need for consent, and how they can be classed as restraint according to the Restraints Principles

Target audience: Health professionals

Status: Released February 2020

Relevance to the Restraints Principles:

Assessment: No
 Alternatives: No
Consent: Yes
Prescribing: Yes
 Documentation: No
 Monitoring: No

Six steps for safe prescribing

Organisation: The Commission and the Department

Aim: To support a person-centred approach to dementia care, with medication a last resort

Overview: Flowchart stepping prescribers through best practice for managing the behaviours and psychological symptoms of dementia

Target audience: Prescribers

Status: Released March 2020

Relevance to the Restraints Principles:

Assessment: Yes
Alternatives: Yes
Consent: Yes
Prescribing: Yes
Documentation: Yes
Monitoring: Yes

3 simple checks to support your residents

Organisation: The Department

Aim: To support a person-centred approach to dementia care

Overview: Single page fact sheet about caring for residents with dementia and managing challenging behaviours

Target audience: Personal care workers in residential aged care

Status: Published July 2020

Relevance to the Restraints Principles:

Assessment: Yes
Alternatives: Yes
 Consent: No
 Prescribing: No
Documentation: Yes
 Monitoring: No

Informed consent: What families need to know about antipsychotics and benzodiazepines in residential aged care

Organisation: The Department

Aim: To support a person-centred approach to dementia care

Overview: Single page fact sheet about alternative strategies, person-centred care and informed consent for medication

Target audience: Residents' families

Status: Published July 2020

Relevance to the Restraints Principles:

Assessment: No
Alternatives: Yes
Consent: Yes
 Prescribing: No
 Documentation: No
 Monitoring: No

Medication and restraint in aged care

Organisation: Dementia Training Australia

Aim: To inform residential aged care providers of issues and responsibilities around minimising the use of restraint

Overview: Video presentation by the Commission's chief clinical advisor, introducing the Quality Standards and Restraints Principles

Target audience: Provider management, health professionals and direct care-staff

Status: Released November 2019

Relevance to the Restraints Principles:

Assessment: Yes
Alternatives: Yes
Consent: Yes
Prescribing: Yes
Documentation: Yes
Monitoring: Yes

Guiding principles for medication management in residential aged care facilities (and companion guide for residents and families)

Organisation: The Department

Aim: To promote safe, quality use of medicines and appropriate medication management

Overview: Describes 12 guiding principles for medication management and provides an implementation guide and resources for each. Restraint is not explicitly addressed but the manual provides prompts and resources that may inform how the Restraints Principles are applied (e.g. policies and procedures for use of medication charts, policies for medication administration as required by relevant jurisdiction). The companion guide for residents and families similarly does not address restraint or consent. They both describe what the Guiding Principles are and provide general FAQs about medication use and links for more information

Target audience: Provider management, health professionals and direct-care staff, residents, carers

Status: Released 2012.

Relevance to the Restraints Principles:

Assessment: No
Alternatives: No
Consent: No
Prescribing: Yes
Documentation: Yes
Monitoring: Yes

Prescribing psychotropic medications to people in aged care – information and resources

Organisation: The Department

Aim: To increase prescriber awareness of available resources

Overview: Brief information booklet providing links to evidence-based information including clinical guidelines, government services, professional development, and other resources

Target audience: Prescribers

Status: Released January 2020

Relevance to the Restraints Principles:

Assessment: No
Alternatives: Yes
Consent: No
Prescribing: Yes
Documentation: No
Monitoring: No

Decision-making tool: Supporting a restraint free environment in residential aged care

Organisation: The Department

Aim: To promote person-centred, information-driven, safety-focused care

Overview: Provides information and practical tools on providing restraint-free care, including posters flow charts, and an information sheet to share with residents' families

Target audience: Provider management, health professionals and direct-care staff

Status: Released 2012; currently under revision

Relevance to the Restraints Principles:

Assessment: Yes
Alternatives: Yes
Consent: Yes
Prescribing: No
Documentation: No
Monitoring: No

Antipsychotic Tracking Tool (APTT)

Organisation: Dementia Training Australia

Aim: To help health professionals monitor antipsychotic use in their residential aged care home

Overview: The tool generates audit reports to help determine the prevalence of antipsychotic use in a given home and compare this to state-based benchmarks (excluding NT; derived from the RedUSE trial described below)

Target audience: Health professionals and pharmacists

Status: Released 2018

Relevance to the Restraints Principles:

Assessment: No
Alternatives: No
Consent: No
Prescribing: No
Documentation: Yes
Monitoring: Yes

Dementia and psychotropic medications

Organisation: NPS MedicineWise

Aim: To facilitate use of alternative management strategies, with psychotropic medications as a last resort

Overview: Suite of resources to support best-practice dementia care, including information, clinical tools, consumer handouts, and links to relevant research

Target audience: Health professionals and direct-care staff

Status: Released May 2020 (as a cohesive program; individual elements available previously).

Relevance to the Restraints Principles:

Assessment: Yes
Alternatives: Yes
Consent: No
Prescribing: Yes
Documentation: Yes
Monitoring: Yes

TOP 5 toolkit

Organisation: Clinical Excellence Commission, NSW Government

Aim: To improve communication between health professionals and families and support patient-centred care

Overview: TOP 5 is a structured approach to identifying non-pharmacological management strategies and developing a personalised care plan. The TOP 5 toolkit includes a range of resources to support both implementation and evaluation.

