MEDI-NEWS

JULY 2021

RESTRICTIVE PRACTICES LEGISLATION UPDATE

Quality of Care Principles 2014

Updates to the *Quality of Care Principles 2014* (the Principles) scheduled for 1 July 2021 and 1 September 2021 are due for inclusion in the current version available at www.legislation.gov.au/Details/F2020C00096.

Important explanatory information is also provided in the Aged Care Quality and Safety Commission's Regulatory Bulletin (RB2021-13) available at https://www.agedcarequality.gov.au/resources/rb2021-13-regulation-restrictive-practices-role-senior-practitioner.

THE KEY UPDATES INCLUDE:

- A revised definition of chemical restraint which now also specifies that it does not include the use of medication prescribed for end-of-life care.

- The term restrictive practice (any practice or intervention that restricts the rights or freedom of movement of the resident) is used to include:
    - Chemical restraint
    - Environmental restraint
    - Mechanical restraint
    - Physical restraint
    - Seclusion

- Multiple provisions for the use of each type of restrictive practice have been specified as well as documentation regarding these that must be in place to support commencement, use, monitoring, review and continuation.

CHEMICAL RESTRAINT

In relation to chemical restraint, the aged care provider must be satisfied that a medical or nurse practitioner has assessed the resident as posing a risk of harm to themselves or others and determined that the chemical restraint prescribed is necessary.

Details of the relevant assessments, behaviours, decision to use chemical restraint and why it is necessary must all be included in the care services plan.

Informed consent to the use of the restrictive practice must be given by either the resident or by the substitute decision maker where the resident lacks capacity, and providers must be satisfied that informed consent has been obtained.

From 1 September, all residents requiring behaviour support must have a **behaviour support plan** as part of their care services plan. Details of information that must be documented are explained in the Aged Care Quality and Safety Commission's Regulatory Bulletin (RB 2021-13).

It is important that restrictive practices, including chemical restraint, are identified when prescribed and the required documentation is available to support the appropriate use.

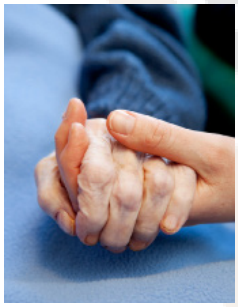
CHEMICAL RESTRAINT DEFINITION (Update)

Chemical restraint is 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, but does **not** include the use of medication prescribed for:

(a) the treatment of, or to enable treatment of, the care recipient for:

(i) a diagnosed mental disorder; or
(ii) a physical illness; or
(iii) a physical condition; or

(b) end of life care for the care recipient



The use of a restrictive practice outside of the provisions in the Principles is a **reportable incident.**

Some of the relevant sections of the updated Quality of Care Principles 2014 are as follows:

15FA Requirements for the use of any restrictive practice

(1) The following requirements apply to the use of any restrictive practice in relation to a care recipient:

(a) the restrictive practice is used only:

(i) as a last resort to prevent harm to the care recipient or other persons; and

(ii) after consideration of the likely impact of the use of the restrictive practice on the care recipient;

(b) to the extent possible, best practice alternative strategies have been used before the restrictive practice is used;

(c) the alternative strategies that have been considered or used have been documented. ***Addition as of 1 September 2021***: in the behaviour support plan for the care recipient;

(d) the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the care recipient or other persons;

(e) the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the care recipient or other persons;

(f) informed consent to the use of the restrictive practice has been given by:

(i) the care recipient; or
(ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice;

(g) the use of the restrictive practice complies with any relevant provisions of the care and services plan for the care recipient

The following addition replaces blue text as of 1 September 2021: provisions of the behaviour support plan for the care recipient that relate to the use of the restrictive practice;

(h) the use of the restrictive practice complies with the Aged Care Quality Standards set out in Schedule 2;

(i) the use of the restrictive practice is not inconsistent with the Charter of Aged Care Rights set out in Schedule 1 to the User Rights Principles 2014;

(j) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

(2) However, the requirements set out in paragraphs (1)(a), (b), (c), (f) and (g) do not apply to the use of a restrictive practice in relation to a care recipient if the use of the restrictive practice in relation to the care recipient is necessary in an **emergency.**

Section 15FB details requirements where the restrictive practice is used in an emergency - *refer to the Principles and RB 2021-13 for further information. However it is noted that an emergency is considered a serious or dangerous situation that is unanticipated or unforseen and requires immediate action, but which should occur rarely in residential aged care.*

15FC Additional requirements for the use of restrictive practices that are chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to a care recipient that is chemical restraint:

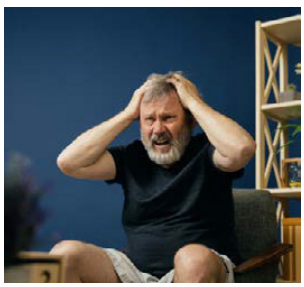
(a) the approved provider is satisfied that a medical practitioner or nurse practitioner has:

