Transcript

Aged Care Quality and Safety Commission

Restrictive Practices

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 **Presented by:**

**moderator:**

Nicola Dunbar

Executive Director, Organisation and Workforce Development, Aged Care Quality and Safety Commission

**Panellists:**

Janet Anderson
Commissioner, Aged Care Quality and Safety Commission

Dr Melanie Wroth
Chief Clinical Advisor, Aged Care Quality and Safety Commission

[The visuals during this webinar are of each speaker presenting in turn via video]

**Nicola Dunbar:**

Hi. Welcome to this webinar about regulation of restrictive practices. My name is Nicola Dunbar. I’m the Executive Director of Organisation and Workforce Development at the Aged Care Quality and Safety Commission.

I’d like to begin by acknowledging the traditional owners of the lands on which we all meet today in our various places across Australia and pay my respects to Elders past, present and emerging.

Thanks for joining us for this webinar which is we’re going to discuss some important changes regarding the use of restrictive practices for aged care providers. Today’s focus is going to be on the requirements for the new legislation which came into force on the 1st of July and which clarify the limited circumstances in which restrictive practices can be used. I know that many people are interested in the new behaviour support plan requirements that are going to be starting on the 1st of September and we’ll be having a second webinar about those particularly in August.

We’ve already had a number of questions from providers about the changes and it’s good to see how engaged people are and how keen everybody is to know about the new requirements, what they’re doing and whether that’s meeting the requirements of the legislation. And the questions that we’ve had so far have been really important in terms of informing the webinar today.

We may have time for questions at the end. So there is a chat function that you would have seen, a question function. So if you put your questions in there we may have time to deal with some of them. If we don’t we’ll be taking those questions on board and feeding them back as FAQs on our website. So please put in your questions and even if we don’t have time they’re still useful and we’ll be able to provide feedback on those.

With the webinar today we have Janet Anderson, the Aged Care Quality and Safety Commissioner, and also Dr Melanie Wroth, our Chief Clinical Advisor. So to start I’m going to hand over to Janet to take us through the changes that have been made.

**Janet Anderson:**

Thanks Nicola and hello everyone. Welcome to the webinar. Let me start with the Royal Commission which made clear what many of us already knew, that restraints have been overused in aged care and have been used in ways that are not consistent with consumer’s rights and dignity. The Royal Commission highlighted that both chemical and physical restrains have often been used in either an unnecessary or inappropriate way, and that the use has for too long been taken for granted as a means of managing people with challenging or possibly inconvenient behaviour in aged care.

Now the legislative changes which came into effect on the 1st of July align with recommendations made both by the Royal Commission and by a review commissioned by the Department of Health called the Independent Review of Legislative Provisions Governing the Use of Restraint in Residential Aged Care. And that report is in fact available online if you want to read it. The new provisions in the Aged Care Act are aimed at driving cultural change across the aged care sector to minimise the use and eliminate the inappropriate use of restraint that is used primarily to influence or control a consumer's behaviour. And we’re going to unpack that a bit over the course of the next hour.

These legislative changes are part of the Government’s five year, five pillar plan to transform the aged care sector which was announced in May as part of the 21-22 Budget. The effect of the amendments is to strengthen and clarify requirements for providers and also strengthen the accountability of providers by making it clear what providers must always turn their minds to when considering using a restrictive practice including how that practice may affect a consumer’s rights.

**Nicola Dunbar:**

Thanks Janet. That’s a useful start in terms of painting the picture of where this has come from. You touched at the end there about consumer rights as being the core part of the legislative changes. Can you expand a bit on that and give us a kind of sense of how that sits within the new legislation?

**Janet Anderson:**

Sure. Whether you’re a provider, an approved provider, member of a senior executive, aged care worker, a consumer, a consumer’s family member, you would understand that people living in residential aged care are entitled to enjoy the same freedoms as any member of the general community, including not having unreasonable or unnecessary restrictions placed on their freedom of movement. So a person’s human rights are not extinguished or even diminished when they move into an aged care service or if they have a cognitive impairment. And that’s recognised in the Charter of Aged Care Rights which would be familiar to all of you I’m sure.

Standard 1 in the Aged Care Quality Standards is also instructive here. The consumer outcome for that standard reads as follows. I the consumer am treated with dignity and respect and can maintain my identity. I can make informed choices about my care and services and live the life I choose. So treating older people in Australia with dignity and respect includes respecting their rights regardless of where they live. And the amending legislation aims to reinforce the rights of aged care consumers to make decisions about their own care, and where they are unable to make those decisions, for their legal representative to exercise that right.

So the enhanced requirements now in the Aged Care Act in relation to restrictive practices are designed to reduce the use of restrictive practices and to prevent the inappropriate use of those practices and to support person-centred care as required under the Aged Care Quality Standards in that Act.

