Monitor 16 of 2021 – Ministerial Responses

Contents

The Hon Greg Hunt MP
Minister for Health and Aged Care

Ref No: MC21-033759

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

19 OCT 2021

Dear Chair Connie

Thank you for your correspondence of 30 September 2021 seeking additional information about the Biosecurity (Human Coronavirus with Pandemic Potential) Amendment (No. 1) Determination 2021 (Amendment Determination).

The emergency determinations made under subsection 477 of the *Biosecurity Act 2015* (Cth), which includes the Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requirements) Determination 2020 (Overseas Travel Ban) enacted on 25 March 2020, aim to control and prevent the entry, emergence, establishment and spread of COVID-19 in Australian territory.

The Overseas Travel Ban Determination prevents Australian citizens and permanent residents from leaving Australian territory, with the exception of direct travel to New Zealand when quarantine-free travel arrangements are in place, unless an exemption applies.

On 11 August 2021, the Amendment Determination removed the automatic exemption for Australian citizens and permanent residents ordinarily resident in a country other than Australia contained in Para 6(a) of the Overseas Travel Ban Determination. At the time of amendment, the severe and immediate threat to human health from COVID-19 was evident in the increasing global cases and we were particularly concerned to manage capacity within, and preventing transmission from, hotel quarantine.

The processes under the Biosecurity Act

I acknowledge the important role that the parliamentary disallowance process plays in ensuring oversight of Commonwealth law. I also acknowledge the Committee's concern that the human biosecurity emergency powers are not subject to disallowance. However, the *Biosecurity Act 2015* (Act) progressed following extensive community consultation and robust debate through both Houses of Parliament. It was subject to rigorous parliamentary scrutiny processes.

As we have seen throughout the pandemic, emergency determinations have been critical in managing human biosecurity risks. Subjecting these determinations to disallowance would undermine the decision-making and risk management processes. The possibility of disallowance would create considerable uncertainty for government, industry and individuals. Disallowance would also undermine the urgent response required to effectively manage emerging biosecurity risks. It is necessary and appropriate that these instruments be exempt from disallowance and not vulnerable to political considerations.

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The Act allows the Australian Government to quickly respond to emerging and continuing human biosecurity threats. Existing accountability controls include:

- emergency determinations can only be made during the period set by the Governor-General
- emergency determinations are only made after I consider the best public health advice available, which is provided to me either by the Australian Health Protection Principal Committee or by the Director of Human Biosecurity, who is also the Commonwealth Chief Medical Officer (CMO).

Public scrutiny of the Government's response to COVID-19 is available through a range of means, including regular Senate Estimates and Senate Select Committee hearings on the Australian Government's response to the COVID-19 pandemic. The Act also sets a number of specific legal tests that must be met for emergency determinations, including that they are:

- necessary to prevent or control the entry, emergency, establishment or spread of a listed human disease into Australia
- likely to be effective in, or to contribute to, achieving the purpose for which it is to be determined
- no more restrictive or intrusive than is required in the circumstances
- to be applied in a manner which is no more restrictive or intrusive than is required in the circumstances
- applied only as long as is necessary.

These specific legal tests ensure decisions are proportionate, particularly noting that consultation beyond Government is not always possible where there is an immediate need to give effect to public health measures. When circumstances permit, however, consultation is undertaken with relevant stakeholders, as was the case with the relevant land councils for the now repealed Biosecurity (Human Biosecurity Emergency (Human Coronavirus with Pandemic Potential) (Emergency Requirement for Remote Communities) Determination 2020.

The Government also allowed for a transition period before the automatic exemption was removed from the Overseas Travel Ban, which was widely advertised via various media sources and Australian Government websites (including Smartraveller), to allow those who fell into the category time to decide which country they would like to remain in.

I understand the Committee is interested in whether that amendment trespassed unduly on personal rights and liberties, including the freedom of movement. As mentioned above, I must be satisfied that the requirement is no more intrusive than is required in the circumstances. As I noted in my recent letter to the Parliamentary Joint Committee for Human Rights, the recent COVID-19 outbreaks of the Delta variant were introduced into Australia by travellers returning from overseas. The amendment to the Overseas Travel Ban Determination was necessary to reduce the risk of bringing overseas-acquired cases of COVID-19 until such a time that the vaccination rates allow for reopening Australia's borders, as outlined in the National Plan.

Decision making under subsection 7(1) of the Overseas Travel Ban Determination

At the beginning of the COVD-19 pandemic, the automatic exemption for residents of another country was included in the Overseas Travel Ban Determination to allow Australian citizens and residents ordinarily a resident in another country to leave Australian territory to return to their usual country of residence.

Given the length of time that the automatic exemption operated (over 18 months), sufficient time was provided for persons falling into this category wishing to return to their usual place of residence, to do so.

Those who fall into the now removed category can still apply for an exemption to leave Australia, as can other Australians. Information on situations which may be assessed and the officers making decisions is available on the Home Affairs website at: www.homeaffairs.gov.au/covid-19/Documents/outward-travel-restrictions-operation-directive.pdf.

Exemptions to the Biosecurity (Human Coronavirus with Pandemic Potential) Amendment (No. 1) Determination 2021

Information on travel exemptions is available on the Department of Home Affairs website at: https://covid19.homeaffairs.gov.au/leaving-australia. This includes the circumstances under which a discretionary exemption may be made, and the types of evidence that is required to support the claim for an exemption. The Department of Home Affairs (including the Australian Border Force) was consulted on these questions.

Updates to the Explanatory Statement

As I consider that the exemptions from the disallowance process for emergency determinations are appropriately justified, I do not consider it necessary to amend the Act or the current explanatory statement as suggested. However, I will ask the department to take the committee's views into consideration when making any further changes to these instruments.

Thank you for writing on this matter.

Yours sincerely

Greg Hunt

The Hon David Littleproud MP

Minister for Agriculture and Northern Australia
Deputy Leader of the Nationals
Federal Member for Maranoa

Ref: MC21-008611

Senator the Hon Concetta Ferravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
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Via sdlc.sen@aph.gov.au

Dear Senator

Thank you for your letter of 30 September 2021 requesting advice for the Senate Standing Committee for the Scrutiny of Delegated Legislation, regarding the need for the *Northern Australia Infrastructure Facility Investment Mandate Direction 2021* (Investment Mandate) to be exempt from disallowance.

The *Northern Australia Infrastructure Facility Act 2016* (the NAIF Act), which is subject to parliamentary oversight, provides the overarching framework for the Northern Australia Infrastructure Facility (NAIF) by establishing its functions and that of the NAIF Board. The NAIF Investment Mandate provides direction from the responsible Ministers to the NAIF and the NAIF Board regarding the NAIF's functions to provide financial assistance for the development of infrastructure. It specifically provides direction relating to the technical and administrative aspects of the NAIF's investment functions, as set out in section 10 of the NAIF Act.

Since the NAIF's establishment in 2016, the Investment Mandate has been exempt from disallowance as per section 9 of the *Legislation (Exemptions and Other Matters) Regulation 2015.* This has enabled continuity of NAIF operations.

