



Regulatory Bulletin

Regulation of physical and chemical restraint

RB 2019-08

This Regulatory Bulletin outlines the requirements that must be met before and during the use of restraint. It outlines how the Commission will assess the use of restraint in the context of the Aged Care Quality Standards (Quality Standards) and the Quality of Care Principles 2014 (the Principles).

Key points

- Restraint must only be used as a last resort and in the least restrictive form.
- The Commission's focus is on ensuring that risks to consumers' safety, health and well-being through the use of restraint are minimised, and consumers are treated with dignity and respect.
- The Principles require providers to satisfy a number of conditions before and during the use of restraint.

- The provider is required to document the alternatives to restraint that have been considered and used.
- The provider is required to have a clinical governance framework in place to minimise the use of restraint. The Commission expects that where restraint is used, such a framework will ensure that informed consent for the restraint has been obtained.
- The consumer must be regularly monitored for signs of distress or harm.
- The restraint must be regularly reviewed with a view to removing the restraint as soon as possible.



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Information in this bulletin applies to:

All residential aged care services and flexible care services through which short-term restorative care is provided in a residential care setting.

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Regulation of physical and chemical restraint

Physical and chemical restraint must only be used as a last resort. From 1 July 2019, approved providers have specific responsibilities under the Quality of Care Principles 2014 relating to the use of physical and chemical restraint in residential care and short-term restorative care in a residential care setting.

The Aged Care Quality and Safety Commission (Commission) assesses the use of the restraint during complaint handling processes and accreditation, assessment and monitoring activities. During these processes, complaints officers and assessors will seek evidence of the actions taken by providers to minimise the use of restraints at their service and where restraint is used, to ensure that it is in accordance with legislative obligations. This evidence is gathered through observation, reviewing records of care, interviews with consumers and their representatives and enquiries of management, staff, health professionals and others at the service.

In this Bulletin:

- **Provider** means both approved provider of residential aged care services and approved provider of flexible care services through which short-term restorative care is provided in a residential setting.
- **Approved health practitioner** means a medical practitioner, nurse practitioner or registered nurse.
- **Care and services plan** refers to the care and services plan required by the Quality Standards.
- **Chemical restraint** means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
- **Commissioner** includes the Commissioner or a delegate of the Commissioner.
- **Consumer** means a person to whom an approved provider provides, or is to provide, care through an aged care service.
- **The Principles** refers to the Quality of Care Principles 2014.
- **Physical restraint** means any restraint other than:
 - chemical restraint; or
 - the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
- **Restraint** means any practice, device or action that interferes with a consumer's ability to make a decision or restricts the consumer's free movement.
- **The Quality Standards** mean the Aged Care Quality Standards.



Quality of Care Principles 2014

From 1 July 2019, the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 amended the Principles so that providers have specific responsibilities in relation to the use of physical and chemical restraint.

The Principles state that restraint cannot be used unless a number of specific conditions are met.

Physical restraint must not be used unless:

- an approved health practitioner, who has day-to-day knowledge of the consumer, has assessed and documented that the consumer requires restraint due to a risk of harm to themselves or others; and
- alternatives to restraint have been used to the extent possible and documented (including those considered but not used); and
- the restraint is the least restrictive form possible; and
- the provider has the informed consent of the consumer or their representative.

Where physical restraint is used in an emergency, the provider must inform the consumer's representative and complete the required documentation as soon as practicable after the restraint has started to be used. The provider must also seek the informed consent of the consumer and their representative to continue using the restraint, as soon as practicable after the restraint starts to be used. The restraint must be used for the minimum time necessary and the need for the restraint regularly monitored and reviewed.

Chemical restraint must not be used unless:

- a medical practitioner or nurse practitioner has assessed the consumer as requiring the restraint and has prescribed the medication the use of which is, or is involved in, the restraint; and
- the decision to use restraint is documented in the consumer's care and services plan; and
- the consumer or their representative is informed before chemical restraint is used or as soon as practical to do so.

The provider must provide information to the practitioner regarding the use of the restraint.

If either physical or chemical restraint is used, the Principles require providers to document certain specified information in the consumer's care and services plan and regularly monitor the consumer for signs of distress and harm.