**Nicola Dunbar:**

So that’s a really solid base for the new requirements in the Act around that person­‑centred approach and consumers rights. How does that play out in terms of the actual changes to the legislation? What does that look like in terms of the changes?

**Janet Anderson:**

Okay. I’m going to use two verbs quite a lot here and Melanie may also deploy them. Strengthen and clarify. That is principally what the amendments have done in relation to the changes from the former provisions relating to restraint to the new provisions relating to restrictive practices. The Aged Care Act, the Quality of Care Principles and indeed the Aged Care Quality and Safety Commission Act have been amended to strengthen and clarify providers’ obligations relating to the use of any restrictive practices for a consumer in residential aged care or receiving short term restorative care in a residential care setting.

Let’s start with terminology. The term restrictive practice has been introduced to encompass all forms of restraint. Restrictive practices is defined as any practice or intervention that has the effect of restricting the rights or freedom of movement of a residential care recipient. Now before I go on I want to draw your attention to a fact sheet that we’ve actually published on our website today which contrasts the provisions which existed before the 1st of July this year and those which came into effect on and from the 1st of July. So if you want a user’s guide, a ready reckoner if you like to the things which have changed, then go to our website, find that fact sheet, and it will give you a very summary guide to those changes.

Now in the previous legislation there were two types of restrain identified, chemical and physical. The amended legislation defines five types of restrictive practices and they all share the common defining characteristic of being used primarily to influence or control a consumer’s behaviour. Those five are chemical, physical, environmental, mechanical and then seclusion. So have in your mind five. Let’s go through each of them quickly.

Chemical restraint is defined in the same way as it was previously. So it’s a practice or intervention that is or that involves the use of medication or a chemical substance for the primary purpose of influencing a care recipient’s behaviour. So it doesn’t include the use of medication which is prescribed either to treat a person’s diagnosed physical or mental illness or for end of life care.

Then we move to physical restraint. Now you would be familiar with the old version where physical restraint was anything other than chemical restraint. It has now been significantly narrowed in its meaning to focus on the use of physical force such as physically holding a consumer down to enable care. Now it does not include situations where physical force may be required momentarily, urgently and without hesitation to prevent a consumer from harming themselves or someone else.

There are three more types. So that’s chemical and physical. The third one is environmental restraint which involves restricting a consumer’s free access to all parts of the environment, such as caring for someone in a secure dementia unit. That is a form of environmental restraint. Or placing a consumer’s walking frame out of reach.

Fourth is mechanical restraint which involves using a device to prevent, restrict or subdue a consumer’s movement. And examples include for example a princess chair, a lap belt, bed rails. And then the fifth is seclusion. This involves the solitary confinement of a consumer where voluntary exit from a space or location is not permitted or facilitated or it is implied that this is the case. So this could include placing a consumer in a room from which they cannot exit and with limited access to their walker or a call bell for example. Now this is a very significant imposition on a person’s rights and should rarely if ever be used in a residential aged care setting.

These changes in terminology have strengthened the alignment between the aged care provisions and those which prevail in disability services. And that will definitely assist providers who are looking after aged care consumers alongside NDIS participants. Our most recently issued regulatory bulletin which you can find on our website actually includes all those definitions and provides additional examples. And we are also working on updating what were known as the restraint scenarios to give additional examples of the new, newly defined types of restrictive practices, and they will be published on our website shortly.

The other thing I’ll add in here is that there’s another new term that has been introduced in the amending legislation which is ‘restrictive practices substitute decision maker’. Now that term replaces what used to be called ‘consumer representative’ because we needed additional clarity as to the role and responsibilities of this role. So the term is new but the role of the restrictive practices substitute decision maker should already be familiar to all residential aged care providers. Under the previous provisions where a consumer did not have the capacity to give their own consent providers were required to ensure that consent was obtained from a person authorised to make that decision under the laws of the state or territory where the consumer resided. So that provider obligation remains in place. Nothing has been changed about that. It has however been clarified through the adoption of this clearer description identifying a restrictive practices substitute decision maker.

**Nicola Dunbar:**

Okay. Thank you Janet for kind of taking us in detail through those changes to the terminology. It’s good that we now have this fact sheet that people can see that detail and what’s in the regulatory bulletin. So we’ve got some terminology changes, we have some new types of restraint that have been specifically pulled out and identified in the legislation. Are there other key changes that providers need to be aware of?

**Janet Anderson:**

Yes there are. And again clarification, strengthening of existing requirements. I’ve got six here and I’ll run through them. Number one, the amendments reinforce the rights of aged care consumers in making decisions about their care. So they include the requirement for the use of restrictive practices to be in accordance with the User Rights Principles and the Charter of Aged Care Rights, and both of those reside in the Aged Care Act.