This approach also provides certainty for NAIF project proponents who invest significant time and resources to demonstrate eligibility for NAIF financial assistance. The NAIF frequently operates in conjunction with lending syndicates and other commercial financiers to achieve a final investment decision. These parties are subject to commercial timeframes, which do not align with parliamentary sitting days, and which could jeopardise NAIF projects if there is a protracted disallowance period.

The NAIF Act was amended by the *Northern Australia Infrastructure Facility (Extension and Other Measures) Bill 2021*. The 2021 Investment Mandate was put in place to allow the NAIF to deliver on additional functions provided through amendments to the Act. The 2021 Investment Mandate also delivers on increased Government oversight of the NAIF's financial assistance by adding the Finance Minister as a jointly responsible Minister.

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The NAIF Act prohibits the responsible Ministers from issuing an investment mandate that seeks to influence or affect the investment of funds in particular projects or to particular cohorts. These governance controls are intended to ensure that the NAIF Board operates with independence in managing the investment of Commonwealth money.

While I note the Committee's option to implement the Investment Mandate without utilising a disallowance exemption, I believe that not having an exemption in place would negatively impact the NAIF's operations. For example, delaying the 2021 Investment Mandate coming into effect until after the disallowance period had passed would have delayed its implementation until early August, preventing the NAIF from being able to provide financial assistance or deliver on reforms for over two months.

The NAIF Act requires that I must undertake a review of the NAIF as soon as possible after 30 June 2024. At that time, an evaluation of the potential impacts of making the Investment Mandate disallowable could be considered as part of this review.

As at 30 September 2021, the NAIF had made 28 investment decisions worth $3.2 billion supporting projects with an estimated total capital value of $6.76 billion. These projects are forecast to generate around $16.25 billion in economic benefit and support around 10,500 jobs. For each of these projects the involvement of the NAIF has been an essential element in attracting private sector financing. Attracting and incentivising private sector investment in Northern Australia remains a vital priority.

Thank you for raising this matter, and to the committee for their consideration of the Investment Mandate in the availability of infrastructure financing for northern Australia.

Yours sincerely

DAVID LITTLEPROUD MP

cc: Senator the Hon Simon Birmingham, Minister for Finance.

The Hon Greg Hunt MP
Minister for Health and Aged Care

Senator the Hon Richard Colbeck
Minister for Senior Australians and Aged Care Services
Minister for Sport

Ref No: MS21-001336

Senator the Hon Concetta Fierravanti-Wells
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15 October 2021

Dear Chair Concetta,

Thank you for your further correspondence of 30 September 2021 on behalf of the Senate Standing Committee for the Scrutiny of Delegated Legislation (Committee) concerning the Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021.

In your letter, the Committee sought advice on the specific training and experience that delegates of the Aged Care Quality and Safety Commissioner are required to have in order to exercise the relevant powers and functions to determine compliance with the requirements when restrictive practices are used in an emergency. Enclosed is advice on the specifics of this training and experience.

The Committee also seeks clarity concerning drafting in relation to arrangements whereby the principles provide that restrictive practices may be used where it is 'not inconsistent with', as opposed to 'consistent with' the Charter of Aged Care Rights. The Committee notes it considers 'not inconsistent' is a lower threshold than 'consistent', and therefore requests that amendments be made to both the *Aged Care Act 1997* and the Quality of Care Principles 2014 to increase the legislative threshold.

While it is agreed 'not inconsistent with the charter' is generally a lower threshold, the arrangements in paragraph 54-10(1)(g) of the *Aged Care Act 1997*, and paragraph 15FA(1)(i) of the Quality of Care Principles 2014 were drafted using this terminology to align with existing arrangements under paragraphs 56-1(m) and 56-1(1) of the *Aged Care Act 1997*. Paragraphs 56-1(m) and 56-1(1) of the *Aged Care Act 1997* require in that a provider must not act in way that is inconsistent with the Charter.

Amending both paragraph 54-10(1)(g) of the *Aged Care Act 1997*, and paragraph 15FA(1)(i) of the Quality of Care Principles 2014 as the Committee has recommended would introduce an inconsistency between these provisions and paragraphs 56-1(m) and 56-1(1) of the *Aged Care Act 1997*.

We are hesitant to make amendments to introduce such an inconsistency, or to make equivalent amendments to all references in the *Aged Care Act 1997* without carefully considering the implications, especially considering the broad nature of the rights under the charter.

However, given the Committee's concerns, we undertake to consider this matter more carefully in the context of the new aged care act, proposed to commence on 1 July 2023 (subject to parliamentary processes).

Further, in response to the Committee's recommendation, a replacement explanatory statement has been prepared. It includes further clarification on the meaning of the term 'emergency', and includes a correction in relation to new paragraph 15FA(1)(i) of the Quality of Care Principles 2014, to clarify that use of restrictive practices must not be inconsistent with the charter, which aligns with terminology used in the legislation. The replacement statement also includes additional information provided to the Committee in this letter and previous correspondence. The replacement explanatory statement will be registered on the Federal Register of Legislation in the coming days, and we have enclosed it for your information.

Thank you for writing on this matter.

Yours sincerely

Greg Hunt

Richard Colbeck

Encl (2)

REPLACEMENT EXPLANATORY STATEMENT

Issued by the authority of the Minister for Senior Australians and Aged Care Services

Aged Care Act 1997

Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021

Purpose

The purpose of the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021* (Amending Principles) is to amend the *Quality of Care Principles 2014* (Quality of Care Principles). The Amending Principles also make consequential amendments to the *User Rights Principles 2014* (User Rights Principles).

The Amending Principles respond to the recommendations of the Royal Commission into Aged Care Quality and Safety (Royal Commission), and the Independent Review of the Legislation Provisions Governing the use of Restraint in Residential Aged Care (Restraint Review). The Amending Principles also form part of the first stage of aged care reform in response to the Royal Commission's Final Report.

The Amending Principles supplement the aged care reforms introduced by the *Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021* (Royal Commission Response No. 1 Act).

The Amending Principles will amend the Quality of Care Principles to set out requirements for approved providers for the use of restrictive practices in relation to aged care recipients in residential aged care, including flexible care in the form of short-term restorative care provided in a residential care setting. This will strengthen protections for care recipients from abuse associated with the inappropriate use of restrictive practices.

The Amending Principles detail:

- the limited circumstances in which a restrictive practice can be used in relation to a care recipient;
- responsibilities of approved providers relating to restrictive practices commencing from 1 July 2021; and
- responsibilities of approved providers relating to behaviour support plans commencing from 1 September 2021.

Schedule 1 sets out the detail of the limited circumstances in which a restrictive practice can be used and the responsibilities of approved providers. Schedule 1 will commence on 1 July 2021 to align with the commencement of the strengthened requirements introduced by the Royal Commission Response No. 1 Act. This will ensure strengthened restrictive practice obligations are applied to approved providers to protect care recipients from the inappropriate use of restrictive practices.

