

## **Parliamentary Joint Committee on Human Rights**

### **ANSWERS TO QUESTIONS ON NOTICE**

#### **HEALTH PORTFOLIO**

### **Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No: No 1**

#### **OUTCOME 6: Ageing and Aged Care**

**Type of Question:** Hansard Page 71 Tuesday, 20 August 2019

**Senator/Member:** The Committee

#### **Question:**

You mentioned that it's not just these principles that we have in front of us today that govern, regulate and stipulate how [the process of prescribing the use of certain drugs] works, that there is actually quite a complex interaction between federal legislation, various state based legislation, the industry guidance and principles which governs how doctors, nurses and aged care facility workers go about their work. That's also the case for what we might consider the pattern of behaviour that could lead to physical restraint as well. Is that correct? It's not just the use of chemical restraints that we're concerned about here; holistically, the whole sphere of aged care is this quite complex interaction of where state legislation ends and federal legislation or regulation principles kick in? ... Is there any way that you can provide to the committee simple guidance on what those instruments might be and how they interact? ... [Please include the] things that a medical practitioner must do before they prescribe interventions around chemical restraints .... [and] registration requirements and those sorts of things.

#### **Answer:**

The National Registration and Accreditation Scheme is established through complementary legislation in each state and territory through the Health Practitioner Regulations National Law Act (the National Law) and is responsible for the regulation of the medical and nursing professions.

Both of these professions are regulated by their respective boards; the Medical Board of Australia and the Nursing and Midwifery Board of Australia (NMBA). Their role includes setting of standards and codes to provide guidance to their professions about what is expected of their practice.

Upon obtaining general registration, all medical practitioners have the competency to prescribe medication.

Nurse practitioners are the only category of nurse who have the competency to prescribe scheduled medicines upon gaining an endorsement from the NMBA. This endorsement requires amongst other requirements the completion of an approved post-graduate qualification.

Doctors and nurse practitioners are given the authority to prescribe within their drugs and poisons legislation in each jurisdiction. This legislation determines who can prescribe, which medicines, in what circumstances, in what manner, for what purpose, as well as additional conditions that must be met to prescribe certain classes of medicines such as certain S4 medicines or S8 medicines.

It is important to note that nurse practitioners are eligible to prescribe under the Pharmaceutical Benefits Scheme. However, this determination requires a nurse practitioner to enter into collaborative arrangements with a named medical practitioner whether through their employer or independently.

An important part of the National Registration and Accreditation Scheme is a formal notification system whereby a member of the public or a health professional can make a complaint if there is a concern that a practitioner may be placing the public at risk.

Before a medical practitioner or nurse practitioner prescribes a medication for the purposes of managing the behavioural and psychological symptoms of dementia, he or she must assess the consumer as requiring the medication.

During the assessment, the medical practitioner or nurse practitioner must satisfy themselves that other non-pharmacological methods have been tried to the fullest extent possible, and those methods have not been successful. The consumer must be experiencing symptoms which are likely to be alleviated by the proposed medication.

The medical practitioner or nurse practitioner would then make a clinical judgement. For example, some behavioural symptoms of dementia do not respond to medications; therefore, it would not be appropriate to prescribe for these behaviours. However, for some behaviours e.g., aggressive or psychotic behaviours, including people who have distressing hallucinations or delusions, medication can be of benefit.

The practitioner must satisfy themselves that the person is sufficiently adversely affected and that other methods have not worked or worked sufficiently.

The practitioner would make a clinical judgement about the person's capacity to provide informed consent to the medication and seek informed consent, either from the person, or their representative if they do not have capacity to consent. Informed consent involves providing information about the reason for the medication, the options and alternatives, the risks and benefits, how long it may be used for and making sure the person and/or their representative understands this information.

Then the practitioner would trial the medication for those specific behaviours, and monitor for any impact. If the symptoms get worse, the medication would be stopped. However, if the symptoms improve, the practitioner may trial taking the person off the medication completely to see if those symptoms return. Some persons may need to stay on medication as their symptoms return if the medication is ceased.

## Parliamentary Joint Committee on Human Rights

### ANSWERS TO QUESTIONS ON NOTICE

#### HEALTH PORTFOLIO

#### **Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No:** No 2

#### **OUTCOME 6:** Ageing and Aged Care

**Type of Question:** Hansard Page 74 Tuesday, 20 August 2019

**Senator/Member:** The Committee

#### **Question:**

Please provide a list of organisations that were consulted [and] a synopsis of the consultation process.