Two, they detail the steps that must be taken before, during and after the use of a restrictive practice. And I encourage you again to carefully read through the principles and our regulatory bulletin to understand these steps.

Three, the amendments strengthen and clarify requirements for providers to consider and apply best practice behaviour supports and plans before contemplating any use of a restrictive practice. Now such practices must be approached only as a last resort and to prevent harm. And I know Melanie will talk further about this.

Four, the amendments also clarify consent requirements, which we know a number of providers have asked questions about which of course underscores just how important this issue is for the sector and indeed for consumers.

Five, the Commission has also been given powers which we can use proportionate to the assessed risk to consumers where a provider is not complying with their restrictive practice responsibilities. So changes to our Act now permit us to issue what’s called a restrictive practices compliance notice if a provider fails to meet its responsibilities under the amended principles. Also we have the potential for a civil penalty to be secured through application to the court if a provider fails to comply with the conditions or timeframe of the restrictive practices compliance notice.

And then sixth, as flagged in the introduction that Nicola provided a requirement for providers has been introduced in the Act to ensure that particular consumers have a behaviour support plan. And that requirement comes into effect from the 1st of September. And as Nicola also said we will be discussing that requirement specifically in the next webinar that we are planning to hold in August.

**Nicola Dunbar:**

Thanks Janet. So you’ve been talking about how the changes clarify when restrictive practices should be used with the aim of minimising and eliminating inappropriate use of restrictive practices. Is there a kind of underlying sense to these changes that an implication that actually what would be better is not to use restrictive practices in aged care at all? Is that kind of what’s underlying this?

**Janet Anderson:**

Look this is a good question and I know that it’s a question that providers are asking themselves and discussing among yourselves. The short answer is that the intention of the new laws is not to render restrictive practices unlawful. That is not the aim. It is not against the law to use restrictive practices with a consumer at any time. So let me be crystal clear. What the amending legislation is saying is that a restrictive practice can only be used as a last resort and to prevent harm when other strategies have been tried and found to be ineffective and those efforts have been documented. And if a restrictive practice is used it must meet the legislative requirements relating to consent, it must be the least restrictive alternative available for the shortest time and subject to monitoring and review. And this applies to every instance of restraint, as I’m sure Melanie will talk about as well.

Now we all know that some people living with advancing dementia and experiencing behavioural and psychological symptoms of that condition can engage in behaviour that places themselves and/or others at risk of harm. Strategies involving avoidance of triggers, absorption in enjoyable activities, de-escalation, redirection, environmental stimuli can each and all be effective in keeping such people and others safe and in supporting their wellbeing and avoiding the use of restrictive practices.

And there may be times when a restrictive practice is necessary to manage a very real and present risk of harm, when all other options have been exhausted. This is where knowing and understanding the consumer and their needs is really important, to address those risks and have measures in place to avoid the use of restrictive practices except as a last resort. So it’s the inappropriate use of restrictive practices that is the issue.

The amended legislation makes clear the issues that providers need to understand and consider in determining whether a restrictive practice is appropriate in a specific circumstance for an individual consumer and if it is used the conditions under which it must be used which accord with the law.

**Nicola Dunbar:**

Thank you. Thanks Janet. That’s very clear. So given the changes that have been made is there any leeway from the Commission’s perspective for aged care providers in complying with the amended legislative requirements?

**Janet Anderson:**

The amended legislation came into effect from the 1st of July and the Commission is obliged and indeed required under our statutory provisions to regulate the sector against that provision. So effectively we are already operating on that basis. We are regulating the sector against the provision introduced from the 1st of July. Now having said that the Quality of Care Principles relating to minimising the use of restraint have been in place since the 1st of July 2019. So when I use the verbs clarify and strengthen you would take from that this is not unfamiliar terrain. The amended responsibilities introduced from the beginning of July this year represent an expansion and consolidation and clarification of principles which should already be very familiar to you, which means that you are building on existing responsibilities if you are a provider. And the new provisions also reflect best practice in relation to minimising restrictive practices.

So in short you’re already a long way there if not fully there. And we know that a number of providers having read the preceding documentation and understanding what the Royal Commission was saying, knowing what the review reported and recommended, have already moved to ensure that their staff are trained and equipped to perform against the new requirements in the Act. And for those providers, including possibly some who are listening today who may be less familiar with the new requirements and are just still getting up to speed, I strongly recommend that you read the regulatory bulletin we’ve recently published and move quickly to put into place the measures that are needed to meet these new requirements and to provide the best care possible to your residents. Fundamentally staff training will be a core element of that and I expect if you are a provider listening you have already turned your mind to the additional support and guidance that your staff will require – executive leadership, on-site managers, clinical staff, care workers, all of them – will require to understand and implement the new provisions.