Schedule 2 will commence from 1 September 2021 to allow sufficient time for aged care providers to prepare to meet the requirements in relation to the implementation of behaviour support plans. While care and services planning is a current requirement of approved providers, the new detailed requirements in the Amending Principles for behaviour support plans may require approved providers to update their policies and procedures. However, it is important to implement the necessary changes in a timely manner to ensure the safety and protections of senior Australians is prioritised.

Approved providers are encouraged to proactively transition to the strengthened preventative approach to manage behaviours of concern, with the intent to reduce restrictive practice use in aged care facilities, prior to 1 September 2021.

The Amending Principles will also make consequential amendments to the User Rights Principles to remove a reference to a provision of the *Aged Care Act 1997* (Aged Care Act) which has been recently repealed.

The Amending Principles are made under the Aged Care Act.

Background

On 1 July 2019, the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* introduced amendments to the Quality of Care Principles, which required residential aged care providers to satisfy a number of requirements in relation to the use of physical and chemical restraint.

These requirements, for the first time, put explicit obligations on approved providers of residential aged care and short-term restorative care in a residential setting in respect of the use of restraint. The regulatory changes required providers to satisfy a number of requirements before restraint could be used, including assessment by an approved health practitioner (for physical restraint) or assessment by a medical practitioner or nurse practitioner who has prescribed the medication (for chemical restraint).

On 22 November 2019, the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* amended the Quality of Care Principles to:

- repeal Part 4A of the Quality of Care Principles at the start of 1 July 2021;
- clarify that the use of restraint must be a measure of last resort; and
- reference state and territory legislation that regulates prescribers of medication, being a medical practitioner or nurse practitioner.

The *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* also amended the Quality of Care Principles to provide for the Minister to ensure that there is a review of the operation of Part 4A of the Quality of Care Principles, relating to physical and chemical restraint. Section 15H of the Quality of Care Principles required that the review consider the effectiveness of the Part 4A in minimising the use of physical restraints and chemical restraint by approved providers in relation to consumers in the period 1 July 2019 to 30 June 2020.

On 31 December 2020, the Restraint Review was finalised and provided to the Department of Health (the Department). The purpose of the Restraint Review was to evaluate whether there had been a reduction in the inappropriate use of restraint since

the introduction of the restraint provisions in the Quality of Care Principles, and whether approved providers' awareness, attitudes, skills and behaviours in relation to restraint had changed. The Restraint Review made 10 recommendations to support the aged care sector to further minimise the use of restrictive practices.

On 1 March 2021, the Royal Commission released their final report, which also made recommendations regarding how relevant legislation should regulate the use of restrictive practices in the aged care sector (see Recommendation 17).

Both the Restraint Review and the Royal Commission's final report recommended that legislation for the use of restrictive practices be strengthened and that providers' responsibilities on the use of these practices be clarified. The recommendations of the Restraint Review and the Royal Commission have been instrumental in the review and strengthening of legislative obligations on approved providers in relation to the use of restrictive practices.

Amendments to the Aged Care Act to regulate the use of restrictive practices in the aged care sector have been introduced by the Royal Commission Response No. 1 Act.

The amendments to the Aged Care Act strengthen the responsibilities on approved providers by including enhanced safeguards and conditions on the use of restrictive practices and allow the Quality of Care Principles to stipulate which kinds of aged care the new restrictive practice obligations apply to, and which practices or interventions are a restrictive practice. The Quality of Care Principles provide legislative detail on the requirements approved providers are to comply with prior to, during, and after the use of restrictive practices.

The amendments to the Aged Care Act also introduce the term 'restrictive practice', and define it as any practice or intervention that has the effect of restricting the rights or freedom of movement of the care recipient. This aligns with the definition of restrictive practices applied under the National Disability Insurance Scheme (see the *National Disability Insurance Scheme Act 2013* and the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*).

The Royal Commission Response No. 1 Act also enhances compliance of approved providers by including civil penalties for those providers who fail to comply with compliance notices produced by the Aged Care Quality and Safety Commissioner (Commissioner) in relation to a breach of restrictive practice responsibilities under the Aged Care Act.

Resources and guidance material

Existing guidance and support materials on best practice use of alternative behaviour supports and restrictive practices are being updated and new guidance is being created to support approved providers to understand and meet their requirements in relation to the use of restrictive practices.

As recommended by the Restraint Review, this includes the review and update of existing guidance including the *Decision Making Tool: Supporting a Restraint-Free Environment'* (Decision Making Tool) and *Scenarios involving physical and chemical*

restraint. This guidance is available on the Aged Care Quality and Safety Commission's website at: https://www.agedcarequality.gov.au/.

Importantly, it should be noted that support for the aged care sector on behaviour support planning and management is also currently available:

- Dementia Support Australia (DSA) provides support for people with dementia who are experiencing changes in behaviour that impact their care or the carer. Services include the Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Teams (SBRT). DSA also provides a variety of resources to inform and assist health care professionals and family members who are supporting a person with dementia.
- Dementia Training Australia (DTA) provides free on-line dementia training, practical resources and training packages, including behaviour support planning. Additionally, DTA provides face-to-face training to providers and the sector, to help staff better understand the causes of behaviour change and to find ways to avoid or reduce them.

Additionally, as part of the 2021-22 Budget, the Government committed additional funding to enhance capability for positive approaches to behavioural and psychological symptoms of dementia and to minimise the use of restraint. This will provide:

- Increased funding for DBMAS and SBRT to support a further 13,000 referrals to these services per year on average.
- Training for representatives of all aged care providers on managing behavioural and psychological symptoms of dementia.

The Government has also increased its investment in pharmacy programs under the Seventh Community Pharmacy Agreement to improve medication management practices, including in residential aged care facilities. This includes the expansion of the Quality Use of Medicine Program and the Residential Medication Management Review (RMMR) Program. In April 2020, the RMMR program was expanded to allow up to two funded follow up services by pharmacists after an initial RMMR has been delivered.

Authority

Section 96-1 of the Aged Care Act provides that the Minister has the power to make instruments providing for matters required or permitted, or necessary or convenient, in order to give effect to the relevant Part or section of the Aged Care Act.

The Quality of Care Principles are made under section 96-1 of the Aged Care Act, and set out matters for the purposes of Part 4.1 of the Aged Care Act.

Item 1 of Schedule 1 to the Royal Commission Response No. 1 Act inserts new paragraph 54-1(1)(f) in Part 4.1 of the Aged Care Act. Paragraph 54-1(1)(f) sets out a new responsibility of an approved provider in relation to the quality of the aged care that an approved provider provides. If an approved provider provides a kind of care specified in the Quality of Care Principles to care recipients, they have a responsibility to ensure a restrictive practice in relation to those recipients is only used in the circumstances set out in these Principles.

The Amending Principles amend the Quality of Care Principles to specify the requirements that are subject to new paragraph 54-1(f), including the kind of care delivered in a residential care setting, the certain practices or interventions that are restrictive practices and the circumstances for the use of a restrictive practice.

The Amending Principles have been made in anticipation of the commencement of the Royal Commission Response No. 1 Act.

