The Hon Anika Wells MP
Minister for Aged Care
Minister for Sport
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Ref No: MC23-003158

Mr Josh Burns MP
Member for Macnamara
Chair of Parliamentary Joint Committee on Human Rights
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Dear ~~Mr Burns~~ Josh,

Thank you for your correspondence of 9 February 2023 regarding the *Aged Care Quality and Safety Commission Amendment (Code of Conduct and Banning Orders) Rules 2022* (Code and Banning Orders Instrument) and *Quality of Care Amendment (Restrictive Practices) Principles 2022*.

Responses to each of the committee's queries are below.

Quality of Care Amendment (Restrictive Practices) Principles 2022

I completely understand and empathise with community concerns regarding the use of restrictive practices in residential aged care. The Government is committed to reducing the inappropriate use of restrictive practices and supports the robust legislative framework which strictly governs their use. Restrictive practices should only every be used as a last resort when they are necessary to protect a care recipient or others from harm.

The Government has undertaken multiple initiatives to reduce the inappropriate use of restrictive practices including strong legislation, strict provider requirements, improved transparency and programs providing support in aged care facilities.

The Quality of Care Amendment (Restrictive Practices) Principles 2022 (Principles) sets out people or bodies who can be a Restrictive Practices Substitute Decision Maker (RPSDM) for the purposes of giving informed consent to the use of a restrictive practice when a care recipient lacks the capacity to consent themselves.

The Department of Health and Aged Care (Department) has advised that the Principles strengthen existing legislative consent requirements for the use of restrictive practices. Existing restrictive practice legislation provides significant safeguards, having strict requirements to only use restrictive practices: as a last resort; to prevent harm; only to the extent necessary; only in proportion to the risk of harm to the care recipient and others; in

the least restrictive form and for the shortest time necessary to prevent harm to the care recipient others. The necessity and effectiveness of any use of a restrictive practice must also be regularly monitored, reviewed and documented.

The Principles seek to resolve issues raised by some jurisdictions where there is a question about whether a person other than the care recipient is able to consent to the use of a restrictive practice, which is leaving care recipients at risk of not receiving the care they require and/or being at risk of harm. The Principles are not intended to override state and territory laws. Where state and territory laws exist to appoint a RPSDM, the Principles provide that they should be relied on. The Principles are intended as an interim arrangement until state and territory guardianship and consent laws can be amended, or until 1 December 2024.

Individuals with a disability who are under 65 years and participants of the National Disability Insurance Scheme (NDIS) will have their own arrangements for consent for the use of Restrictive Practice under the NDIS legislation. People with a disability over 65 in residential aged care will be afforded the protections and safeguards under the Principles. The NDIS and aged care legislation reflect the specific needs of their users.

The committee considers further information is required to assess the compatibility of this measure with these rights, and as such seeks the minister's advice in relation to:

(a) what guidance has been provided to aged care providers to assist them in assessing if a care recipient lacks capacity to give consent (and so when it is, or is not, appropriate to rely on the consent arrangements in the instrument);

The Aged Care Quality and Safety Commission (Commission) has a suite of resources available, including training, to support approved providers in meeting their obligations under the *Aged Care Act 1997* including the use of restrictive practices and informed consent. Guidance is also available from other sources including Capacity Australia, Dementia Australia and Dementia Services Australia.

When assessing whether a care recipient lacks capacity to consent, approved providers rely on guidance such as a care recipient's cognitive assessment, the provider's clinical governance framework, and consultation with the care recipient and/or their representative.

(b) what guidance has been provided to aged care providers to enable them to determine if the law in their state or territory allows for the appointment of an individual or body to give consent to the use of restrictive practices;

The Department continues to engage with states and territories on the use of restrictive practices and laws regarding the appointment of a RPSDM. State and territory agencies are best placed to provide advice to service providers or members of the community who may need to access guardianship tribunals in each jurisdiction for appointments of a RPSDM. The Department has advised that states and territories are aware of the Principles' sunsetting date on 1 December 2024 and are collaborating to work towards a longer term solution through the establishment of a national working group facilitated by the Department. This group is also looking at sharing communication products and resources. The Commission has a critical role in sector engagement and education. In reviewing services they seek evidence of actions taken to minimise the use of restrictive practices, and

where used, ensures it complies with legislation including that appropriate consent has been obtained. This will include whether the provider can demonstrate that they have done everything possible to determine whether the relevant state or territory has a 'clear mechanism for appointing' a RPSDM before using the Principles.