**Nicola Dunbar:**

Thank you Janet. I’ll give you a break now and turn to Melanie, but before I do we’ve had some questions that have come through from people who haven’t been able – the fact sheet that Janet mentioned around the amendments and the differences between the old legislation and the revised legislation, some people were saying that they were unable to find it. I’ve just checked with our staff and apparently it just takes a little bit of time. It only got put up just before 5:00 and it takes a little bit of time to come through on our website. Somebody from the Commission has just checked and it is now there. So please go in. You might need to refresh but that fact sheet is now up on the website.

So Melanie we’ve heard that one of the aims with the legislative changes is to ensure that restrictive practices are used as a last resort. What does that mean? What are the things that people need to consider when they’re thinking about restrictive practices as a last resort?

**Dr Melanie Wroth:**

Last resort really is fairly self-explanatory in that it means every single conceivable effort should be made to do everything that can possibly be done to allow good care to continue without the need for the use of restrictive practices.

Good care really is at the basis of this, good general care, which as the need requires can morph or you can build on good care to start to manage behaviour. And if you’re intending to use restrictive practices obviously then your behaviour management has to be formalised into a plan. But it really starts with care planning and understanding and knowing the consumer or the resident as an individual. So really understanding the person, it’s actually got person-centred care at the very core of it. And I think if you imagine for yourself if you’re going into aged care and that you may start to find yourself in a position where you’re responding in a way that you haven’t responded in the past because of such things as being unable to recognise people that you would otherwise have known, you’re unable to interpret your environment, you’re unable to understand what’s happening to you in terms of the sensations you’re feeling and what you’re hearing, and crucially you’re unable to communicate effectively what your needs and wishes are, what you don’t like and what you do like.

So good person-centred care is very easy for somebody with no cognitive impairment because they’ll tell you what they don’t like and they’ll tell you what they do like and what they want. And when that’s no longer the case that’s when you start to have to think for them in terms of trying to avoid the things that would be irritating or annoying to that particular person and trying to do the things for them that enhance their quality of life and enhance their enjoyment. Such knowledge about the person’s background and their life history and their life story, their life context, that will guide your conversation with them, guide the way you approach them, guide the sort of person that they would want to be near and want to interact with and the sort of people that they don’t want to, the sort of situations that they would never have wanted to be in, the sort of foods they would never have wanted to eat, the sort of things that they would want to eat. And you can see that by knowing these sort of things it’s absolutely a person-centred approach but it will enable you to respond much more meaningfully and effectively to a person who is starting to be unable to communicate their own needs themselves.

And it’s important to remember that it’s not just looking at the things that they don’t like but it’s the absence of things. So if somebody is bored or lonely or frightened, anticipating what situations are going to make the person bored, anxious or frightened or lonely, then avoiding those, talking to them and reassuring them before they’re starting to get agitated, I think you will be able to see easily that very good person-centred care and good predictive behaviour management starts morphing into what you might document as a behaviour management plan.

So prevention is the first step of making sure that the emerging of behaviours even occurs before the need for the use of restrictive practices. And behaviour management at the foundation of this needs to adapt. So it’s sometimes a case of trial and error. You know that the person used to love coffee. Well then the cup of tea alternative strategy is probably never going to work and if it doesn’t work once it’s probably not very helpful to keep trying it night after night when you could be trying something else. And the person at night is only going to know what to try if it’s well documented. So those are starting to become the foundations of a behaviour support plan or a behaviour management plan and I think that you will see that many people are already doing this very well.

So this knowledge and understanding needs to be really part of business as usual in your service. That thinking about how to avoid things and how to respond appropriately to that person as an individual are all things that need to be done before you’re even thinking about using a restrictive practice.

Then obviously if you are contemplating using a restrictive practice you then start to get into the other requirements in terms of looking at what alternative strategies can be used more formally, what advice and support you need if it’s got beyond your own working out. And do please remember that Dementia Support Australia runs the Dementia Behaviour Management Advisory Service and also the Severe Behaviour Response Team which will give you in person assessment and support and telephone 24 hours a day advice line. So if things are getting beyond your own ability to manage something especially if it’s becoming an emergency, then do avail yourself of external advice as well.

So we will of course be continuing to update our website as further resources become available.

**Nicola Dunbar:**

Okay. Thanks. Thanks Melanie. So you’ve talked, and I think that the approach that you’ve described about how the fundamental basis of any decision making about restrictive practices is really embedded in person-centred care and an understanding of the needs of the person. If you’ve got to the point of having that understanding and considering some kind of restrictive practices, recognising that this is the last resort, what are the things that need to happen at that point? What are the things that providers need to think about if they’ve kind of got to the point of we’ve tried other things, we know this person, things are not working, what do we need to do? We might need to go to restrictive practices. What are the things that they need to think about in that context?