Section 4 of the *Acts Interpretation Act 1901* provides that a power to make a legislative instrument in an Act may be exercised between the enactment and commencement of an Act. The new instrument-making powers introduced by the Royal Commission Response No. 1 Act have been exercised to make this instrument before that Act commences. It is important that the Amending Principles be made between the enactment and the commencement of the Royal Commission Response No. 1 Act to ensure the new regulatory requirements for the use of restrictive practices commence at the same time as the new restrictive practice responsibilities under the Aged Care Act. This will also ensure continuity of the regulation of the use of restrictive practices, as current Part 4A of the Quality of Care Principles is due to self-repeal on 1 July 2021. Should Part 4A of the Quality of Care Principles self-repeal without the Amending Principles replacing those provisions, there will be a limited legislative basis to regulate the use of restrictive practices in the aged care sector.

Under subsection 33(3) of the *Acts Interpretation Act 1901* where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend or vary any such instrument.

Commencement

Sections 1 to 4 and anything in the Amending Principles not elsewhere covered by the commencement information table will commence the day after this instrument is registered.

Schedule 1 to the Amending Principles will commence on 1 July 2021.

Schedule 2 to the Amending Principles will commence on 1 September 2021.

Consultation

The Department of Health has undertaken extensive consultation in relation to the use restrictive practices in aged care, through the Royal Commission and the Restraint Review. The recommendations of the Royal Commission and the Restraint Review have instrumentally informed the amendments in relation to the use of restrictive practices to the Aged Care Act and these Amending Principles.

The Department also undertook consultation with the Aged Care Clinical Advisory Committee (ACCAC) in relation to restrictive practices and to seek their feedback on the proposed amendments to the Quality of Care Principles. This committee includes representatives with clinical expertise in the use of restrictive practices including the

NDIS Senior Practitioner, geriatricians, psychiatrists, GPs, pharmacists, nurse practitioners, and representatives for aged care providers and aged care consumers.

The Department also undertook consultation with the Restraint Advisory Group established to support the Restraint Review, both during the period of the review and following the review to seek their feedback on the proposed amendments to the Quality of Care Principles. The Restraint Advisory Group includes representatives of aged care provider peak bodies, aged care consumer peak bodies, the Australian Guardianship and Administration Council, the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care and academics with expertise in aged care clinical practice.

The advisory groups were generally supportive of the strengthened legislative provisions. While it was noted the regulation of prescribing practitioners was outside the scope of this legislation, it was recommended that further guidance be provided on responsibilities of providers and prescribers on the use of chemical restraint.

In addition, a few minor edits to provide additional clarification were recommended by these advisory groups. The Amending Principles were revised in response to this feedback.

Suggestions from the ACCAC and the Restraint Advisory Group were also taken into account when drafting this explanatory statement, communication materials and policy guidance. This included suggestions for further clarification and examples to assist providers to understand and comply with strengthened requirements on the use of restrictive practices from 1 July 2021, and on the requirements for behaviour support plans from 1 September 2021.

Regulation Impact Statement

Consistent with the Office of Best Practice Regulation's Regulatory Impact Statement (RIS) requirements, the Department certified that a package of independent reviews undertook a process and analysis equivalent to a RIS in regards to restrictive practices amendments. The certification and list of reviews can be found in the Explanatory Memorandum for the *Aged Care and Other Legislation Amendment (Royal Commission Response) No.1 Bill.*

Details of the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*

Section 1 Name
Section 1 provides that the name of the Amending Principles is the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021*.

Section 2 Commencement
Section 2 sets out the commencement dates for Sections 1-4 and each schedule to the Amending Principles.

- Sections 1 to 4 and anything in the Amending Principles not elsewhere covered by the commencement information table will commence the day after this instrument is registered.
- Schedule 1 will commence on 1 July 2021.
- Schedule 2 will commence on 1 September 2021.

Section 3 Authority
Section 3 provides that the Amending Principles are made under the *Aged Care Act 1997*.

Section 4 Schedules
Provides that each Schedule is amended or repealed as set out in the applicable item in that Schedule, and any other item in that Schedule has effect according to its terms.

Schedule 1 – Amendments commencing 1 July 2021

Part 1 – Main Amendments

Quality of Care Principles 2014

Item 1 - Section 4 (paragraph (e) of note)
Item 1 repeals paragraph (e) of the note to section 4 of the Quality of Care Principles and substitutes new paragraphs (e) restrictive practice, and (f) staff member. The note to section 4 sets out terms that are defined in the Aged Care Act. The effect of this amendment makes clear that these expressions are defined in the Aged Care Act, and therefore do not need to be redefined in the Quality of Care Principles.

Item 2 - Section 4
Item 2 amends section 4 of the Quality of Care Principles, which sets out the definitions of words and terms used throughout the instrument.

Item 2 inserts ten new definitions into section 4 of the Quality of Care Principles. The new terms defined are *approved health practitioner, care and services plan, chemical restraint, environmental restraint, mechanical restraint, medical practitioner, nurse practitioner, physical restraint, registered nurse, and restrictive practices substitute decision-maker*.

An approved health practitioner is defined as a medical practitioner, nurse practitioner or registered nurse.

A care and services plan is defined to mean the care and services plan documented for the care recipient in accordance with the Aged Care Quality Standards set out in Schedule 2 to the Quality of Care Principles. A note to this definition directs the reader to Standard 2 (ongoing assessment and planning with consumers) set out in clause 2 of Schedule 2.

A chemical restraint is defined to have the meaning given by new subsection 15E(2) (see Item 9 below).

An environmental restraint is defined to have the meaning given by new subsection 15E(3) (see Item 9 below).

A mechanical restraint is defined to have the meaning given by new subsection 15E(4) (see Item 9 below).

Both a medical practitioner and a nurse practitioner are defined to have the meaning as in the *Health Insurance Act 1973* (see section 3 of that Act).

A physical restraint is defined to have the meaning given by new subsection 15E(5) (see Item 9 below).

A registered nurse is defined to have the same meaning as in the *Health Insurance Act 1973*.

A restrictive practices substitute decision-maker, for a restrictive practice in relation to a care recipient, means a person or body that, under the law of the State or Territory in which the care recipient is provided with aged care, can give informed consent to the following if the care recipient lacks the capacity to give that consent:

- The use of the restrictive practice in relation to the care recipient; and
- If the restrictive practice is chemical restraint, the prescribing of medication for the purpose of using the chemical restraint.

State and territory legislation regulates who can give informed consent to the use of a restrictive practice and the prescribing of medication for the purpose of using that medication as a chemical restraint. The Amending Principles do not affect the operation of any law of a state or territory in relation to restrictive practices. The Amending Principles seek to complement and clarify those state and territory laws which protect individuals from interference from their personal rights and liberties.

Seclusion is defined to have the meaning given by new subsection 15E(6) (see Item 15 below).

Item 3 - Subsection 13(4)
Item 3 amends subsection 13(4) of the Quality of Care Principles to omit the phrase "documented for the care recipient in accordance with the Aged Care Quality Standards set out in Schedule 2", and substitutes the words "for the care recipient". This is consequential to Item 2 above, which sets out a definition for a care and services plan with reference to Standard 2 of the Aged Care Quality Standards, which sets out ongoing assessment and planning standards.