(c) who determines whether there is a 'clear mechanism for appointing' a person under the state and territory laws, or what is a 'significant delay' in deciding an application for appointment under the state or territory laws;

Approved providers should contact the relevant state or territory body for advice on laws regarding the appointment of a RPSDM under the state and territory law in their jurisdiction. The relevant state or territory body is best placed to provide advice on current laws for that jurisdiction.

The Department are engaging with states and territories and will continue to collaborate with jurisdictions to support them to assist the sector in understanding what is considered a significant delay in their jurisdiction.

The Department has advised me there is no specific timeframe that is to be considered a 'significant delay' and it will depend on the circumstances of each situation. The intention is to ensure informed consent can be given when there is a significant delay by a tribunal or similar decision-making body, recognising the time it may take for state and territory bodies to decide applications. However, a 'significant delay' is more likely to be considered months or years rather than days or weeks. The relevant state or territory body may also provide advice on standard timeframes for seeking a decision from the relevant tribunal or decision-making body.

(d) who is authorised to give consent under the instrument if an application for an appointment to consent to the use of restrictive practices has been made under state or territory law but not yet determined, but there is no significant delay in deciding the application (yet no one is yet appointed);

In the scenario described above, an approved provider cannot use a restrictive practice in relation to a care recipient who does not have the capacity to consent until such appointment has been made under the relevant state or territory law.

However, a restrictive practice can be used without consent (including where a RPSDM has not yet been appointed) in an emergency through existing legislation (see section 15FA of the Quality of Care Principles 2014). This ensures approved providers can appropriately and rapidly respond to an emergency to protect a people in their care or other persons from immediate harm. The approved provider has additional reporting obligations where a restrictive practice is used in an emergency. An emergency is a serious or dangerous situation that is unanticipated or unforeseen and that requires immediate action. If a provider uses a restrictive practice in an emergency, the provider must, as soon as practicable after the restrictive practice starts to be used, inform the RPSDM about the use of the restrictive practice, and ensure the use is appropriately documented in the care and services plan. During an emergency, providers must still ensure the least restrictive form of a restrictive practice is being used and for the shortest period possible.

(e) are all the state and territory laws that allow for the appointment of an individual or body to give consent to the use of restrictive practices consistent with the

Convention on the Rights of Persons with Disabilities. If not, what is the Commonwealth, as the signatory to the Convention, doing to ensure the use of restrictive practices in aged care is compatible with human rights (now, and in two years when the instrument reverts back to provide that consent will only be as set out in state and territory law);

The Department has advised me that it is a matter for states and territories to ensure that their laws, including their laws that allow for the appointment of a person or body to give consent to the use of a restrictive practice, is consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Given the Commonwealth's role in the aged care sector and the fact it is a signatory to the UNCRPD the Department on behalf of the Commonwealth is continuing to encourage states and territories ensure their legislation is consistent with the UNCRPD. This is being done through existing forums and engagement including a National Working Group on restrictive practices established to discuss each state and territory government's legislative framework for substitute decision making in a residential aged care context and encourage amendment where required.

(f) why does the instrument not require that restrictive practices substitute decision-makers must have a duty to seek to ascertain the wishes of the care recipient and, where possible, act in a manner consistent with their will and preferences;

The Principles only apply where the care recipient lacks capacity to provide consent to the use of a restrictive practice and there is no relevant state or territory law to appoint a RPSDM. The Department has advised me that the Aged Care Act does not allow for subordinate legislation to prescribe obligations on other persons beyond the approved provider. The Principles clarify that for items two to four of the hierarchy the RPSDM has a personal interest in the care recipient's welfare on an unpaid basis, and with whom the care recipient has a close continuing relationship.

(g) will substitute decision-makers as specified in this instrument have the necessary skills and expertise to be able to properly give informed consent to the use of restrictive practices;

The skills and expertise of each RPSDM will vary. In providing consent to the use of a restrictive practice for the consent to be valid it must be informed, voluntary, current and specific, and provided by an individual who has the requisite capacity to understand and communicate their consent.

Consent is informed when the RPSDM is provided sufficient information about the decision before giving their consent. In the context of restrictive practices, this means that generally a care recipient or RPSDM should be provided with accurate and relevant information from the approved provider regarding:

- the proposed restrictive practice, including whether it involves medication or an intervention
- the reason for the use of the proposed restrictive practice
- best practice alternative strategies that have been used with the care recipient before the restrictive practice was proposed
- any alternative options available to them (including not taking or using the medication or intervention)

- the risks and benefits of the use of the restrictive practice and any alternative options.