Key findings: In a 12-month evaluation of the TOP 5 intervention in 7 providers in NSW, the toolkit was perceived positively. The majority of staff found it useful and easy to use, and agreed that the toolkit improved patient care

Target audience: Health professionals and direct-care staff

Status: Released 2014, with trial conducted 2014–2015

Relevance to the Restraints Principles:

Assessment:	Yes
Alternatives:	Yes
Consent:	No
Prescribing:	No
Documentation:	Yes
Monitoring:	No

Reviewing and tapering antipsychotic medicines for BPSD⁶

Organisation: NPS MedicineWise

Aim: To provide guidance to clinicians and support documentation

Overview: Prompts documentation of reason for review, recommendations and outcomes

Target audience: Health professionals

Status: Published November 2019

Relevance to the Restraints Principles:

Assessment:	Yes
Alternatives:	No
Consent:	No
Prescribing:	Yes
Documentation:	Yes
Monitoring:	Yes

Deprescribing guide for antipsychotics for treatment of behavioural and psychological symptoms of dementia

Organisation: NSW Therapeutic Advisory Group

Aim: To provide information that can be applied to communications between clinicians, patients and/or carers.

Overview: Covers patient assessment and deprescribing strategies

Target audience: Health professionals

Status: First published October 2018

Relevance to the Restraints Principles:

Assessment:	Yes
Alternatives:	Yes
Consent:	Yes
Prescribing:	Yes
Documentation:	Yes
Monitoring:	Yes

⁶ BPSD – Behavioural and psychological symptoms of dementia

Trials of workforce initiatives

Embedded residential care pharmacists

Organisation: University of Canberra

Aim: To improve quality and safety of medicine use, especially by reducing inappropriate modification (e.g., crushing tablets)

Overview: Originally a controlled trial conducted at two sites (one control, one intervention) of one multi-site residential aged care provider in the ACT. The program involved creation of a provider-based pharmacist position to perform medication reviews and quality improvement activities

Key findings: The proportion of medications that were inappropriately modified was reduced at the site with the pharmacist but not at the control site. The intervention was also associated with more efficient medication rounds and increased documentation (McDerby et al. 2019)

Target audience: Pharmacists. Health professionals and other direct-care staff were indirectly targeted, through the pharmacist

Status: The trial was conducted 2017–2018; rollout to all aged care homes across the ACT announced March 2019. The Government has provided funding of \$3.7 million to the ACT primary health network (PHN) for this expansion of the trial. Country SA PHN has engaged the Pharmaceutical Society of Australia to implement a similar model in that region.

Relevance to the Restraints Principles:

Assessment: No
 Alternatives: No
 Consent: No
 Prescribing: No
Documentation: Yes
Monitoring: Yes

Reducing Use of Sedatives (RedUse)

Organisation: University of Tasmania

Aim: To reduce antipsychotic and benzodiazepine use in residential aged care

Overview: Single arm trial conducted in 150 residential aged care homes across Australia, after a pilot trial in Tasmania (25 sites, 2008–09). The program involved: (a) creation of a champion nurse role to drive practice change within each home, and (b) a structured 3-step approach to medication review

Key findings: After 6 months, antipsychotics and benzodiazepines were ceased or reduced for 40% of residents (Westbury et al. 2018). This reduction was not offset by increases in prescribing of other medications (e.g. antidepressant). In comparison, 5% of psychotropics were ceased or reduced in an earlier study of usual care (Yang et al. 2014). Direct-care staff reported increased knowledge of psychotropics, but wanted to learn more about non-pharmacological approaches

Target audience: Registered nurses working within residential aged care, associated GPs and pharmacists. Other direct-care staff were indirectly targeted, through nurse champions

Status: The trial was conducted 2014–2016 (Paola 2019). In 2019, 11 pharmacists were appointed by the Commission to deliver the RedUse program to nominated champion nurses and champion pharmacists in remote and very remote locations. They will also provide advice and support to others, including community pharmacists and GPs.

Relevance to the Restraints Principles:

Assessment: Yes
 Alternatives: No
 Consent: No
 Prescribing: No
Documentation: Yes
Monitoring: Yes

Halting Antipsychotic use in Long-Term care (HALT)

Organisation: Dementia Centre for Research Collaboration

Aim: To reduce antipsychotic use in residential aged care

Overview: Single-arm trial conducted in 23 nursing homes in Sydney. The program involved: (a) education for residential care nurses, GPs, and pharmacists on antipsychotics and alternative management strategies; and (b) a tailored deprescribing protocol. Nurse 'champions' within each nursing home trained other staff members and promoted practice change on the ground

Key findings: Analysis of retrospective and baseline data found that contraindications for psychotropics were common, and standard procedures (particularly a doctor's or pharmacist's recommendation for review) had been insufficient to ensure evidence-based prescribing. Written consent was accessible for only one resident – a record of consent was either lacking (55%) or unclear (29%) for the vast majority of resident prescribed a psychotropic agent (Harrison et al. 2020).

There was an 80% reduction in the number of residents on regular antipsychotics at 12 months, with no effect on behavioural/psychological symptoms of dementia (Brodaty et al. 2018). Nurses were key drivers of deprescribing and reported that direct care staff were enthusiastic about and willing to apply the person-centred care approach. Nurse champions saw the intervention as effective in increasing understanding of the potential harms associated with antipsychotic treatment, and awareness of alternatives to antipsychotics (Chenoweth et al. 2018). They also felt the program gave direct-care staff a chance to see that antipsychotics could be deprescribed without adverse effects on residents' behaviour. However the train-the-trainer model was considered insufficient to improve staff competence in delivering non-pharmacological approaches (Aerts et al. 2019).

Target audience: Registered nurses working within residential aged care, associated GPs and pharmacists. Other direct-care staff were indirectly targeted, through nurse champions

Status: Trial was conducted 2014 – 2016.

Relevance to the Restraints Principles:

Assessment:	Yes
Alternatives:	Yes
Consent:	No
Prescribing:	No
Documentation:	Yes
Monitoring:	Yes

5.6 Future directions

The Royal Commission is due to deliver its final report by February 2021.