Item 4 - Subsection 13(4) (note)
Item 4 repeals the note to subsection 13(4) of the Quality of Care Principles. This note referred the reader to Standard 2 (ongoing assessment and planning with consumers) set out in clause 2 of Schedule 2 of the Quality of Care Principles. This note is no longer required as a new definition for care and services plan has been inserted into section 4, which directs the reader accordingly (see Item 2 above).

Item 5 - Subsection 15B(4)
Item 5 amends subsection 15B(4) of the Quality of Care Principles to omit the phrase "documented for the care recipient in accordance with the Aged Care Quality Standards set out in Schedule 2", and substitutes the words "for the care recipient". This is consequential to Item 2 above, which sets out a definition for a care and services plan with reference to Standard 2 of the Aged Care Quality Standards, which sets out ongoing assessment and planning standards.

Item 6 - Subsection 15B(4) (note)
Item 6 repeals the note to subsection 15B(4) of the Quality of Care Principles. This note referred the reader to Standard 2 (ongoing assessment and planning with consumers) set out in clause 2 of Schedule 2 of the Quality of Care Principles. This note is no longer required as a new definition for care and services plan has been inserted into section 4, which directs the reader accordingly (see Item 2 above).

Item 7 - Subsection 15C(4)
Item 7 amends subsection 15C(4) of the Quality of Care Principles to omit the phrase "documented for the care recipient in accordance with the Aged Care Quality Standards set out in Schedule 2", and substitutes the words "for the care recipient". This is consequential to Item 2 above, which sets out a definition for a care and services plan with reference to Standard 2 of the Aged Care Quality Standards, which sets out ongoing assessment and planning standards.

Item 8 - Subsection 15C(4) (note)
Item 8 repeals the note to subsection 15C(4) of the Quality of Care Principles. This note referred the reader to Standard 2 (ongoing assessment and planning with consumers) set out in clause 2 of Schedule 2 of the Quality of Care Principles. This note is no longer required as a new definition for care and services plan has been inserted into section 4, which directs the reader accordingly (see Item 2 above).

Item 9 - Part 4A
Item 9 inserts a new Part 4A of the Quality of Care Principles.

The Restraint Review and the Royal Commission's Final Report recommended legislative provisions on the use of restraint be strengthened. The amendments in

Part 4A are designed to address these recommendations and to ensure the rights of care recipients are given primary consideration, and to provide further protection for care recipients in relation to the use of restrictive practices.

Providing clarity about restrictive practices and interventions has been requested by the aged care sector to ensure they can comply with their responsibilities regarding the use of restrictive practices in aged care.

It is considered reasonable that these matters be dealt with in delegated legislation as they relate to operational matters such as process and procedures, in that it outlines the steps that an approved provider must take to ensure that restrictive practices are only used in very limited situations. Including these arrangements in delegated legislation will also allow flexibility to respond to unforeseen issues and respond to community and sector concerns in a timely manner. As these matters relate to actions taken in response to restrictive practices it is appropriate (including from a community expectations perspective) that there is flexibility for appropriate and prompt action in response to any unforeseen matters. It is intended that the Australian Government's ability to undertake such actions will prevent impacts on the rights of older Australians.

The Government will continue to monitor these arrangements and will review whether they should be included on the face of the Act as part of the current project to introduce a new Aged Care Act. On 1 March 2021, in response to the recommendations of the Royal Commission's Final Report, the Government committed to immediately commence work on a new consumer-focused Aged Care Act.

The new Act will replace the existing aged care legislative framework and is intended to commence from 1 July 2023, subject to parliamentary processes. As part of the project, the Government will consider how existing aged care arrangements should be dealt with under the new legislative structure, including whether certain arrangements should be included on the face of the Act, rather than in delegated legislation.

New Division 1 - Preliminary

New Division 1 sets out the purpose of the new Part 4A of the Quality of Care Principles.

New section 15D - Purpose of this Part

New section 15D provides the purpose of new Part 4A. Part 4A:

- specifies the kinds of aged care that the restrictive practices requirements apply to; and
- provides that certain practices or interventions are restrictive practices; and
- sets out circumstances for the use of restrictive practices in relation to care recipients; and
- specifies other responsibilities of approved providers.

New section 15DA - Kinds of aged care for the purposes of paragraph 54-1(1)(f) of the Act

New section 15DA specifies that for the purpose of paragraph 54-1(1)(f) of the Aged Care Act, the kinds of care that restrictive practice obligations apply to are residential care, and flexible care in the form of short-term restorative care provided in a residential care setting.

New Division 2 – Restrictive practices

New Division 2 sets out what practices or interventions are considered restrictive practices for the purposes of 54-9(2) of the Aged Care Act.

New section 15E - Practices or interventions that are restrictive practices

New subsection 15E(1) sets out five types of restrictive practices in relation to a care recipient for the purposes of 54-9(2) of the Aged Care Act. These are:

- chemical restraint;
- environmental restraint;
- mechanical restraint;
- physical restraint; and
- seclusion.

The strengthened and clarified definitions of the types of restraint described in section 15E are intended to ensure better understanding by approved providers on what constitutes a restrictive practice and the circumstances for the use of a restrictive practice. The proposed definitions align with the definitions applied under the National Disability Insurance Scheme, bringing aged care sector practice into line with the disability sector.

All forms of restrictive practices defined under section 15E are practices or interventions that are used for the primary purpose of influencing a care recipient's behaviour.

Chemical restraint

New subsection 15E(2) sets out what constitutes a chemical restraint. 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:

- the treatment of, or to enable treatment of, the care recipient for a diagnosed mental disorder, a physical illness or a physical condition; or
- end of life care for the care recipient.

The most common type of chemical restraint used in aged care is psychotropic medicine. Psychotropic medications are any drug capable of affecting the mind, emotions and behaviour. The three main classes of psychotropic medicines prescribed are antidepressants, anxiolytic/ hypnotics (mostly benzodiazepines to manage anxiety and insomnia) and antipsychotics. Other psychotropic classes include anticonvulsants and stimulants. The Aged Care Quality and Safety Commission's resource '*Psychotropic medications used in Australia information for aged care*' includes details of the types of medications used in aged care settings.

The definition excludes medication prescribed for a diagnosed mental disorder, a physical illness or physical condition or end of life care. This allows for the continued use of these medications where there is a genuine and clear medical need. Where medication is prescribed for the medical treatment of a diagnosed mental disorder, a physical illness or physical condition or end of life care, approved providers need to ensure they are using the medication as prescribed.

If medication is prescribed as a chemical restraint, an approved provider must meet the additional requirements for the use of restrictive practices that are chemical restraint listed under new section 15FC of the Quality of Care Principles (see below). This includes documenting the medical or nurse practitioner's decision to use chemical restraint and the care recipient's behaviours that are relevant to the need for the chemical restraint.

Environmental restraint
New subsection 15E(3) defines what restrictive practices will be taken to be an environmental restraint. Environmental restraint is a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour.