When the use of chemical restraint is being considered, additional safeguards are required under the legislation in the form of:

- a medical practitioner or nurse practitioner has assessed the care recipient as requiring the restraint; and
- a medical practitioner or nurse practitioner has prescribed medication for the purpose of using the chemical restraint; and
- the assessment is recorded in the care and services plan for the care recipient.

The care recipient or RPSDM should have the opportunity to review and ask questions about the use of any restrictive practice and given sufficient time to do so.

The approved provider should be satisfied that the care recipient or RPSDM has the requisite capacity to understand the decision and to communicate their decision.
The care recipient or RPSDM must be able to come to a considered and independent decision, free from duress or coercion.

If effective consent has not been obtained by the approved provider, the approved provider will not have the benefit of the immunity provision set out in section 54-11 of the *Aged Care Act 1997*.

(h) do all states and territories have laws that allow for a medical treatment authority to be appointed in writing, and if not, what can aged care providers do to seek consent;

It is only in the event that a care recipient is receiving aged care in a state or territory without an explicit legal avenue to appoint a RPSDM, and the care recipient has no family or friends (i.e. unable to use items one to four of the Principles, that a medical treatment authority for the care recipient can act as the RPSDM as the last resort. If a medical treatment authority is not in place for the care recipient, the provider will be required to apply to the relevant court or tribunal to have a person or body, appointed as the medical treatment authority for example a public guardian.

In the rare event that a medical treatment authority is the only eligible item in the hierarchy, Table 1 in the Principles Explanatory Statement sets out information on the medical treatment authority arrangements for each state and territory at the time of registration of the instrument. As this was a point in time reflection of state and territory laws, approved providers should either contact or review information provided by the relevant state or territory body to confirm the relevant medical treatment authority. The relevant state or territory body is best placed to provide advice on the current medical treatment authority.

(i) since this instrument came into force how many notifications in aged care facilities across the Commonwealth have been made specifying that restrictive practices have been used without consent (organised per jurisdiction); and

The mandatory reporting of the inappropriate use of restrictive practices occurs through the Serious Incident Response Scheme (SIRS) managed by the Commission as the Regulator. Given the short period of time since the commencement of the legislation this data is not yet publicly available. The Commission will publish data on the number of incidents on the

inappropriate use of restrictive practices in its next Sector Performance Report due later this month. The publicly available data is not broken down by state or territory or notes which incidents were due to a lack of consent.

(j) how is specifying persons as those who may give consent for the purposes of granting immunity from all civil and criminal liability consistent with the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, access to justice and the right to an effective remedy.

I understand and appreciate community concern regarding the rights of older people and the use of restricted practises in residential aged care. Significant checks and balances were enacted to ensure the immunity provision only protects approved providers in very limited circumstances. The immunity does not prevent approved providers or their staff from potentially being charged with a criminal offence or a civil claim being brought in negligence where the use of the restrictive practice was not in accordance with the legislative requirements.

The intention in using an immunity provision is to ensure approved providers in jurisdictions without appropriate legal consent laws who rely on informed consent given through the Principles are not criminally or civilly liable under state and territory laws. This will instil confidence in approved providers to rely on the Principles without fear of prosecution, provided they follow all of the strict legislative requirements. Without assurances that they will not be prosecuted for using the Principles, approved providers may choose not to use restrictive practices when they are a necessary last resort to protect the aged care recipient. This could result in harm to the care recipient and others. This also aims to close the gap that currently exists in some jurisdictions and ensure, where necessary, restrictive practices can be used to protect care recipients and others, including those with a disability.

The immunity only applies where consent was given by a person or body in the hierarchy who may not be authorised by state or territory law and the restrictive practice is used in accordance with all relevant legislative requirements. This includes requirements to only use restrictive practices: as a last resort; to prevent harm; only to the extent necessary; only in proportion to the risk of harm to the care recipient and others; in the least restrictive form and for the shortest time necessary to prevent harm to the care recipient others. The necessity and effectiveness of any use of a restrictive practice must also be regularly monitored, reviewed and documented.

These amendments necessarily have to take into account the rights of the care recipient the subject of a restrictive practice as well as the rights of other care recipients and persons, including those with disability. This is consistent with the UNCRPD.