Counsel Assisting's final recommendations include several relevant to this review, including recommendation 29 which specifically addresses the regulation of restraint (see box below), as well as recommendations regarding the need for mandatory minimum qualifications and national registration of personal care workers (recommendations 48 and 47), accreditation of general practices providing primary health care services for aged care recipients exclusively (recommendation 63) and the restricted prescription of antipsychotics (recommendation 71) (Royal

Commission into Aged Care Quality and Safety 2020a).

In the meantime, the Australian Government's 2020–21 budget committed \$408.5 million to improving the aged care system, in part to respond to both the Royal Commission's interim findings and the COVID-19 pandemic.

The government has 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 2020b, Australian Government Department of Health n.d.)

Counsel Assisting's final submissions

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)⁷;
- 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.

⁷ The final report, to which this document is a supplement

6 State and territory policy settings

Each Australian state and territory has enacted similar, but not identical, legislation regarding a range of relevant issues including consent to medical treatment, mental health and disability services and regulation of unregistered health workers. The relevant legislation is discussed below.⁸

6.1.1 Restraint

There is significant variation in how restraint is defined and regulated in state and territory legislation. For example, in guardianship legislation:

- Queensland and Tasmania have specific provisions for restrictive practices in their guardianship legislation; the Queensland Civil and Administrative Tribunal (QCAT) and the Guardianship and Administration Board in Tasmania have legislation granting powers to consent to restraint. Both states' legislation includes conditions that must be met before restraint can be consented to, and time limits and requirements for review are imposed.⁹
- New South Wales, Tasmania, Victoria and South Australia 'confer a legislative grant to guardians of "coercive powers"'. South Australian legislation (*Guardianship and Administration Act 1993*) 'explicitly provides for a tribunal to determine where a person should live, detention in that place and use of force in providing care or treatment' (Royal Commission into Aged Care Quality and Safety 2019a).
- The Northern Territory, ACT and Western Australia do not specifically

mention restrictive practices or coercive powers (Chandler et al. 2017).

However, as articulated by the Office of the Public Advocate (Victoria) 'guardianship [is] considered a last resort, if there is no less restrictive alternative to protect and promote the human rights of an adult with disability' (Office of the Public Advocate (Victoria) n.d.).

Besides guardianship, state and territory mental health and disability legislation may address restraint. However, this legislation variously omits restrictive practices entirely (ACT disability, NSW mental health and disability, WA disability), explicitly excludes conditions related to ageing (VIC disability¹⁰), or only covers specific disability and mental health services (ACT mental health, NT disability and mental health, QLD disability and mental health, SA disability and mental health, TAS disability and mental health, VIC mental health, WA mental health).

Though not currently applicable to residential aged care, explicit inclusion of restrictive practices provisions in Queensland's *Disability Services Act 2006* (along with related initiatives) is noted to have:

- Improved transparency, consistency and accountability around the use of restrictive practices
- Increased consistency, professionalism and oversight of behaviour support practices
- Contributed to reduced use of restraints and improved outcomes for people

⁸ This information was compiled in June 2020 and updated with information that came to light through review activities.

⁹ When other states' civil and administrative tribunals deal with decision making regarding restraint, they often aim to include similar requirements in their orders (Chandler et al. 2017).

¹⁰ The Victorian Senior Practitioner has given a direction to provide guidelines and standards for the use of physical restraint in the disability sector, under the *Disability Act 2006* (Victorian Senior Practitioner 2019).

with disability (Office of the Public Advocate (Qld) 2017).

On that basis, the Office of the Public Advocate in that state has recommended it be considered in the aged care sector (where it is not currently applicable) (Office of the Public Advocate (Qld) 2017).

The disability sector is also supported by legislation and ongoing national reform driven by the NDIS Quality and Safeguards Commission (see section **Error! Reference source not found.** for more information).

Although Australian governments have long been committed to the reduction of restraint in mental health settings, there is no national legislation regarding restraint in these settings (Royal Commission into Violence Abuse Neglect and Exploitation of People with Disability 2020), and no consistent definition of restraint across state/territory mental health acts (RANZCP 2017). In 2015, a position paper released by the National Mental Health Commission recommended a number of actions to reduce the use of seclusion and restraints in mental health settings, building on the Seclusion and Restraint Project by the Melbourne Social Equity Institute of the University of Melbourne. These included:

- Education for mental health practitioners
- Agreed definitions, targets and reporting frameworks
- Evaluation of seclusion and restraint practices and interventions
- A national approach to regulation (National Mental Health Commission 2015).

In Victoria, the *Supported Residential Services (Private Proprietors) Act 2010* provides for specific rights and protections for people living in privately funded residential aged care services.

The Act sets out rights and principles including dignity and respect and freedom from abuse, neglect or exploitation. It goes on to state 'if a restriction on the rights of any resident set out in the principles ... is necessary, and more than one option is available in implementing that restriction, the option chosen must be that which is the least restrictive of the resident's rights in the circumstances'. However, the statute does not apply to residential aged care services that are government subsidised, effectively excluding the majority of aged care services from its operation (Office of the Public Advocate (Qld) 2017).

In recent NSW case law, the Guardianship Division of the Civil and Administrative Tribunal decided that 'the definitions of physical and chemical restraint contained in the [Restraint] Principles in relation to people living in residential aged care should also be used by this Tribunal when there is evidence that such restraints are being used on a person who is unable to provide their own consent' (VZM 2020).

Other relevant initiatives include the policy directive from the NSW Government regarding seclusion and restraint in public health settings (published March 2020) that highlights concepts of prevention and least restrictive practice, governance and reporting. The Directive includes a paragraph on residential aged care that highlights key components of the Restraints Principles (with a focus on physical restraint) and explicitly bans the use of:

- Seclusion
- Posey crisscross vests
- Leg or ankle restraints
- Manacles/shackles (hard)
- Soft wrist/hand restraints (NSW Government 2020).