(i) assessed the care recipient as posing a risk of harm to the care recipient or any other person; and
(ii) assessed that the use of the chemical restraint is necessary; and
(iii) prescribed medication for the purpose of using the chemical restraint;

(b) the following matters have been documented in the care and services plan for the care recipient

The following addition replaces blue text as of 1 September 2021: behaviour support plan for the care recipient:

(i) the assessments;
(ii) the practitioner's decision to use the chemical restraint;
(iii) the care recipient's behaviours that are relevant to the need for the chemical restraint;



(iv) the reasons the chemical restraint is necessary;
(v) the information (if any) provided to the practitioner that informed the decision to prescribe the medication;

Proposed Addition as of 1 September 2021:

(vi) a description of any engagement with persons other than the practitioner in relation to the use of the chemical restraint;

(vii) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments;

(c) the approved provider is satisfied that informed consent to the prescribing of the medication has been given by:

(i) the care recipient; or
(ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

(2) However, the requirements set out in paragraphs (1)(b) and (c) do not apply to the use of a restrictive practice in relation to a care recipient if the use of the restrictive practice in relation to the care recipient is necessary in an **emergency.**

Note:

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

(a) for medical practitioners—Good medical practice: a code of conduct for doctors in Australia, which in 2021 could be viewed on the website of the Medical Board of Australia.

https://www.medicalboard.gov.au

(b) for nurse practitioners—Code of conduct for nurses (which in 2021 could be viewed on the website of the Nursing and Midwifery Board of Australia

https://www.nursingmidwiferyboard.gov.au

Section 15GA details the requirements for monitoring that must be in place, and evidence of this should be documented in a resident's clinical notes. This information is relevant for the medical or nurse practitioner to consider when carrying out regular review with consideration to reduce/ withdraw or continue the medication. RNs are suggested to document a summary of the relevant information in preparation for the medical or nurse practitioner's review based on the day-to-day documentation in behaviour records and of observations about the medication's efficacy or not as well as any adverse effects noted.

15GA Responsibilities while restrictive practice being used

If an approved provider uses a restrictive practice in relation to a care recipient, the approved provider must ensure that while the restrictive practice is being used:

(a) the care recipient is monitored for the following:

(i) signs of distress or harm;
(ii) side effects and adverse events;
(iii) changes in mood or behaviour;
(iv) changes in well-being, including the care recipient's ability to engage in activities that enhance quality of life and are meaningful and pleasurable;
(v) changes in the care recipient's ability to maintain independent function (to the extent possible);
(vi) changes in the care recipient's ability to engage in activities of daily living (to the extent possible); and

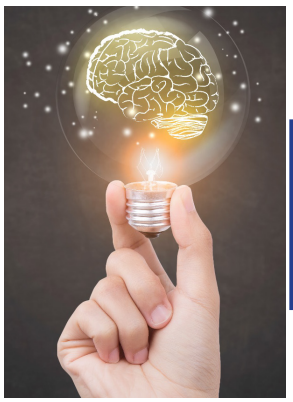
(b) the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and

(c) the effectiveness of the use of the restrictive practice, and the effect of changes in the use of the restrictive practice, are monitored; and

(d) to the extent possible, changes are made to the care recipient's environment to reduce or remove the need for the use of the restrictive practice; and

(e) if the restrictive practice is chemical restraint—information about the effects and use of the chemical restraint is provided to the medical practitioner or nurse practitioner who prescribed the medication for the purpose of using the chemical restraint as mentioned in paragraph 15FC(1)(a).

Division 5 containing Sections **15HA to 15HG** will be introduced from 1 September 2021 and detail the requirements and responsibilities for behaviour support plans and the information that must be specified in them. Refer directly to the Principles (www.legislation.gov.au/Details/F2020C00096) and information in RB 2021-13 (https://www.agedcarequality.gov.au/resources/rb2021-13-regulation-restrictive-practices-role-senior-practitioner) to understand and prepare the necessary behaviour support plans for residents for 1 September 2021.



PSYCHOTROPIC ACTION PLAN

1. Ensure the diagnosis/indication (i.e. reason for use) for all psychotropic medications, particularly those that may be used in behaviour management, is known and documented by the current prescriber.

2. Ensure chemical restraints are appropriately identified by the prescriber and where this is unclear, consider referral to specialist (e.g. geriatrician, psychogeriatrician) for confirmation regarding the use and ongoing benefit of a psychotropic, including determining whether it is a chemical restraint in the specific circumstances.

3. Ensure there is consent as per state/territory legislation for psychotropic medication use. This can be obtained from the resident with capacity or their substitute decision-maker where they lack capacity to understand and provide informed consent to the medication use.