The care recipient's environment is taken to include the care recipient's room, any common areas within the facility, and the common grounds outside of the facility. It does not include areas within the facility that a care recipient would not normally be permitted, such as the kitchen, meal preparation areas, laundry, maintenance areas or medication storage areas. Additionally, it does not include other care recipient's rooms.

Environmental restraint may involve restricting a care recipient from accessing a room or area within their environment, or an item or activity. For example, locking away cutlery, tea/coffee, or mobile phones, in cupboards and/or drawers, or restricting a care recipient from accessing activities such as watching television, or making tea or coffee is environmental restraint.

Number keypads on doors are a restrictive practice if it prevents a care recipient from accessing a part of their environment or limits their movements. While keypads are commonly used within facilities for the safety of care recipients, they are a restrictive practice if a care recipient cannot leave freely. If facilities provide codes to care recipients or staff are available to open doors when required, this would not be considered an environmental restraint. However, when a keypad code is given to care recipients, but they are unable to remember it or have cognitive impairments, this is an environmental restraint.

While environmental restraints are commonly used for the safety of care recipients they can have unanticipated effects on other care recipients rights. Therefore, any environmental restraint should not only consider the impact for the care recipient but for all care recipients that have access to that environment and/or item or activity.

Mechanical restraint
New subsection 15E(4) defines what restrictive practices will be taken to be a mechanical restraint. Mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient.

Examples of mechanical restraint include bed rails, tray tables, belts, harnesses, restrictive clothing, and the use of straps to restrain any part of the body, splints or gloves. Devices used for therapeutic purposes or non-behavioural purposes are not considered to be mechanical restraints, such as splints/casts for broken bones, or wheelchairs for someone unable to walk long distances.

Devices used for safety purposes or to prevent harm, even if consented to by the care recipient, are considered to be a mechanical restraint if not used for therapeutic or non-behavioural purposes.

Physical restraint
New subsection 15E(5) defines what restrictive practices will be taken to be a physical restraint. Physical restraint is a practice or intervention that is or involves the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary purpose of influencing the care recipient's behaviour. This does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered the exercise of care towards the care recipient.

An example of the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from harm may be where a person holds a care recipient back from crossing the road where the care recipient began to move forward without consideration of the oncoming traffic. Another example may be where a person catches a care recipient when they begin to fall down.

Examples of physical restraint are pulling a care recipient in a direction they do not wish to go, or holding a care recipient down to administer medication.

Assisting care recipients during activities of daily living and therapeutic activities where the care recipient is unable to perform these tasks themselves or has requested assistance, for example, assisting during dressing, shaving, teeth brushing, or assisting to complete physiotherapy activities, are not considered to be physical restraint.

Seclusion
New subsection 15E(6) defines what restrictive practices will be taken to be seclusion. Seclusion is a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night for the primary purpose of influencing the care recipient's behaviour where:

- voluntary exit is prevented or not facilitated; or
- it is implied that voluntary exit is not permitted.

Seclusion involves the solitary confinement of a care recipient. Examples of seclusion are locking a care recipient in their room or other area of the facility, ordering a care recipient to a specific area within the facility with them believing they are not permitted to leave or staff, and other care recipients retreating to other rooms while the care recipient is unable to follow.

A care recipient choosing to go to their own room or bathroom and locking the door is not seclusion, provided they are free to leave when they wish to. Additionally, care recipients required to isolate for the purpose of complying with state and territory public health directives would not be considered to be seclusion, as the primary purpose for such an action is not to influence the care recipient's behaviour.

New Division 3 – Circumstances for the use of restrictive practices
New Division 3 sets out the circumstances in which an approved provider may use a restrictive practice or intervention for the purposes of paragraph 54-1(1)(f) of the Aged Care Act.

New section 15F - Circumstances for the use of restrictive practices
New section 15F provides that, for the purposes of paragraph 54-1(1)(f) of the Aged Care Act, the circumstances in which an approved providers may use a restrictive practice in relation to a care recipient are that the requirements set out in Division 3, that apply to the restrictive practice in relation to the care recipient, are satisfied.

The note to section 15F provides that the use of a restrictive practice in relation to a residential care recipient of an approved provider other than in these circumstances is a reportable incident (see paragraph 54-3(2)(g) of the Act). The purpose of this note is to highlight the requirement of approved providers to comply with the reportable incident provisions in the Aged Care Act and the Serious Incident Response Scheme (SIRS).

Under SIRS, approved providers have specific responsibilities to establish and maintain incident management systems that identify, manage, record and resolve incidents. The SIRS also requires approved providers to report all serious incidents affecting residential care recipients, which occur, or are alleged or suspected to have occurred, to the Aged Care Quality and Safety Commission. Any use of a restrictive practice that is inconsistent with Part 4A of the Quality of Care Principles is a reportable incident.

New section 15FA - Requirements for the use of any restrictive practice
New subsection 15FA(1) provides that the following requirements apply to the use of any restrictive practice in relation to a care recipient:

- the restrictive practice is used only:
    - as a last resort to prevent harm to the care recipient or other persons; and
    - after consideration of the likely impact of the use of the restrictive practice on a care recipient;
- to the extent possible, best practice alternative strategies have been used before the restrictive practice is used;
- the alternative strategies that have been considered or used have been documented;

- 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;
- 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;
- informed consent to the use of the restrictive practice has been given by the care recipient, or if the care recipient lacks capacity to give that consent, their restrictive practice substitute decision-maker;
- the use of the restrictive practice complies with any relevant provisions of the care and services plan for the care recipient;
- the use of the restrictive practice complies with the Aged Care Quality Standards set out in Schedule 2 to the Quality of Care Principles;
- the use of the restrictive practice is not inconsistent with the Charter of Aged Care Rights (see Schedule 1 to the User Rights Principles);
- 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.

These requirements will ensure that restrictive practices are only used as a necessary and proportionate response to the circumstances of a particular care recipient, and ensures the rights of care recipients are given primary consideration and protection.

Where a restrictive practice is used, the approved provider must ensure it uses the least restrictive form of restraint to address the risk of harm. To use the least restrictive form of restraint, the approved provider must have regard to the total period for which restraint will be used, including periods of release. This should be determined before the restraint is commenced.

The approved provider must also consider whether the risk of harm can be managed by using any alternatives to the restrictive practice, and use those alternatives to the extent possible. It is intended that the approved provider assess and manage any changed behaviour of a care recipient, and identify and implement strategies to address those behaviours before restrictive practices are considered and used. The approved provider should also, wherever possible, proactively examine the triggers of behaviours to address the causes of these behaviours. The use of restraint must always be the last resort and used only as a temporary solution following the application of alternative behaviour supports.

There are limited situations where it may be appropriate to use restrictive practices to ensure the safety of residential aged care recipients and others, including in emergencies. However, the amendments introduced by the Amending Principles seek to clarify that this is a safety measure of last resort where all other interventions have been employed and excluded. Restrictive practices must only be used in a way that supports good clinical practice and provides safe and improved care for consumers.