6.1.2 Consent and substitute decision making

In 2014, the Australian Law Reform Commission recommended reform of national, state and territory laws, and legal frameworks concerning individual decision making to ensure that:

- Supported decision making is encouraged
- Representative decision makers are appointed only as a last resort
- The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives (Australian Law Reform Commission 2014).

However, such reform is in early stages, and there are numerous challenges to overcome in embedding the principles recommended by the Law Reform Commission (Alston 2017).

Across Australia, it is presumed that all adults have decision-making capacity (e.g. to consent to or refuse treatment) unless it is proven otherwise. In common law, a person has capacity to make treatment decisions if they are able to both:

- Understand and remember the information needed to make the decision and its consequences of the decision
- Use and weigh that information as part of their decision-making process (Queensland University of Technology 2020a).

State and territory legislation also includes a presumption of capacity, unless the contrary is shown.

If a person lacks such capacity,¹¹ legislation exists in each state and territory that allows for the formal appointment of a guardian

and otherwise identifies substitute decision makers (known variously as a healthcare decision maker, health attorney, person responsible, medical treatment decision maker). However, this jurisdictional legislation has been described as a 'patchwork', with the frameworks relating to substitute decision makers variously contained in (or paired with) legislation relating to guardianship or advance care planning (Northern Territory Government 2019). However, similarities in the legislation include:

- A framework to determine a person's substitute decision maker for health care according to a hierarchy (that includes a person appointed in an advance directive or enduring power of attorney, a guardian appointed in a guardianship order and family, and other people who have a relationship to the individual concerned)
- Principles to guide healthcare decision makers
- Provisions to authorise healthcare without consent (e.g. in an emergency, or for routine/minor healthcare treatments)
- Provisions for obtaining consent when a decision maker is not available
- Provisions related to participation in medical research (Northern Territory Government 2019).

Although informed consent of the individual (e.g. resident in an aged care home) is considered best practice, in many instances individuals most likely to be subjected to restraint may also be deemed to lack the decision-making capacity (e.g. due to disability or dementia). For this reason, state and territory legislation regarding guardianship, powers of attorney and advance care directives and the like

¹¹ The threshold for appointment of a guardian is also defined variously in guardianship legislation, e.g. ability to 'make reasonable judgments', 'incapable of managing his or her person' or 'not capable' of managing affairs 'impaired capacity', 'mental incapacity', 'impaired decision making ability' (Alston 2017).

are relevant to consent and decision making by proxy.

Legislation relevant to consent and medical decision making in Australian states and territories is summarised below. Though focused on decision making for palliative and end-of-life care, relevant information, including capacity and consent to medical treatment and substitute decision making, has been summarised (by jurisdiction) by the End of Life Research Program at the Australian Centre for Health Law Research, Queensland University of Technology (White et al. n.d.).

It should be noted, however, that a legal argument can be made that chemical restraint does not constitute medical treatment or health care (Chandler et al. 2017).

Australian Capital Territory

Relevant legislation:

Medical Treatment (Health Directions) Act 2006

Guardianship and Management of Property Act 1991

Powers of Attorney Act 2006

Notes:

A person is presumed to have the capacity to make healthcare decisions.

The definition of capacity is slightly different depending on whether the substitute decision maker is an attorney appointed under an enduring power of attorney, a guardian or a health attorney (default decision maker – see below) (Queensland University of Technology 2020a).

An adult can make an advance health direction to refuse, or require the withdrawal of, medical treatment generally or a particular kind of medical treatment.

A health direction may be made in writing, orally or in any other way, but cannot be made by a person for whom a guardian is appointed under the *Guardianship and Management of Property Act 1991* or anyone else who has impaired decision-making capacity.

If there is no relevant health direction in place and no enduring power of attorney or guardian has been appointed, the default decision maker ('health attorney') is the first adult of:

- The person's domestic partner (in a close and continuing relationship)
- Unpaid carer
- Close relative or friend (Queensland University of Technology 2020b).

However, a health attorney does not have specific power to refuse treatment or withdraw consent to treatment (Queensland University of Technology 2020b).

An attorney (under an enduring power of attorney) may only consent to treatment for mental illness if the principal lacks decision-making capacity, does not have an advance consent direction under the *Mental Health Act 2015* authorising the treatment and expresses willingness to receive the treatment.

A decision-maker must give effect to the protected person's wishes wherever possible, and the protected person's life (including lifestyle) must be interfered with to the smallest extent necessary.

New South Wales

Relevant legislation:

Guardianship Act 1987

Notes:

To obtain valid consent, health practitioners must tell the patient the general nature and effects of the proposed treatment, the associated risks and the general nature, effects benefits and risks of alternative treatments (including no treatment). A patient has the right to give or withhold consent to any proposed treatment (Public Guardian (NSW) 2011).

'In New South Wales if a medical practitioner believes that a person has impaired capacity and is unable to make a decision concerning their care, they must seek consent from a person who is authorised to provide consent under the *Guardianship Act 1987* (NSW).'

The Guardianship Act does not define capacity, but rather states that a person is incapable of giving consent if he or she cannot:

- Understand the general nature and effect of the proposed treatment
- Indicate whether or not he or she consents to the treatment (Queensland University of Technology 2020c).

The 'Person Responsible' for a patient will be the individual highest on the hierarchy:

- An appointed guardian (including enduring guardian) with the function of consenting to medical and dental treatment
- A spouse or de facto spouse who has a close and continuing relationship with the person
- The carer or person who provides or arranges domestic services and care regularly or did so before the person went into residential care, and who is unpaid (note: the carers pension does not count as payment)

- A close friend or relative, provided they are not receiving remuneration for any services provided.