4. Involve a specialist behaviour management service such as Dementia Support Australia (DSA) to suggest potential causes or triggers for behaviours and provide strategies for management.

5. Ensure residents with behaviours have known or potential triggers and non-pharmacological strategies documented in their care services plan (or behaviour support plan which is required from 1 September 2021) together with information about the assessments and the use of any restrictive practices and the relevant consent obtained.

6. Ensure there is a record of each episode of behaviour and how it is managed, which should reflect recognition of triggers identified in the care plan/behaviour support plan and the implementation of the strategies included.

7. Ensure there is documentation as evidence of regular review by the prescriber which describes the basis for changing the dose, ceasing, or continuing the psychotropic medication. Prior to the prescriber's planned review of a chemical restraint, suggest that an RN summarises the following in relation to the resident's overall response to the psychotropic medication in the period since the last review to facilitate informed review by the prescriber:

(i) efficacy or lack thereof and whether there have been any changes in symptoms of distress or risk of harm.

(ii) any changes in mood, behaviour, well-being, ability to engage in meaningful/enjoyable activities, or changes in functional abilities such as mobility

(iii) adverse effects observed (or note that there were not any)

(iv) the frequency and severity of episodes of behaviours and how they were managed

(v) the concurrent use of non-pharmacological interventions and their efficacy.

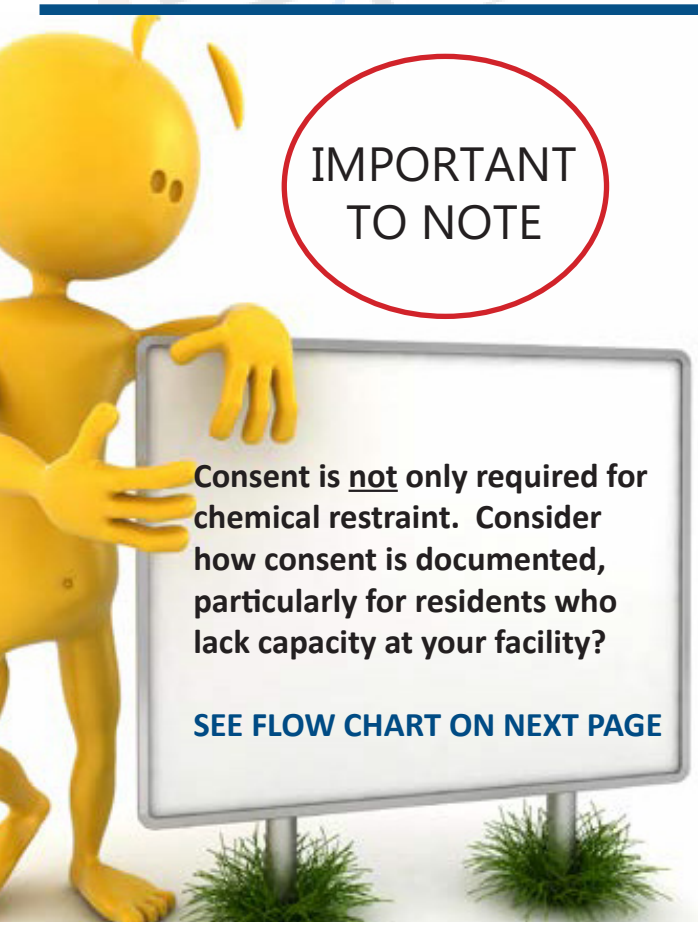
It is important to regularly document these in progress notes and behaviour assessments and records.

As stated in RB 2021-13, Informed consent means the consumer, or a substitute decision maker, has been provided with all relevant information regarding a practice, including the use of any restrictive practice, in order to make a decision about its use, has agreed to its use and this consent is documented.

Treatment with psychotropic medications requires valid informed consent from the consumer or their substitute decision-maker as specified in state/ territory consent legislation.

The following should be explained to gain informed consent in relation to medication prescribing and use:

- Common side effects and risks of the medication
- Alternatives to the use of the medication
- The plan in regard to dosage changes (increases or decreases) and cessation of the medication
- The likely outcome of not taking the medication
- The degree of uncertainty of the diagnosis and any therapeutic outcome in relation to the treatment
- Any significant long-term physical, emotional, mental, social, sexual or other outcome which may be associated with use of the medication
- Whether the treatment is conventional or non-conventional, and its approximate cost
- How the medication will be administered and in the case of 'when required' administration, how the need for administration will be assessed and authorised.