Informed consent requirements

Any decision to restrain a consumer carries significant ethical and legal responsibilities. Care recipients must provide informed consent to the use of a restrictive practice wherever possible. If a care recipient does not have capacity to consent, consent must be obtained from someone with authority to provide it, in this case, the care recipient's restrictive practices substitute decision-maker (see Item 8 above).

The care recipient or their restrictive practice substitute decision-maker may withdraw their consent at any time. Therefore, the approved provider should take steps to regularly communicate with the consumer or their substitute decision maker, and obtain informed consent contemporaneously.

The care recipient should be supported or assisted to make their own decisions. This includes communicating with them in a way they can understand and they should be given the opportunity to discuss their concerns and expectations. The communication is enhanced if restrictive practices substitute decision-makers and the care recipient's family are given written information that they can keep and review at any time.

Informed consent must be obtained before the restrictive practice is used, unless the restrictive practice is necessary in an emergency (see new subsection 15FA(2)). If the use of a restrictive practice was used in an emergency and the care recipient lacked capacity to consent to the use of the restrictive practice, the restrictive practice substitute decision-maker must be informed as soon as practicable after the restrictive practice starts to be used (see new paragraph 15GB(a) below).

State and territory legislation regulates who can give informed consent to the prescribing of medication for the purposes of chemical restraint on behalf of a care recipient who cannot consent because they lack capacity. State and territory legislation also regulates who can give informed consent to the use of restrictive practices other than chemical restraint on behalf of a care recipient who lacks capacity to provide consent. The amendments introduced by the Amending Principles do not affect the operation of those state and territory laws, which protect individuals from undue interference with their personal rights and liberties in relation to the use of restrictive practices.

The state and territory legislation referred to in the Amending Principles is not incorporated by reference. The relevant legislation, at the time of making the Amending Principles, for each state and territory is set out in Table 1. This table also provides details of relevant organisations who may be able to provide additional information.

Table 1 – State and Territory legislation

State	Legislation	Relevant organisations
ACT	*Guardianship and Management of Property Act 1991* *Medical Treatment (Health Directions) Act 2006* *Public Trustee and Guardian Act 1985 (ACT)* *Power of Attorney Act 2006 (ACT)*	Public Trustee and Guardian (ACT) ACT Civil and Administrative Tribunal (ACAT) Public Advocate – ACT Human Rights Commission
NSW	*Guardianship Act 1987* *Guardianship Regulations 2016* *Powers of Attorney Act 2003 No 53*	Public Guardian (NSW) NSW Civil and Administrative Tribunal NSW Trustee and Guardian
NT	*Adult Guardianship Act 2016* *Guardianship of Adults Regulations 2016* *Northern Territory Civil and Administrative Tribunal Act 2014* *Advance Personal Planning Act 2013 (NT) (the Act)*	Northern Territory Civil and Administrative Tribunal Office of the Public Guardian (NT)

State	Legislation	Relevant organisations
QLD	*Guardianship and Administration Act 2000* *Public Guardian Act 2014* *Human Rights Act 2019* *Powers of Attorney Act 1998*	Office of the Public Guardian (QLD) Public Advocate (QLD) Queensland Civil and Administrative Tribunal
SA	*Consent to Medical Treatment and Palliative Care Act 1995* *Consent to Medical Treatment and Palliative Care Regulations 2014* *Advanced Care Directives Act 2013* *Guardianship and Administration Act 1993* *Guardianship and Administration Regulations 2015*	Office of the Public Advocate South Australian Civil and Administrative Tribunal
TAS	*Guardianship and Administration Act 1995* *Guardianship and Administration Regulations 2017* *Guardianship and Administration (Corresponding Law) Notice 2014* *Guardianship and Administration (Corresponding Law) Notice 2011*	Office of the Public Guardian (TAS) Guardianship and Administration Board
VIC	*Guardianship and Administration Act 2019* *Guardianship and Administration Board (Application) Regulations 1994* *Medical Treatment Planning and Decisions Act 2016*	Office of the Public Advocate (VIC) Victorian Civil and Administrative Tribunal
WA	*Guardianship and Administration Act 1990 (WA)* *Guardianship and Administration Regulations 2005*	State Administrative Tribunal Office of the Public Advocate (WA)

While every effort has been made to verify the accuracy of this information, the relevant legislation may change from time to time. The table does not capture relevant policy directives or other guidance information used by state and territory governments. The table is provided for guidance only, and further information and clarification should be sought from the relevant state and territory jurisdictions.

Emergency use of restrictive practices

New subsection 15FA(2) sets out that selected requirements do not apply to the use of the restrictive practice if the use of the restrictive practice in relation to a care recipient is necessary in an emergency. The requirements that do not apply are new paragraphs 15FA(1)(a), (b), (c), (f) and (g), set out as follows:

- the restrictive practice is used only:
    - as a last resort to prevent harm to the care recipient or other persons; and
    - after consideration of the likely impact of the use of the restrictive practice on the care recipient;
- to the extent possible, best practice alternatives have been used before the restrictive practice is used;
- the alternative strategies that have been considered or used have been documented;
- informed consent of the use of the restrictive practice has been given by the care recipient, or if the care recipient lacks capacity to give that consent, their restrictive practice substitute decision-maker; and

- the use of the restrictive practice complies with any relevant provisions of the care and service plan for the care recipient.

The exemption of these requirements is intended to ensure an approved provider can appropriately and rapidly respond to an emergency to protect a care recipient or other person from immediate harm.

While the restrictive practice is being used, the approved provider must monitor and review the necessity for the continued use of the restrictive practice (see new section 15GA below).

New subsection 15FA(3) specifies that the exemption of these requirements only applies while the emergency exists.

The note following subsection 15FA(3) provides that new section 15GB sets out other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency (see below for further detail). The requirements outlined in new section 15GB ensure that approved providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

An emergency situation is not expected to last for an extended period of time. An emergency situation will be considered to have ended when there is no immediate risk of harm or injury for the care recipient or others. If a restrictive practice is required to be continued after the emergency situation has ended, approved providers will be required to comply with all legislative requirements relating to the use of restrictive practices, including obtaining informed consent for ongoing use of a restrictive practice.

It is expected that approved providers will be actively engaged in care recipient's behaviour support planning and that this will reduce any occurrence of emergency use of restrictive practices. This should include consideration of any escalation points for any changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for care recipients.

Oversight of emergency use of restrictive practices
The reference to 'emergency' in new subsection 15FA(2) is not defined, and therefore is intended to have its ordinary meaning. An emergency may include an unforeseen occurrence, or sudden or urgent occasion for action. In aged care the scope of emergency situations can be quite broad and adopting a prescriptive definition is likely to result in unintended consequences and may exclude situations of genuine emergency. Situations where restrictive practices are required in residential aged care in the event of an emergency should be following unanticipated or unforeseen events which requires immediate action and therefore should be rare. This term has not been defined in the legislation, so not to speculate or limit the term, as not all circumstances are known or predictable.