However, 'a "person responsible" cannot consent to using any restrictive practices on behalf of a person with a disability' (NCAT 2019). This is echoed in NSW Health's advice regarding consent for adults lacking capacity to consent (in the state's public health setting): 'If the purpose of the intervention is not to treat a medical condition (for example, the purpose is to address a behavioural issue) the person responsible may not be able to provide consent, and consent from a guardian with a restrictive practices function may be required' (NSW Health 2020).

The NSW Civil & Administrative Tribunal states that:

- 'If a person can provide their own valid consent to the use of restrictive practices, then there is no need for substitute consent'
- 'If substitute consent is needed, only a guardian with a restrictive practices function can provide consent'
- The guardian should consent to restraint only as a last resort, and when there are no less restrictive options available (NCAT 2019).

In a recent decision, the Tribunal explicitly noted that although an aged care provider may comply with the Restraint Principles (and its obligations under the *Aged Care Act 1997* (Cth)) by seeking consent for restraint from a 'consumer's representative', in NSW only a guardian appointed under the Guardianship Act with the appropriate decision-making authority has the legal authority to consent to physical or chemical restraint if the person is incapable of giving their own consent (VZM 2020).

In addition, a person considered incapable of providing consent to their own treatment is still considered to be objecting to treatment if they indicate or have previously indicated, by whatever means, that they do not want the treatment carried out and have not withdrawn their objection (Public Guardian (NSW) 2011).

The Guardianship Act details how an enduring guardian can be appointed and the decisions he/she can make on behalf of the appointer, including where he/she is to live and what health and personal care he/she is to receive. It also governs guardianship orders.

Part 5 of the Guardianship Act specifically refers to medical and dental treatment. The objects of the Part are to ensure individuals are not deprived of necessary treatment due to lack of capacity AND to ensure that any medical or dental treatment provided is provided for the purpose of promoting and maintaining their health and wellbeing. Part 5 details the hierarchy of 'persons responsible' and able to give consent on another's behalf, and when treatment may be provided without another person's consent of a person responsible. A medical practitioner providing 'minor treatment' is required to certify in writing in the patient's clinical record that:

- (a) the treatment is necessary and is the form of treatment that will most successfully promote the patient's health and wellbeing, and
- (b) the patient does not object to the carrying out of the treatment.

Northern Territory

Relevant legislation:

Advance Personal Planning Act 2013

Guardianship of Adults Act 2016

Powers of Attorney Act 1980

Notes:

A person is presumed to have capacity to make healthcare decisions. A person has decision-making capacity if he or she can:

- Understand and retain information about the matter
- Weigh the information in order to make a decision
- Communicate that decision in some way.

A person is not deemed to have impaired capacity just because he or she engages in 'unconventional behaviour' (Queensland University of Technology 2020d).

An adult with capacity can make an advance personal plan that may give directions regarding health care or medical treatment, or appoint a substitute decision maker, to take effect if they lose capacity.

If an advance personal plan has not been made, or does not contain directions relevant to the situation (including appointment of a substitute decision maker), a guardian can be appointed by the Northern Territory Civil and Administrative Tribunal (NTCAT). Unlike other jurisdictions, the NT does not legally recognise default decision makers. If a legally recognised decision maker has not been appointed, NTCAT has the power to give or refuse consent to treatment (Queensland University of Technology 2020d).

Law reform is currently being explored to optimise the principle of 'least restrictive interference', to recognise a person's family and other support people as potential decision makers, and to simplify

arrangements for consent to 'routine' health care (Northern Territory Government 2019).

Queensland

Relevant legislation:

Guardianship and Administration Act 2000

Powers of Attorney Act 1998

Notes:

A person is presumed to have decision-making capacity, as long as they are able to:

- Understand the nature and effect of healthcare decisions
- Freely and voluntarily make those decisions
- Communicate their decision (Queensland University of Technology 2020e).

If a person has lost capacity and does not have an Advance Health Directive with relevant provisions, the first person on the following list who is available, willing and able to act can be a substitute decision maker, make health care directions or provide consent for another person:

- A guardian appointed by the Queensland Civil and Administrative Tribunal
- An attorney appointed under an enduring power of attorney or an advance health directive
- A default decision maker ('statutory health attorney') – the first of the following available and willing to act as decision maker:
 - Spouse or partner
 - Unpaid carer
 - Close relative or friend (Queensland University of Technology 2020e).

The restrictive practices provisions in the *Guardianship and Administration Act 2000* specifically apply to people with intellectual or cognitive disability who are

receiving care from a Queensland Government-funded disability service provider under the *Disability Services Act 2006*. Similarly, though dementia has in some cases been considered a mental illness and therefore technically in scope of the Mental Health Act, this Act only relates to involuntary assessment and treatment of mental illness. Therefore provisions regarding use of restraints in both of these instruments do not apply to residential aged care services. (Office of the Public Advocate (Qld) 2017).

South Australia

Relevant legislation:

Advance Care Directives Act 2013

Consent to Medical Treatment and Palliative Care Act 1995

Guardianship and Administration Act 1993

Notes:

A person is presumed to have capacity to make medical treatment decisions unless they cannot:

- Understand information relevant to the treatment decision
- Retain such information
- Use such information in the course of making the decision OR
- Communicate their decision.

However, a person:

- Is not incapable of understanding information simply because he/she can't understand technical or trivial matters
- Is not incapable of retaining information even if they can only do so for a limited time
- May fluctuate between having impaired and full decision-making capacity
- Does not have impaired decision-making capacity simply because a decision results (or may result) in an

adverse outcome (Queensland University of Technology 2020c).