**Dr Melanie Wroth:**

Well what I have seen is that in some places there’s a really streamlined approach to making decisions about restrictive practices and monitoring and reporting and continuing to try alternative strategies and continuing to try to enhance the person’s quality of life while they’re doing it, and monitoring for risk of harm as well as monitoring for ongoing needs. So all of those things need to happen. And if it’s happening and it’s well embedded in the organisational governance it happens in a really consistent, streamlined and obvious way so that a provider or service manager can say ‘Well this is how we make decisions. This is how we made this decision for this person. This is where it’s documented and these are the things we took into account, and this is the monitoring we’re doing as a consequent’.

So as far as organisational governance and embedding it into that, I think that I would really recommend that you have a clear person or people who’ve got really good knowledge of what’s required and where decisions are being made in respect of consumers and restrictive practices that that person is overseeing those decisions and that decisions are clearly escalated to that person. And that approach is obviously much more effective than if everybody thinks they know what they’re doing. Some do and some don’t and things are being in an ad hoc and sometimes in a way that does not sit well within the legislation.

So I think that just as a provider you need to ensure that you’re fulfilling the legislative requirements but also, and because it interlinks beautifully, that you’re checking that you’re not doing anything that’s inconsistent with the rights of the consumer and that you’re always making sure that you’ve got really robust person-centred care.

One of the things that I think is important is that when you’re considering using restrictive practices that it has to be you go back to first of all somebody needs to be able to say why they think something is or isn’t a restrictive practice, and that means going back to the definitions, but also don’t forget that you’re meant to be addressing risk. You are meant to be able to articulate what is the risk that this particular restrictive practice is addressing. And if you say well it’s for safety, well that’s not really articulating what the risk is because in some cases for safety when you actually tease it out it’s actually not really for safety of that consumer, it’s because their behaviour is annoying or intrusive. Or in some cases a restrictive practice is used on one consumer, for example locking the door to their room to protect them from the behaviour of another consumer, so managing one consumer’s behaviour with a restrictive practice for another consumer is obviously fraught with problems. And going back to the definitions and trying to work out what the risk is for that consumer is really going to be fundamental.

**Nicola Dunbar:**

Okay. One of the things that you mentioned when you were talking about the things that providers need to when they’re considering restrictive practices, you mentioned consent. And that is an issue that comes up quite frequently. We’ve had a lot of questions about it already and there are a number of questions that have been raised by the participants in the webinar. Can you give us a bit more information about informed consent and what it means in the context of the amended legislation?

**Dr Melanie Wroth:**

Sure. Well informed consent has always meant the same thing. The legislation currently I think has just articulated it more clearly. But there’s a really big difference between agreeing to something, consenting to something and giving your fully informed consent. And we do see where providers are trying hard to document consent by asking somebody for example to sign a form, which if it’s a generic form or a blanket form or a proactive form – so sometimes there’s a form saying ‘I consent to treatment that may be given in relation to my care’ – that’s not informed consent for anything in particular actually, but it’s certainly not informed consent for the use of restrictive practices.

So informed consent needs to be given by somebody with the capacity to give it. Of course the first person who has the right and should be giving consent is the person themselves. When it comes to restrictive practices often the person themselves will not have the capacity to give their own informed consent and that’s when consent needs to be given on their behalf by a properly identified person with the legal authority to make that decision on behalf of the person. And the informed part of informed consent needs to be in italics. It’s the crucial part of it. It’s so that the person making the decision is able to understand the reason for whatever the proposed management, either medication or other restrictive practice is, they need to understand the risk it’s addressing and what the hoped for result or benefit is going to be. So how is this restrictive practice going to address that risk.

The person giving informed consent needs to be able to understand what available options there are for managing the particular risk or problem, including the option of not using it. So what’s the risk to the person if I choose not to give my consent for this? And they need to understand the risks and benefits of each option and be able to come to a considered decision and be able to communicate that decision. They also need to understand that consent is not ongoing, indefinite, once you’ve signed the form it’s open slather, that you can withdraw your consent at any time, and that consent may very well be very short term. So if for example you’re proposing to use a medication that’s got quite a high risk of sedating somebody and the potential harms that sedating medications can confer on a person, that you might want to know how sedated that person is, whether they’re actually eating, whether they’ve got any ability to enjoy any component of their quality of life, or whether the harms are outweighing the potential benefits. You might also want to know if it’s having the desired effect because if you’re consenting to something as a trial and it doesn’t work, well then you’d want to stop it. And if it’s doing more harm than good or more harm than you hoped it would then also you might want to stop it or lower the dose.