Aged Care Quality Standards

The use of chemical and physical restraint may be assessed under a number of the Quality Standards, which came into effect on 1 July 2019. The Quality Standards specifically require providers who deliver clinical care to have a clinical governance framework in place that includes minimising the use of restraint and organisational wide governance systems for regulatory compliance that includes compliance with the Principles on minimising the use of restraint (Standard 8).

Several other Standards are also relevant, including:

- **Standard 1:** consumer dignity and choice, whereby the consumer is supported to take risks to live the best life they can
- **Standard 2:** ongoing assessment and planning with consumers
- **Standard 3:** personal care and clinical care which is best practice and responsive to consumers' changing needs
- **Standard 4:** a service environment that is safe and comfortable and promotes the consumer's independence, function and enjoyment
- **Standard 8:** organisational governance where the organisation's governing body is accountable for delivery of safe and quality care.

Frequently asked questions

1. What types of evidence might the Commission review in relation to the use of restraint?

The Commission will seek a range of evidence in relation to the use of restraint, depending upon the complaint or focus of the assessment activity. This could include:

- the actions taken by the provider to consider and use alternative strategies to minimise the use of restraints at their service, consistent with best practice and regulatory requirements
- where physical restraints are used, how long they are used for, observations of those restraints, monitoring the welfare of any consumer subject to restraint, evidence of restraints being removed at recorded intervals
- observations of consumers moving freely, or being enabled to move freely, indoors and outdoors
- interviews with staff to test their understanding that restraint is to be used only where it is necessary to prevent harm and all other reasonable strategies have been exhausted
 - staff can describe the checks that need to occur before restraint is applied, the way that consumer representatives are advised, how staff monitor the use of the restraint and the review of practice after restraint had been applied



- interviews with consumers and representatives about their engagement with the provider in providing consent for restraint, use of restraint and efforts to minimise its use
- documented system to determine and record consumer consent for the use of restraint and the terms of that consent
- documentation in the consumer's care and services plan that records:
 - the consumer's behaviours which are relevant to the need for the restraint
 - the alternatives to restraint that have been used (if any)
 - the reasons the restraint is necessary
 - the care to be provided to the consumer in relation to the consumer's behaviour
- the plans to review the need for ongoing restraint
- monitoring is taking place of the effects or side effects of the restraint on the consumer
- the consumer is regularly monitored for signs of distress or harm from the use of restraint
- written evidence of an organisation wide system designed to minimise and monitor the use of restrictive practices, including reporting to organisation management or to the organisation Board.

2. How does the Commission use the risk screening questions about restraint?

To help determine the focus of an unannounced assessment contact, the assessment team will interview the person in charge of the service. This will include asking questions to identify key areas of risk. The assessment team will use the discussion about the risk-based questions as an opportunity to understand the use of restraint at the service in more detail, including asking questions about consumers who are restrained and the types of restraint being used. If restraint is to be a focus of an unannounced assessment contact, a sample of consumers is selected and their experience in relation to restraint followed through the assessment.

Refer to **Regulatory Bulletin Assessment contacts in residential and home services** for details on how the Commission determines the focus of unannounced assessment contacts.



3. Are providers required to seek informed consent before using chemical restraint?

If a medical practitioner or nurse prescribes medication, including psychotropics, for the purpose of chemical restraint, they are responsible for seeking informed consent. In doing so, the practitioner must be aware of their ethical and legal obligations, including under relevant state and territory laws.

While the provider is not responsible for obtaining consent for chemical restraint, the Commission expects clinical governance arrangements to be in place to ensure that consent has been obtained, and that this is consistent with state and territory laws. This falls predominantly within Standard 8 of the Quality Standards. Providers are expected to:

- have effective organisation wide governance systems in place including a clinical governance framework which minimises the use of restraint; and
- have effective organisation wide governance systems for regulatory compliance.

These governance systems ensure that clinical care provided in the service is safe, of good quality and accords with relevant legal requirements.

Under the Principles, the aged care provider must inform the consumer or their representative about the use of the chemical restraint. The aged care service must provide this information before commencing the chemical restraint if it is practicable to do so,

or immediately after. This communication should be done in a way that the consumer or their representative can understand, include an explanation on the advantages and disadvantages of restraint, and they should be given the opportunity to discuss their concerns and expectations.