Although they have capacity, a person can appoint a substitute decision maker (in an Advance Care Directive), A Medical Agent (under a Medical Power of Attorney) or an Enduring Guardian (under an Enduring Power of Guardianship).¹² If none of these have been appointed, the default decision maker ('person responsible') is the first of the following available and willing to make the decision:

- A guardian appointed by the South Australian Civil and Administrative Tribunal (SACAT) with the power to consent to medical treatment
- A prescribed relative if the relationship is close and continuing (there is no hierarchy within the list of prescribed relatives)
- An adult friend (with a close and continuing relationship)
- An adult who oversees the person's day-to-day supervision, care and wellbeing
- The SACAT (on application).

The Office of the Public Advocate (SA) has published a document titled 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings'. The document is a guide for Guardians of the Office of the Public Advocate, but 'can be used as a guide' by private guardians or substitute decision makers. The stated purpose is to, whenever possible, prevent and minimise the use of restrictive practices. This document notes that a guardian or substitute decision maker can provide consent for physical, mechanical or chemical restraint (of behaviour not due to a mental illness and not requiring the use of force to administer).

However, this document also notes 'although a person overseeing ongoing

day to day supervision, care and wellbeing of a patient can provide health consent generally, the Advanced Care Directive Regulations forbid such a person providing consent to chemical restraint'.

If force is required to administer chemical restraint (of behaviour not due to a mental illness), consent of a more formally-appointed decision maker is required (Public Advocate (SA) 2015).

Under the *Guardianship and Administration Act 1993*, the SACAT has the power to determine where a person should live, including detention in that place, and may authorise use of force in providing care and treatment (Royal Commission into Aged Care Quality and Safety 2019a).

Tasmania

Relevant legislation:

Guardianship and Administration Act 1995

Notes:

A person is presumed to have capacity to make medical treatment decisions, but is considered incapable of giving consent if they cannot:

- Understand the general nature and effect of the proposed treatment
- Indicate whether or not they consent to the treatment (Queensland University of Technology 2020c).

If a person with a disability is incapable of giving consent and a common law Advance Care Directive doesn't exist, consent for medical treatment must be given by the 'person responsible' or the Guardianship Board. The Act sets out the hierarchy of 'persons responsible' (guardian, spouse, carer, close friend or relative).

¹² Due to legislative change, it is no longer possible to appoint a Medical Agent or an Enduring Guardian, but appointments made under previous legislation are valid (Queensland University of Technology 2020g).

Treatment can be carried out without consent if there is no person responsible, the treatment is necessary to promote the person's health and wellbeing and the person does not object to the treatment (Queensland University of Technology 2020c).

An appointed guardian can decide where a represented person is to live, restrict or prohibit visits to/from individuals if in the best interests of the represented person and to consent to any health care in the best interests of the represented person, and to refuse or withdraw consent for any such person.

Victoria

Relevant legislation:

Medical Treatment Planning and Decisions Act 2016

Guardianship and Administration Act 2019

Powers of Attorney Act 2014

Notes:

An adult is presumed to have decision-making capacity, meaning they are able to:

- Understand information relevant to the decision and the effect of the decision
- Retain that information to the extent necessary to make the decision
- Use or weigh that information as part of the decision-making process
- Communicate the decision and the person's views and needs about the decision (Queensland University of Technology 2020c).

If a person lacks capacity to make a decision about a proposed treatment, and there is no relevant Advance Care Directive, a medical treatment decision maker is the first of the following who is

available, willing and able to make the decision:

- A decision maker appointed by the individual (under the Medical Treatment Act or earlier legislation)
- A guardian appointed by the Victorian Civil and Administrative Tribunal
- A default decision maker – the first of the following in a close and continuing relationship with the person, and available and willing to act:
 - Spouse or domestic partner
 - Primary carer who is in a care relationship with the person and has principal responsibility for the person's care
 - The first of the person's oldest adult child, oldest parent, or oldest adult sibling (Queensland University of Technology 2020f).

The Medical Treatment Act in Victoria also allows for the appointment of a support person to facilitate 'supported decision-making'. Though the primary role of the support person is to assist someone with decision-making capacity to make his/her own decisions, an official guide to the Act notes that a support person 'may play a role in medical treatment decisions if the person does not have decision-making capacity'. In these circumstances, the support person's role will be 'to advocate for the person and to ensure treatment is provided in accordance with the person's preferences and values' (Victorian Government 2019).

Western Australia

Relevant legislation:

Guardianship and Administration Act 1990

Notes:

A person is presumed to have capacity to make healthcare and treatment decisions unless he/she unable to make reasonable judgments in relation to the proposed treatment.

If a person lacks capacity, and relevant instructions in an Advance Health Directive, the first of the following available, willing and able to act as a substitute decision maker may provide consent:

- An Enduring Guardian appointed under an Enduring Power of Guardianship
- A guardian appointed by the State Administrative Tribunal (SAT)
- A default decision maker ('person responsible') – e.g. the first of the following adults:
 - The person's spouse or de facto partner
 - The person's nearest relative who maintains a close relationship
 - An unpaid primary provider of care and support
 - Any other person who maintains a close personal relationship with the person.

If none of these are available, the SAT may appoint a guardian.

6.1.3 Health professional regulation

The proportion of the direct care workforce in residential aged care that are registered nurses, enrolled nurses or allied health professionals has decreased significantly over recent years, with their work increasingly delegated to unregistered and often unqualified and untrained personal care workers (Royal Commission into Aged Care Quality and Safety 2020a). At the same time, as noted in section 2.1, the level and complexity of residents' needs have been increasing.

In 2018, the Aged Care Workforce Strategy Taskforce noted that current challenges include poor employee engagement and enablement along with key capability gaps, and skills and competencies misalignment (Aged Care Workforce Strategy Taskforce 2018).