So you can see easily that consent for something as simple as Panadol for a headache where everybody can really understand it, the risks are low, the potential for doing good is high, there aren’t that many reasonable alternatives, it’s actually not a very complex process. But where there are lots of options and particularly where the stakes are high, the risks of harm are high, and the monitoring – you might well want to know a bit more detail about some of those things. So informed consent needs to be very specific to the actual decision that the person is being asked to make and the informing part of it needs to be done by somebody with a true understanding of the risks and potential benefits and harms of the proposed restrictive practice.

And I think we’ll probably get onto it a bit later but the provider does need to be sure that informed consent has been obtained and the mechanism of that varies a little bit between chemical and non-chemical restrictive practices. But that’s what informed consent actually means.

**Nicola Dunbar:**

So that’s a nice lead in Melanie in terms of the responsibilities for providers here to be sure that informed consent has occurred and that that is different between chemical and physical. Can you expand a little bit more about that, about what those responsibilities are, and particularly as they’re different?

**Dr Melanie Wroth:**

Yep. So medication use is complex and the mechanism of action, the way medication interacts with other medication that the person might be on, or with other chronic or other health conditions that the person might have. Medications will have very different effects in different people given their own special physical circumstances and the other things that they’re taking at the same time, and their sensitivity to side effects.

So knowledge of different medications really is not something that a lay person has insufficient detail to be the person obtaining informed consent and that is why the responsibility for informed consent about medication rests with the prescriber. So the person who’s proposing to prescribe or offering to prescribe a particular medication needs to have that conversation with the correct person, the person themselves or their legally identified authorised substitute decision maker. They need to have that conversation with them so that that person if they are consenting understands why it’s being used, what they’re hoping to achieve, what are the risks, the potential harms and how that’s going to be monitored and altered. So that clearly rests with the prescriber.

And what the provider needs to do in relation to this is have a really good process of communicating with each prescriber that comes to their service – so it’s usually a GP but it might be a nurse practitioner – that there’s an agreed process which needs to work for the service and the GP obviously of how the prescriber is going to communicate the fact that they’ve obtained informed consent and who they’ve obtained it from. So there needs to be some way that the prescriber can reassure themselves that that’s happened. The detail of what was discussed, that does not need to be recorded by the provider who may not have been present at the conversation. They need to understand that informed consent has been given. And if the family, if it's them giving – and I shouldn’t say the word family. If the substitute decision maker has got further concerns or is seeking more information then that should be referred back to either a pharmacist in the case of more information or to the prescriber for more information or for review or further discussion of their concerns.

If it’s for non-chemical restrictive practices then the appropriate assessment and documentation needs to be overseen much more directly by the provider so that the conversation in relation to informing of all of the components that are involved in informed consent, that needs to be well documented, dated, who was present, what was canvassed and what consent has been given, and with any particular provisos or conditions on that consent. So sometimes a person may give consent but only in certain circumstances, so consent can absolutely be conditional. And if the circumstances change materially so that all of the conversation that was had around consent, those things no longer apply, obviously you would need to go back to the person making the decision and update them as to how the situation’s changed and seek their ongoing or new consent for that.

**Nicola Dunbar:**

Thank you. Obviously consent is an important topic and we’ve had quite a few questions come through about it. I hope we’ve addressed some of those. We probably haven’t addressed all of them but we will have a chance probably – we might not have time today but we’ll be able to come back and address those key issues with FAQs about consent.

I’m going to move on to a different area now. Still with Melanie. The situation can happen where a consumer or their family member might request some form of restrictive practices. What implication does that have about the provider’s obligations and responsibilities under the legislation?

**Dr Melanie Wroth:**

So the responsibilities are still exactly the same. If somebody’s requested it then obviously that needs to be assessed in terms of what risk is the request hoping to address. And just because somebody has requested something doesn’t actually mean that they are aware of all the options and all of the implications and potential consequences of that, and that’s what needs to occur before the person can give informed consent. So it’s not the case that just because somebody’s requested it it means they’re automatically giving informed consent. And a good example of that is in relation to bed rails where families might request bed rails for safety or just not even for safety, just because they had them in hospital, and when they are made aware of all the potential risks of that, such as the person may try to climb over the bed rails, in which case they’ll fall from a greater height and have a greater risk of harm, that body parts can get caught in the bed rails, that people can’t get up independently and go and get themselves a drink of water or toilet themselves or walk around their room or notify people when they’re lonely. And of course there’s the risks of injury against the rail and suffocation and death if they get caught against the bed rail. And when those risks are explained to people some people who request it no longer actually want it. They can see that for their particular person the harms outweigh the benefits. So it’s just as important to go through the informing part of the informed consent in that situation.