#### **Answer:**

On 17 January 2019, Minister Wyatt announced that physical and chemical restraint was to be better regulated.

In February 2019, the Department of Health (the Department) convened a small working group of key stakeholders (Key Stakeholder Working Group) to discuss the regulation of physical and chemical restraint in residential aged care.

The Key Stakeholder Working Group was comprised of representatives from:

- Aged and Community Services Australia;
- Aged Care Guild;
- Aged Care Quality and Safety Commission;
- Australian Commission on Safety and Quality in Health Care;
- Australian Nursing and Midwifery Federation;
- Catholic Health Australia;
- COTA Australia;
- Dementia Australia;
- Department of Social Services;
- HammondCare;
- Leading Age Services Australia;
- Older Persons Advocacy Network;
- Resthaven;
- University of Tasmania; and
- University of Sydney.

The Consultation process included the circulation of relevant papers by the Department and Key Stakeholder Working Group meetings by teleconference on 4 and 18 March 2019.

At the teleconference of 4 March, stakeholders broadly agreed that the appropriate approach would be to closely model the proposed regulation on the elements of the Decision Making Tool: Supporting a Restraint Free Environment in Residential Aged Care.

Following these discussions, advice was sought from the Australian Government Chief Medical Officer's Clinical Advisory Committee. The Clinical Advisory Committee advised that physical and chemical restraint should be treated differently in the regulation, given the prescribing practitioner's responsibility to seek informed consent for chemical restraint.

The key principles for the proposed regulatory arrangement were discussed at the second meeting of the Key Stakeholder Working Group on 18 March 2019. Following this, the Department circulated the summary of discussions, noting that the proposed changes would form the basis of Drafting Instructions for amendments to legislation. Comments and feedback from the Key Stakeholder Working Group was sought at that time.

## Parliamentary Joint Committee on Human Rights

### ANSWERS TO QUESTIONS ON NOTICE

#### HEALTH PORTFOLIO

#### **Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No:** No 3

#### **OUTCOME 6:** Ageing and Aged Care

**Type of Question:** Hansard Page 75 Tuesday, 20 August 2019

**Senator/Member:** The Committee

#### **Question:**

In the department's view, does [the instrument] engage Australia's obligations under the convention against torture? That's a shorthand version of a longer protocol which includes prohibitions against inhuman treatment. The evidence that we've received today is that, in the view of some submitters, it does engage them. If the department thinks it doesn't, could you explain why you think it doesn't? And if the department thinks it does, could you explain why it doesn't say it in the explanatory memorandum?

#### **Answer:**

The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention) applies where the perpetrator is a public official or person acting in an official capacity. The *Quality of Care Amendment (Minimising the Use of Restraints) Principles* (the Instrument), made under the *Aged Care Act 1997* (the Act), regulates approved providers of aged care. The Australian Government implemented the requirements under the Convention through the *Crimes (Torture) Act 1988*.

The Instrument is designed to reduce the use of such restraints by an approved provider in relation to a consumer of aged care services.

As such, approved providers operate in a context that is different from a custodial or other similar situation in which the Convention would apply. In order to consider the application of the Convention, one needs to consider the terms of the Convention itself. It defines torture as a person in an official capacity inflicting severe pain or suffering on a person as a means of obtaining information or a confession, punishing a person for an act committed, or intimidating or coercing someone on discriminatory grounds.

Such a situation seems unlikely to arise, as approved providers are generally private entities. Aged care services are not staffed by persons acting in an official capacity, let alone persons acting in an official capacity to inflict severe pain or suffering on a person as a means of obtaining information or a confession, punishing a person for an act committed, or intimidating or coercing someone on discriminatory grounds within the terms of the Convention.

**Parliamentary Joint Committee on Human Rights**

ANSWERS TO WRITTEN QUESTIONS ON NOTICE

HEALTH PORTFOLIO

**Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No:** No 4

**OUTCOME 6:** Ageing and Aged Care

**Type of Question:** Written Question on Notice

**Senator/Member:** The Committee

**Question:**

How do the consent arrangements for the use of physical restraints operate? In particular:

- a) when can consent be sought from the representative of an aged care consumer rather than the consumer themselves? If more than one person qualifies as a consumer's representative under the instrument, who decides which person will ultimately be deemed to be the consumer's representative (and on what basis)?
- b) if consent is obtained from a representative in accordance with the terms of the instrument, but that person does not have authority under relevant state and territory laws to provide such consent, what are the legal consequences for approved providers (and their employees) in using such restraints? (i.e. would the terms of the instrument be relevant in determining whether consent had properly been obtained for the purposes of criminal, civil and other relevant laws?).
- c) how long is consent valid for? (i.e. is it necessary to obtain consent each time a physical restraint is used?).
- d) are supported decision-making arrangements provided for under the instrument?
- e) does the definition of 'restraint' in the instrument mean that, even where an aged care consumer requests to certain restrictive practices (such as a bed rail or concave mattress), all other requirements in section 15F would also first need to be met before that request could be implemented?
- f) why is 'emergency' not defined in the instrument?

**Answer:**

- a) Consent to use physical or chemical restraint should be given by the person themselves unless they lack the capacity to do so.

When the approved provider (in the case of physical restraint) has determined that the person cannot give their own fully informed consent, then consent should be sought from their representative.

While some consumers may have an appointed legal representative, in practice relationships of support may operate on an informal level.



The meaning of 'representative' within the Instrument is intended to provide for the operation of practical decision-making arrangements.

- b) Where a provider meets its responsibilities under the Act, this does not excuse it from complying with state and territory laws. Legal action may be taken against the approved provider if it does not comply with relevant State and Territory laws.
- c) Under the Instrument, the requirements (including informed consent) of section 15F must be met in relation to each specific 'use' of restraint. For example, if bedrails are used because a consumer is experiencing side effects while on antibiotics for 14 days, the 'use of restraint' is the two-week period while the care recipient is on antibiotics.
- d) To facilitate the use of supported decision-making arrangements, consumer rights have been set out in the Charter of Aged Care Rights in Schedule 1 to the *User Rights Principles 2014* (the User Rights Principles). The Charter has 14 high-level consumer rights, including the right to have control over and make choices about care, personal and social life.

Providers are also required to meet the Aged Care Quality Standards (the Standards), set out under the *Quality of Care Principles 2014*. Under the Standards, providers are required to demonstrate that each consumer is supported to exercise choice and independence. Consumers who need support to make decisions are expected to be provided with access to the support they need to make, communicate and take part in decisions that affect their lives.

- e) While a consumer or their family may request the use of restraints, there is substantial evidence that shows the negative consequences associated with its use. Accordingly, a provider is required to comply with section 15F of the Instrument in circumstances where a consumer requests the use of restraint.
- f) In the Instrument, an 'emergency' is given its ordinary meaning, being an 'unforeseen occurrence, a sudden and urgent occasion for action'. It is not possible to codify the circumstances that may give rise to an emergency, as the circumstances will be highly variable and complex.

**Parliamentary Joint Committee on Human Rights**

ANSWERS TO WRITTEN QUESTIONS ON NOTICE

HEALTH PORTFOLIO

**Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No:** No 5

**OUTCOME 6:** Ageing and Aged Care

**Type of Question:** Written Question on Notice

**Senator/Member:** The Committee

**Question:**

How do the consent arrangements for the use of chemical restraints operate? In particular:

- a) what are the *legal* obligations of prescribers, particularly in relation to obtaining informed consent (including the consequences for prescribers in not obtaining informed consent)?
- b) why are approved providers not also required by the instrument to obtain informed consent from consumers *prior* to the application of chemical restraint, or, at a minimum, to confirm and document that consent has been provided to the prescriber before chemical restraints are applied?

**Answer:**

The National Registration and Accreditation Scheme is established through complementary legislation in each state and territory through the Health Practitioner Regulations National Law Act (the National Law) and is responsible for the regulation of the medical and nursing professions. It is not Commonwealth legislation.

Both of these professions are regulated by their respective boards; the Medical Board of Australia (MBA) and the Nursing and Midwifery Board of Australia (NMBA). Their role includes setting of standards and codes to provide guidance to their professions about what is expected of their practice. All registration standards, codes and guidelines developed by a National Board are admissible in proceedings under the National Law.

In line with the provisions of the National Law, the MBA and NMBA have each published a code of conduct to set the professional expectations for their respective professions. The MBA's Good medical practice: a code of conduct for doctors in Australia and the NMBA's Code of conduct for nurses set the expectations of the MBA and NMBA for a range of topics including: communication with patients and/or their carers; gaining informed consent; and the use of scheduled medicines. Both codes of conduct require practitioners to comply with relevant legislation administered by states and territories, including medicines and poisons legislation which governs the prescribing, dispensing and administration of scheduled medicines.