Though a number of health disciplines are regulated by national boards, unregistered health workers (which includes the personal care workers comprising 70 per cent of the total workforce providing direct care in residential aged care settings) are not subject to the national regulation arrangements under the *Health Practitioner Regulation National Law Act 2009* (Cth), nor required to hold formal registration.

The Department is currently exploring options for aged care worker regulation and has completed the first stage of this project. This project involved extensive stakeholder consultation to ascertain views regarding requirements for worker regulation, in particular for personal care workers. Following this consultation, a second stage is planned to explore options for national worker screening arrangements that would align with requirements for workers in the NDIS. This second stage will also explore, in parallel, a code of conduct for aged care workers, with stakeholders indicating a preference for a code that aligns with the NDIS code.

Alongside this initiative, a national code of conduct (code) is being implemented to guide unregistered health workers, and allow complaints agencies in each jurisdiction to respond to breaches of the code and take disciplinary action (COAG Health Council 2015, Royal Commission into Aged Care Quality and Safety 2019a). However, as noted by the Royal Commission, 'there may be some ambiguity about the extent to which personal care workers provide health services that come within the ambit of the regime, [and] health services may have different meaning in each state or territory legislation' (Royal Commission into Aged Care Quality and Safety 2019b).

Putting this caveat aside, in order to be operational in each jurisdiction the code must be supported by local legislation. Therefore, the extent to which the code has been implemented in each jurisdiction varies. For example:

- In the ACT, the legislation to implement the code was scheduled for introduction to the ACT Legislative Assembly in early 2019. Once passed by the Assembly, the National Code will be enforceable in the ACT, through amendments to the *Human Rights Commission Act 2005* (ACT Government Department of Health 2018).
- In NSW Schedule 3 of the Public Health Regulation 2012 sets out the code (NSW Government Department of Health 2017).
- In Queensland, the code has been in operation since 1 October 2015, under the Health Ombudsman Regulation 2014 (Queensland Health 2015).
- From 18 March 2019, South Australia has implemented the Code of Conduct for Certain Health Care Workers under the Health and Community Services Complaints Regulations 2019. This replaces the previous Code of Conduct for Unregistered Health Practitioners and aligns South Australia with the

national code approved by the COAG Health Council (Health and Community Services Complaints Commissioner 2019).

- In Victoria, Schedule 2 of the *Health Complaints Act 2016* sets out the code (Health Complaints Commissioner n.d.).
- In 2017 the Northern Territory released a discussion paper relating to the code. If implemented in the NT, the code would be established under the Regulation of the *Health and Community Services Complaints Act 1998* (Northern Territory Department of Health 2017).
- Currently, the code is not in effect in Western Australia. Legislative changes are required to give effect to the code, and at this stage there is no timeline available for completing the necessary legislative amendments (personal communication, Health and Disability Complaints Office).
- Implementation of the code in Tasmania is via amendments to the Tasmanian *Health Complaints Act 1995*. The *Health Complaints Amendment (Code of Conduct) Act 2018* was passed by Tasmanian Parliament in 2018 but has not yet been proclaimed. As such, the amendments are yet to commence. The *Health Complaints Amendment (Code of Conduct) Act* provides for the code of conduct to be prescribed and drafting of regulations for this purpose has commenced. The intention is for the amendments to commence in line with the making of the regulations (personal communication, representative of the Department of Health, Tasmania).

As at December 2019, the code is not in effect in the ACT, Tasmania, NT or WA (PACFA 2019).

In Victoria, however, a newly created Victorian Disability Worker Commission came into effect on 1 July 2020. Under its direction, the Disability Service Safeguards Code of Conduct articulates the obligations of Victorian disability workers and provides a standard to protect people with disability from harm and abuse. It is designed to ensure consistency between disability workers regulated by the national NDIS legislation and those who are not. Of most relevance to the use of restraints are the stated obligations to:

- Act with respect for individual rights to freedom of expression, self-determination and decision making in accordance with applicable laws and conventions
- Provide supports and services in a safe and competent manner, with care and skill
- Promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability
- Take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability (Victorian Disability Worker Commission 2020a).

The legislation also requires mandatory notification (by employers and workers) if 'a disability worker practised, or is practising, as a disability worker in a manner that constitutes a significant departure from accepted professional standards' (Victorian Disability Worker Commission 2020b).

7 Primary care and prescribing in residential aged care

The interface between clinical care and other types of care delivered in residential aged care homes is somewhat unclear, and therefore accountability is sometimes uncertain (Ibrahim 2019).

Although good access to primary healthcare is of great importance to the complex cohort of people living in residential aged care homes, challenges have been noted, including a lack of attractive remuneration for providing such services. In particular, 'usual' remuneration (through the Medicare Benefits Schedule) may be inadequate considering associated travel time and non-contact hours necessitated by the context (e.g. liaison with families and aged care staff) (Reed 2015, Belcher et al. 2020, Ibrahim 2019).

A number of models exist for the provision of primary health and prescribing services in residential aged care, including:

- A 'continuity model', where GPs effectively 'follow' long-term patients as they move into residential aged care
- A 'panel model', in which GPs provide care to several patients in nearby homes (and are eligible for an associated practice incentive payment)
- GPs with a special interest in residential aged care providing regular services to larger groups of patients in these settings
- GPs providing team-based care in residential homes (e.g. supported by practice nurses or nurse practitioners)
- GPs partnering with residential aged care homes to provide primary care services (and potentially clinical governance)

- Hospital-based in-reach services for acute illnesses (Reed 2015).

Though the continuity model may be the preferred model, according to the Royal Australian College of General Practitioners (RACGP), in reality most patients change GPs within months of moving into residential care (Reed 2015).

To support GPs caring for older Australians, the RACGP publishes an aged care clinical guide (the *Silver Book*).