REFERENCES

- Regulatory Bulletin - Regulation or restrictive practices and the role of the Senior Practitioner, Restrictive Practices (RB2021-13. Australian Government, Aged Care Quality and Safety Commission. https://www.agedcarequality.gov.au/resources/rb2021-13-regulation-restrictive-practices-role-senior-practitioner).
- Federal Register of Legilslation Quality of Care Principles 2014. Australian Government. www.legislation.gov.au/Details/F2020C00096
- NCAT Factsheet, Guardianship Division. Consent to Medical or Dental Treatment. NSW Civil & Administrative Tribunal. https://ncat.nsw.gov.au/ncat/case-types/guardianship/consent-to-medical-or-dental-treatment.html
- NSW Legislation. Guardianship Act 1987. NSW Government. https:// legislation.nsw.gov.au/view/html/inforce/current/act-1987-257
- NSW Legislation. Guardianship Regulation 2016. NSW Government. https://legislation.nsw.gov.au/view/html/inforce/current/sl-2016-0556
- Capacity Australia Mini-Legal Kits. https://capacityaustralia.org.au/resources/mini-legal-kits/

Documentation and Consent Requirements in NSW for psychotropic medications

Psychotropic Medication

Chemical Restraint

(Regular or PRN medication for behaviour management)

Documentation of:

- **Behaviours relevant to the need for the restraint**
- **Triggers and non-pharmacological strategies with evidence of use**
- **Prescriber's assessment and reason for prescribing / continuing**
- **Informed consent from substitue decision maker where resident lacks capacity**

Regular medical review and documentation to support continued use:

- more frequently when commenced or dose changed
- at least every 12 weeks
- Trial of dose reduction or withdrawal with improved or resolved behaviour

Not Chemical Restraint and in NSW is <u>major</u> medical treatment

(e.g. antidepressants for depression)

Documentation of:

- **Diagnosis**
- **Non-pharmacological strategies where applicable** (e.g. psychologist counselling and engagement in activities for resident with depression)
- **Informed consent**

Regular medical review and documentation to support continued use

Not Chemical Restraint and in NSW is <u>minor</u> medical treatment

(e.g. metoclopramide for nausea, anticonvulsant for epilepsy)

Documentation of:

- **Diagnosis**
- **Informed Consent**
- **Treatment may proceed without consent if the person responsible cannot, will not or is unable to consent and the resident is not objecting**

Regular medical review and documentation to support continued use

***Documentation includes medical progress notes, behaviour management/ support plan, behaviour monitoring records, care plan, +/- Psychotropic Management and Consent Form**

The following table explains consent requirements in NSW

meditrax™ Medication Management Specialists

Summary of consent for medical and dental treatment

Check Capacity Australia Mini-Legal Kits for similar information in other states/territories at https://capacityaustralia.org.au/resources/mini-legal-kits/.

Type	Treatment	Who can consent
Urgent treatment	Treatment considered urgent and necessary to: • Save a patient's life • Prevent serious damage to health • Prevent or alleviate significant pain or distress (not including special treatment)	No consent needed
Major treatment	• Any treatment involving general anaesthetic or sedation (except as listed in minor below) • Medications affecting the central nervous system (except as listed in minor) • Drugs of addiction (except as listed in minor) • Long-acting injectable hormonal substances for contraception or menstrual regulation • Any treatment for the purpose of eliminating menstruation • Testing for HIV • Any treatment involving substantial risk to the patient • Any dental treatment resulting in the removal of all teeth or which significantly impairs chewing	Person responsible can consent. Request and consent must be in writing or, if not practicable, later confirmed in writing. If there is no person responsible or the person responsible cannot be located, or will not or is unable to respond, only NCAT can consent.
Minor treatment	• All treatments (except those listed in major or special) • Treatment involving general aesthetic or sedation: - for management of fractured or dislocated limbs - for endoscopes inserted through an orifice, not penetrating the skin or mucous membrane. • Medications affecting the central nervous system used: - for analgesic, antipyretic, antiparkonsonian, antihistaminic, antiemetic, antinauseant or anticonvulsant purposes - only once - for PRN (as required) not more than 3 times per month - for sedation in minor procedures (unless dental)	Person responsible can consent. If no person responsible or the person responsible cannot, will not or is unable to consent, the doctor or dentist may treat without consent. However the doctor or dentist must note on patient's record that the treatment is necessary to promote the patient's health and wellbeing and that the patient is not objecting
Special treatment	• Use of medication affecting the central nervous system where dosage, duration or combination is outside accepted norms • Androgen-reducing medications for behavioural control • Termination of pregnancy • Treatments intended or likely to result in infertility • Vasectomy and tubal occlusion • Aversives: mechanical, chemical or physical • Any new treatment that has not yet gained the support of a substantial number of doctors or dentists specialising in the area	Only NCAT can consent
Objection to major or minor treatment	If the patient indicates, or has previously indicated, that he or she does not want the treatment carried out.	Only NCAT can consent