In terms of consent can I just make a note of the OPAN resources that the Commission commissioned OPAN to do. And it’s on an OPAN page. It’s also linked from the Commission’s page called Medication: It’s Your Choice. And there’s a six minute animation video which goes through – it’s designed for consumers but we’ve had many carers go ‘Ah, thank you. Now I understand’. But being the substitute decision maker for somebody is actually a really important job. It’s not just saying yes to the doctor. It’s not just agreeing. You actually have rights and responsibilities. You’ve got a responsibility to make sure that you who best know the person are satisfied that it’s going to be of overall benefit and that all of the things that can go wrong or can flow from restrictive practices are happening in as minimal a possible way.

**Nicola Dunbar:**

Thank you. I want to cover Melanie just with you one more thing quickly before we move on and that’s about emergency situations. So again we’ve had a number of questions that have been raised around that, about what is the responsibility, what is an emergency situation, what are the responsibilities in those kinds of circumstances?

**Dr Melanie Wroth:**

Yep. So an emergency situation in the commonly understood way is really something that comes up suddenly, unpredictably, it couldn’t have been foreseen or it couldn’t have been foreseen in a timely manner, and that the risk of harm to the person or to others is very high, that somebody’s going to have an immediate risk to their health or safety and that something needs to be done right now. So obviously in that situation the immediate risk needs managing as what’s termed an emergency. It’s quite different from the response you would have to a medical emergency. It’s really where you need to try and mitigate the risk of harm in a way that’s going to be most effective and least distressing to everybody.

And sometimes – absolutely don’t want to minimise how challenging these situations can be – sometimes behaviours can escalate completely unpredictably, completely out of the blue, and people are genuinely frightened and at risk of serious injury. And sometimes that really just needs a response of calling emergency services and having staff retreating to somewhere safe. That’s unusual to be that sudden and that severe but there are all greys leading up to that. The Commission would have – so separate provisions apply to emergency use where obviously you have to notify the substitute decision maker as soon as practicable, and clearly you need to try and interrogate the situation, try and work out why it happened and see what you can put in place to prevent that happening again. And if you’re contemplating restrictive practices then you need to go through the normal process. But again you would be I hope contacting the 24 hour Dementia Support Australia support line if you were having a difficulty with frequent emergencies.

If restrictive practices are used either regularly, routinely, frequently, and being termed emergency without really robust attempts going on immediately to try to prevent these things escalating to that point, then obviously one would have to question the efficacy of the behaviour management or the timely implementation of the least restrictive restrictive practices to mitigate the emergency situation.

**Nicola Dunbar:**

Thanks Melanie. Janet I’m going to follow up with you quickly around this issue about emergency from a perspective of some people might be saying that having those provisions around use of restrictive practices in an emergency might give a sense of here’s a get out of jail free card for example. What’s your view around the use of those provisions for use of restrictive practices in emergencies?

**Janet Anderson:**

I think Melanie has really set the field for this very cogently. Let’s start back with Melanie’s rendering of the common meaning, a situation which is extraordinary and requires an urgent or immediate response. So by definition where a provider was using the emergency provision routinely we would certainly have grounds as the Commission to question the circumstances in which they were activating this provision including the effort or planning that they had put into obtaining consent. So the amendments do make clear that consent must be obtained and recorded prior to use either from the consumer themselves, or as Melanie has outlined so clearly from a restrictive practices substitute decision maker in the event that consumer lacks capacity. Now in an emergency the substitute decision maker must be informed as soon as possible after the application or use of any restrictive practice and that must be noted in the care and services plan.

But I say again, and as Melanie has underscored so effectively, where restrictive practices are required in residential aged care in the event of an emergency, that would be rare given the requirements around behaviour supports and person-centred care, which have been outlined so well by Melanie. So a lack of evidence of effort to avoid emergency circumstances or inappropriate justification for the absence of effort to consider behavioural supports or to understand individual consumer needs, would lead the Commission in the direction of finding non‑compliance. Now that’s not a certainty but I have given you a clear indication of the signals that we would be reading about whether a provider had tried hard enough, whether this was a situation which could reasonably have been anticipated and prevented from occurring or whether it is genuinely an emergency in the true sense of that word, and could not have been forestalled or mitigated satisfactorily in the absence of the use of restrictive practice.

**Nicola Dunbar:**

So following on from that Janet the question about how the Commission will be monitoring, enforcing the requirements of the revised legislation on providers, what’s the approach going to be about that monitoring and enforcing function?

**Janet Anderson:**

Well I think people watching this webinar would have already gleaned that the Commission takes very seriously the use of restrictive practices by aged care services and will continue to focus on ensuring that providers are taking all steps necessary to treat consumers with dignity and respect, to minimise the use of restrictive practices, and where a restrictive practice is used, to ensure that it’s used appropriately in accordance with legal requirements. So we will continue to make good use of all the information which becomes available to us through complaints, through serious incident reports, through site audits, the quality indicator program, to undertake risk‑based profiling to assist us in determining whether providers are meeting their obligations under the principles and the Quality Standards. And where we determine that a provider is non‑compliant with their responsibilities, we will take as we always do proportionate, regulatory action to ensure that consumers are protected from harm and that providers meet their responsibilities.