Replacing previous editions of the RACGP's *Medical care of older persons in residential aged care facilities* guide, the *Silver Book* currently addresses 'Common clinical conditions in aged care' (Part A) and 'General approaches to aged care' (Part B). Part A includes guidance on the management of BPSD (including short-term use of pharmacotherapy) and deprescribing, while Part B provides specific advice on the use of PRN medications for the management of changed behaviours. Part C of the guide ('Organisational approaches to aged care') is due for release in late 2020 (Royal Australian College of General Practitioners 2019).

In the context of chemical restraint, one of the key issues with respect to the implementation of the Restraints Principles is the interface between residential aged care providers and prescribers. Their respective obligations (regarding assessment and consent, for example) is particularly ambiguous when it comes to medications prescribed for non-regular administration, such as PRN administration.

8 COVID-19 and restraint in aged care

Australian authorities' classification of COVID-19 as a pandemic on 27 February 2020 resulted in a raft of actions aimed at prevention and control of the disease. This section summarises national advice (at the time of writing) on guidance related to COVID-19 that may have had an impact on service providers' use of restraint (e.g. prevention/risk management and containment protocols in homes with confirmed case/s of the disease).

The impact of COVID-19 on the conduct of the review (as opposed to restraint practices) was considered in the project and evaluation plan.

Since March 2020, multiple guidelines have been issued on the management of COVID-19 in residential aged care settings, including those by the Infection Control Expert Group¹³ (Australian Government Department of Health 2020c), the Communicable Diseases Network Australia (CDNA 2020), Commonwealth Department of Health (Australian Government Department of Health 2020d, CDNA 2020), Dementia Support Australia (DSA) (Dementia Support Australia 2020) and, more recently, by a consortium of consumer and carers peak organisations¹⁴ (Industry code for visiting residential aged care homes during COVID-19 2020).

These guidelines recommend restrictions such as social distancing and self-isolation, consistent with COVID-19 safety measures recommended to the general population. However, in the context of residential aged care, some of these measures could be

considered physical restraint. DSA argues that 'enforced immobility should only be considered as a last resort and in line with guidelines and specific protocol for use (consent, other options exhausted, monitor and review regularly)' (Dementia Support Australia 2020).

Restrictions that potentially constitute restraint, recommended in COVID-19 guidelines released to date, include:

- Restricted movement inside/outside the home. For residents, this may involve:
 - Social isolation in a single room
 - Being housed together ('cohorted') with suitable roommates
 - Not having access to:
 - Their usual allied health or support staff if these staff are confined to one wing of the home to limit the risk of infection
 - Outdoor areas on a regular basis
- Restricted engagement with other residents:
 - While exercising
 - In common areas
- Visitor restrictions, relating to:
 - The number/frequency of visitors permitted – often guidelines state that only one care and support visit can be made to a resident per day
 - Duration of visit – this may range from 30 minutes to two hours in the case of short and long visits, respectively
 - Visitor age – persons aged under 16 years are generally not permitted to visit

¹³ Commonwealth Department of Health, as part of a collection of resources for health professionals, including aged care providers, pathology providers and health care managers.

¹⁴ Carers Australia, Council on the Ageing (COTA) Australia, Dementia Australia, Federation of Ethnic Communities Council of Australia, National Seniors Australia, Older Persons Advocacy Network, Aged & Community Services Australia, Aged Care Guild, Anglicare Australia, Baptist Care Australia, Catholic Health Australia, Leading Age Services Australia and UnitingCare Australia.

- Requirement that visitors:
 - Provide proof of immunisation for the 2020 influenza season before entry (unless medically exempt)
 - Book timeslots for visits (which may limit resident access to visitors because available timeslots may not align with visitor availability).

Noting that complaints against rigid and inflexible visitation processes have been made in response to COVID-19 related measures, DSA suggests that exceptions to visitor restrictions (specifically, allowing for longer visits) may be made on compassionate grounds in cases where a resident:

- Is dying or in palliative care
- Has dementia (e.g. where a visitor has a clearly established and regular pattern of involvement in a resident's care and support, including behaviour support for people with dementia)
- Has visitors from family and friends who have travelled extensive distances to visit (Dementia Support Australia 2020).

It is important to note that all homes must comply with their state or territory Emergency and Health Directives should an outbreak occur.

During previous infectious disease outbreaks, compassionate visits have been restricted (Industry code for visiting residential aged care homes during COVID-19 2020). However, COVID-19 has necessitated a more sustained period of action compared to the usual period for other infectious outbreaks. The Commission released a fact sheet to accompany the industry code, which outlines how the code will be considered in the management of regulatory and complaints activities (Aged Care Quality and Safety Commission 2020b).

In March, the Commission wrote to all residential aged care providers to advise that they are expected to exercise care and compassion in applying infection control restrictions during the COVID-19 pandemic, and provided examples of innovative ways providers have been supporting consumers to stay connected with loved ones. Examples of innovation include:

- Communicating with residents and families through newsletters and website updates
- Enabling visits outside where social distancing can be maintained
- Encouraging residents and their families to write letters and postcards
- Facilitating video calls using platforms such as Facetime, Zoom and Skype (Aged Care Quality and Safety Commission 2020c).

On 22 July 2020, the OPAN hosted a webinar, entitled 'Caring for people with dementia during COVID-19 restrictions' (OPAN 2020). The webinar covered:

- What it's like for a person living with dementia during COVID-19
- Lessons learned from the first wave
- Strategies for caring for a person with dementia during COVID-19
- Risks of chemical restraint.

The Commission has developed a page dedicated to COVID-19 information for aged care providers, including links to updated state/territory advice on visitor restrictions and exclusions (Aged Care Quality and Safety Commission 2020d).

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