If the consumer or their representative has concerns about the medication, they should be referred to the medical or nurse practitioner who prescribed the medication.

4. Is the restraint self-assessment mandatory?

The Self-Assessment Tool for Recording Consumers Receiving Psychotropic Medications (psychotropic medications self-assessment tool) provides details of the type of information that the Commission will seek to review when undertaking assessments of aged care services against the Quality Standards, and as part of that, monitor how services are effectively overseeing the use of restraints.

Use of the psychotropic medications self-assessment tool is not mandatory. Providers are encouraged to use it to support continuous improvement processes in relation to how they use and minimise the use of restraint.

Providers may also or instead use other tools that give them the required information and may adapt the tool to their purposes.

The **Self-Assessment Tool for Recording Consumers Receiving Psychotropic Medications** can be found on the Commission website.



5. Is a secure dementia unit considered physical restraint for the purposes of the *Quality of Care Principles 2014*?

Yes, unless the consumer is able to freely exit. Some aged care providers have a secure dementia care unit or wing, which is designed specifically for people with dementia or similar conditions. Access to/egress from the physical environment usually will require a PIN-code or use other strategies to reduce the risk of wandering. Caring for a consumer in a secure unit is subject to the requirements in the Principles including, but not limited to, obtaining the informed consent of the consumer or their authorised representative.

6. Is a perimeter alarm considered physical restraint for the purposes of the *Quality of Care Principles 2014*?

No, not in itself. The aged care provider may use an alarm system to notify staff if a consumer enters or exits the service. If this alarm system does not prevent the consumer from leaving the service, the alarm system does not restrict the consumer's free movement. Therefore, this type of perimeter alarm in itself is not considered a physical restraint.

However, if the alarm is used to alert staff and the actions of staff prevent a consumer from leaving, then the consumer is being physically restrained and the requirements in the Principles apply.

7. Is the use of a coded key pad on doors to exit the facility considered a restraint?

Yes. Aged care providers may require consumers to use a PIN-code to exit the home. If the PIN code is not provided to the consumer, or if they are unable to use the PIN-code for other reasons (such as poor memory, vision impairment, out of reach), this restricts their ability to leave the home. A physical environment that restricts consumers' free movement is a physical restraint. The organisation must take the steps set out in the Principles for consumers who are subject to this form of restraint.

The Commission would be looking for evidence that physical restraints of an environmental nature are based on the least restrictive option. For example, for consumers who have been assessed by an approved health practitioner as requiring this type of restraint due to a risk of harm to themselves or others, has the basis for this decision been noted in their care and services plan, is the decision for this restraint transparent and is it reviewed as circumstances change.

Under the Quality Standards, the service environment is expected to promote the free movement of consumers including access to outdoor areas, even if for safety reasons some consumers' access or egress is restricted. Arrangements to protect consumers need to be in line with their assessed care and services plan and the least restrictive option for them.



8. Is a bed against a wall or use of bed rails considered restraint?

Yes. The use of bed rails or a bed pushed against a wall are restricting the free movement of the person using that bed and are therefore considered a restraint.

This does not mean that the restraint cannot be used if a consumer requests this situation; rather, it means that the requirements in the Principles must be met. If the consumer has the capacity, they are able to consent to the restraint.

Of note, a low bed is not generally considered a restraint as this is a recommended strategy to minimise the use of other forms of restraint, unless the use of a low bed restricts the movement of the consumer to get in and out of bed themselves. In this event and in the absence of documentation to determine the use of the low bed, this would be considered a form of restraint.

In this circumstance, as in all circumstances (except in an emergency) where physical restraint is used, the Commission would be looking for the provider to demonstrate that:

- the provider has the informed consent of the consumer (or their representative); and
- the consumer is regularly monitored, and information is recorded in the consumer's care and services plan; and
- updates are made to the use of these restraints over time as the needs of the consumer change.

Restraint Scenarios booklet

The Commission has released the Restraint Scenarios booklet, which details case studies and explores whether the provider's response can be defined as restraint. The Restraint Scenarios booklet can be found on the Commission [website](#).

Need to know more?

If you have any questions, contact the Commission's Regulatory policy Team by email on:

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