So our new powers include the opportunity to issue a restrictive practices compliance notice, where a provider is not or may not be complying with its responsibilities in relation to the use of restrictive practices as set out in the Quality Care Principles. There is also as I’ve mentioned before the potential for civil penalties in the circumstances where there is non-compliance with the notice. So providers – and I know there would be people online from approved providers – those of you who want to understand more about our powers should familiarise yourselves with our Compliance and Enforcement Policy, which again is available from our website and which we’ve updated specifically to take into account the new provisions as they’ve been introduced from the 1st of July this year.

**Nicola Dunbar:**

Thanks Janet. One final question. What is the Commission doing – so we talked about monitoring enforcement but we’re also here to help and support the sector with these changes. What is the Commission doing around supporting the sector and consumers around these changes?

**Janet Anderson:**

Well I think there have been lots of mentions throughout the course of the last hour about the range of guidance and resources and other information which we are producing and will continue to produce. Please go to our website to have a look for it. There is provider facing material. I’ve already talked about the regulatory bulletin. There is also information and guidance on advocacy, behaviour support planning, capacity to consent, dementia, and also these are part of the guidance already made available for the Quality Standards. Further information is planned and will be forthcoming including an ALIS module or numbers of modules over time.

Now the consumer facing resources are just as important. We already have links on our website to resources on advocacy and decision making, medication management, complaints management, and the Serious Incident Response Scheme, among other material. Melanie has referred already to the Older Person’s Advocacy Network, OPAN, and some of the really good work that they’re doing. I would direct you in that attention. You can find the links on our website. And there is more that we’re also producing for consumers as well.

I’ll close on this section by referring to the work being done with the Department of Health and Dementia Support Australia to develop additional guidance on behaviour support planning which we expect should be available in August. And I know that there are a number of providers online who are very keen to get access to that.

**Nicola Dunbar:**

Thanks Janet. We’re actually almost out of time with all of the information that we’ve covered, so we won’t be able to go into detail with your questions now. But we’ve had a lot of questions and we really appreciate all of the questions that are coming through. That will really help us with FAQs and with the resources that we provided to you over the next couple of weeks. So thank you every much for everybody who’s been putting in their comments and their questions. It’s been great.

Janet before we close I’ll just go back to you, if there are any kind of key points that you would like people to take away with them from today?

**Janet Anderson:**

Thanks Nicola. And thank you all for the questions you’ve submitted. As Nicola said we will be looking at them closely and using them to inform the guidance and resources we make available. A lot of information has been covered today and you will want some time to think it through and to do your own research. There are further details available on our website to help you understand your new obligations if you’re a provider and to help you know your rights if you’re a consumer.

Importantly aged care staff need to be trained in the new clearer expectations. And if you’re an approved provider listen to this. You know your obligations in that regard. The foundational principle on which the new restrictive practices obligations are based is that every consumer’s needs and expectations are factored into the way in which you as a provider interact with them and support them. You treat them as individuals who deserve to live with dignity and respect and you provide services which keep them and those around them free from harm.

The same principles are those which animate the Quality Standards and you are very familiar with those. So this is not new terrain. So for that reason the requirements shouldn’t be an enormous stretch for you. The restrictive practices requirements are an extension, a clarification, a strengthening of what you already know and do. And that’s the expectation that we have of you if you’re a provider as the regulator of aged care. So I urge you to get across your responsibilities in this area, and if you’re a provider to support your site managers, clinical staff, aged care workers, to provide care in accordance with these new strengthened responsibilities. There’s a lot of information available to help you and certainly get in touch if there’s any points of clarification that would assist you in fulfilling your statutory responsibilities to aged care consumers. Thank you.

**Nicola Dunbar:**

Thanks Janet. So just to finish up thank you everybody for participating today. Thank you Melanie and Janet for providing such a comprehensive overview of the changes to the restrictive practices legislation.

There will be a recording of this webinar on our website in the next few days and we will have another one coming up in August about behaviour support plans and the systems that need to be put in place for that. So keep an eye open for the details of those. We will be taking the questions that you’ve been sending us and we’ll be developing FAQs out of that. So that’s fantastic. I just wanted to say one more thing before we finish. A reminder that OPAN will be hosting its second webinar on alternatives to chemical restraint in supporting consumers living with dementia, and that’s on this Thursday at 11:30. And it will have some of the practical ways that providers and consumers can care for their consumers under this new legislation. The details for this is on the OPAN website.

So that’s all from us tonight. Thank you very much and we’ll see you for the next webinar in August.

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