Additionally, medical practitioners and nurse practitioners are required to seek informed consent before using restraint on a consumer under the general law. Otherwise such conduct would amount to an unlawful assault or trespass against the consumer. Accordingly, civil and/or criminal action under the State or Territory law may be taken should the practitioner fail to seek such consent.

The responsibility for seeking informed consent for prescription of medications rests with the medical practitioner or nurse practitioner (rather than the approved provider).

If an approved provider uses chemical restraint (that is, administers the medication as prescribed by the medical practitioner or nurse practitioner), the provider must inform the consumer's representative as soon as practicable. The requirement for the provider to inform the consumer's representative is a practical and enforceable condition.

**Parliamentary Joint Committee on Human Rights**

ANSWERS TO WRITTEN QUESTIONS ON NOTICE

HEALTH PORTFOLIO

**Inquiry into Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019**

**Ref No:** No 6

**OUTCOME 6:** Ageing and Aged Care

**Type of Question:** Written Question on Notice

**Senator/Member:** The Committee

**Question:**

How does the instrument achieve the objective of promoting a restraint-free environment and ensuring that restraint is not used until all alternatives have been explored? In particular:

- a) what evidence was relied on in designing the instrument to achieve the above objective?
- b) noting that the use of chemical restraint is not used for therapeutic purposes, why is there no requirement that approved providers (as opposed to the practitioners) only use chemical restraint where:
- it is the least restrictive form of restraint possible;
  - it is for the minimum time necessary;
  - the necessity for chemical restraint is regularly monitored and reviewed;
  - the aged care consumer has been assessed as posing a risk of harm to themselves or others; and
  - other alternatives have first been used where possible?
- c) why is there no requirement in the instrument that approved providers take all reasonable steps to reduce and eliminate the need for the use of restrictive practices?
- d) why is there no express requirement in the instrument that restraints only be used as a last resort and be in proportionate to the potential negative consequence or risk of harm?

**Answer:**

The Instrument introduces two new provider responsibilities to promote, for the first time, a restraint free environment under Commonwealth aged care law.

The Department of Health convened a Key Stakeholder Working Group, to discuss how regulation could be strengthened to minimise the use of physical and chemical restraint in residential aged care. The Working Group considered a number of sources of evidence, including:

- Recommendations from a range of recent independent reviews:
  - the 2017 Australian Law Reform Commission Report *Elder Abuse – A National Legal Response* (Recommendation 4-10);
  - the 2017 Carnell/Paterson *Review of National Aged Care Quality Regulatory Processes* (Recommendation 7); and
  - The Australian Commission on Safety and Quality in Healthcare’s 2018 publication *The Third Australian Atlas of Healthcare Variation* (Recommendation 5).
- The *Decision-making Tool: supporting a restraint free environment in residential aged care* (2012) developed by the University of Adelaide;
- *The National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*; and
- Consultations with the Department of Social Services’ Quality and Safeguards Policy Branch.

The Working Group also sought advice from the Aged Care Clinical Advisory Committee. The Committee advised that it is the prescribing clinician’s responsibility to seek informed consent for chemical restraint, and noted the regulation of prescribers does not fall within the remit of the Instrument.

The decision to prescribe medication for the purpose of chemical restraint is a clinical decision. Before a medical practitioner or nurse practitioner prescribes such medication, he or she must conduct an assessment and have regard to a number of factors whilst drawing on their clinical experience. As the medical practitioner or nurse practitioner is responsible for conducting the assessment and prescribing the medication, the prescriber (rather than the approved provider) is best placed to consider such matters as: whether non-pharmacological measures have been used; risks to the consumer; how long the medication should be used, among others.

The Instrument promotes a restraint free environment by limiting the use of restraints to circumstances where a number of conditions have been met. The explanatory statement and Instrument highlight providers must take all reasonable steps to minimise the use of physical and chemical restraint. This is achieved in practical terms, by imposing conditions on providers to use alternatives to the use of restraint and to regularly monitor the consumer.

Those conditions also define what a ‘last resort’ means. The Explanatory Statement to the Instrument notes that use of restraint must be the last resort. This intent is provided for in the Instrument, through binding legal requirements to assess the consumer, use alternatives to the extent possible, and to regularly monitor and review the consumer. These safeguards establish clearly defined obligations for approved providers, and ensure that the human rights of care recipients are the first priority.