The arrangements under new subsection 15FA(2) are intended to ensure that an approved provider can appropriately and rapidly respond to an emergency to ensure the protection of a care recipient or other person from immediate harm. Once the

emergency is over, the provider should revert to the usual policies and procedures regarding the application or use of any restrictive practice for the care recipient. This includes reduction or removal of the restrictive practice, assessment, consideration and use of alternative strategies, and subsequent update and review of the care recipient's Behaviour Support Plan and care and services plan.

It is expected that approved providers will be actively engaged in a care recipient's day to day care and support needs, including behaviour support planning, and that this understanding and engagement will reduce the occurrence of emergencies. While the term 'emergency' is not specifically intended as a discretionary term, the Commissioner, in monitoring compliance with provider responsibilities relating to the use of restrictive practices, will be reviewing care and services plans where emergency use of restrictive practices has been applied.

This review will include considering the care recipient's care needs in the lead up to the emergency, whether the emergency could have been anticipated given past history of behaviour, and what action was taken to deal with the situation prior to it becoming critical. Approved providers should be conscious of alternative strategies to avoid the need for emergency use of restrictive practices. This includes actively responding to the needs of their care recipients in order to avoid the deterioration of health or escalation of changed behaviours, to a point where emergency use of restrictive practices may be required.

If the provider considers that emergencies are occurring for extended periods of time or are occurring regularly for one or more care recipients, this may also indicate that an approved provider is not meeting their responsibilities and the Commissioner would monitor or investigate these circumstances. Where there is evidence that insufficient action has been taken by a provider to avoid emergency use of restrictive practices for a care recipient, the Commissioner, or delegate, may take further regulatory actions where it is deemed appropriate and proportionate in order to address any non-compliance.

New section 15FB - Additional requirements for the use of restrictive practices other than chemical restraint

Section 15FB relates to additional requirements regarding the use of environmental restraint, mechanical restraint, physical restraint and seclusion.

New subsection 15FB(1) sets out the requirements that apply to the use of a restrictive practice in relation to a care recipient that is not chemical restraint. These requirements are that:

- an approved health practitioner (that is, a medical practitioner, nurse practitioner or registered nurse as defined in section 4 of the Quality of Care Principles) who has day-to-day knowledge of the care recipient has assessed the care recipient as posing a risk of harm to the care recipient or any other person and has assessed that the use of the restrictive practice is necessary;
- the approved health practitioner's assessment has been documented.

The intent of subsection 15FB(1) is to ensure that a health practitioner that is familiar with the care recipient's care needs assesses whether the use of a particular restrictive practice is necessary. Day to day knowledge of the care recipient is expected to

support better understanding of the care recipient and their behaviour, as well as warning signs or triggers and how these can be addressed through the use of alternative behaviour supports in the first instance.

Emergency use of restrictive practices
Subsection 15FB(2) sets out that the requirement to document the assessment by the approved health practitioner does not apply to the use of a restrictive practice that is not a chemical restraint in relation to a care recipient, if the use of the restrictive practice is necessary in an emergency. This exemption is intended to ensure an approved provider can appropriately and rapidly respond to an emergency to ensure the protection of a care recipient or other person from immediate harm.

As stated in subsection 15FB(3), this exemption only applies while the emergency exists. The approved provider must document the assessment that the use of the restrictive practice was necessary after the emergency situation has passed. This must be completed as soon as practicable after the restrictive practice starts to be used (see new section 15GB below).

The note following subsection 15FB(3) identifies that section 15GB sets out other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency. The requirements outlined in new section 15GB ensure that approved providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

Approved providers should be actively engaged in care recipient's behaviour support planning to reduce the risk and occurrence of emergencies occurring. Approved providers are to consider escalation points for changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for care recipients.

<u>New section 15FC - Additional requirements for the use of restrictive practices that are chemical restraint</u>
The additional requirements introduced by new section 15FC only apply to the use of chemical restraint.

Subsection 15FC(1) sets out the requirements that apply to the use of a restrictive practice in relation to a care recipient that is chemical restraint. These requirements are that:

- the approved provider is satisfied that a medical practitioner or nurse practitioner has:
    - assessed the care recipient as posing a risk of harm to themselves or other persons; and
    - assessed that the use of the chemical restraint is necessary; and
    - prescribed medication for the purpose of using the chemical restraint;
- Matters, including the assessments by the medical or nurse practitioners; practitioners' decisions to use the chemical restraint; care recipient behaviours that are relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary, and information (if any) provided to the medical or nurse practitioner that informed their decision to prescribe the

medication, have been documented in the care and services plan for the care recipient;

- the approved provider is satisfied that informed consent to the prescribing of the medication has been given by the care recipient or, if the care recipient lacks capacity to give that consent, their restrictive practice substitute decision-maker.

Only a medical practitioner or nurse practitioner can assess whether a chemical restraint is necessary. Prescribing medical or nurse practitioners are required to document the reason they have prescribed medication for the purpose of chemical restraint and they must have obtained informed consent from the care recipient or, if the care recipient lacks capacity, from their restrictive practice substitute decision-maker.

If medication has been prescribed as a chemical restraint, approved providers must engage with the prescribing practitioner and the care recipient to communicate the impact and effectiveness of the restraint and any conditions around its use(see new section 15GA described below).

The approved provider is required to satisfy themselves that the prescribing practitioner has obtained informed consent for the use of the medication as a chemical restraint.

Regulation of medical practitioners and nurse practitioners in relation to the use of chemical restraint

The note following subsection 15FC(1)(c) refers to the codes of appropriate professional practice which apply to medical practitioners and nurse practitioners. These codes of conduct are included for information but are not incorporated by reference.

Before prescribing medicines, including antipsychotics and benzodiazepines, medical practitioners and nurse practitioners are responsible for obtaining informed consent from their patients (aged care recipients).

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.

In line with the provisions of the Health Practitioner Regulation 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.

In 2021, the MBA's code could be viewed on their website https://www.medicalboard.gov.au and NMBA's code could be viewed on their website: https://www.nursingmidwiferyboard.gov.au.

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.

Emergency use of restrictive practices
Subsection 15FC(2) sets out the requirements that do not apply to the use of a restrictive practice that is a chemical restraint in relation to a care recipient if the use of the restrictive practice is necessary in an emergency. The requirements that do not apply are new paragraphs 15FC(1)(b) and (c), which relate to:

- documenting the matters, the assessments by the medical or nurse practitioners; practitioners' decisions to use the chemical restraint; care recipient behaviours that are relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary, and information (if any) provided to the medical or nurse practitioner that informed their decision to prescribe the medication, in the care and services plan;
- the approved provider being satisfied that informed consent to the prescribing of the medication has been given by the care recipient, or if the care recipient lacks capacity to give that consent, their restrictive practice substitute decision-maker.

These exclusions are intended to allow approved providers to respond to an emergency situation where a care recipient or other person may be at risk of immediate harm in that moment.

As stated in subsection 15FC(3), this exemption only applies while the emergency exists. The approved provider must document the assessment that the use of the restrictive practice was necessary after the emergency situation has passed. This must be completed as soon as practicable after the restrictive practice starts to be used (see new section 15GB below).

The note following subsection 15FC(3) identifies that section 15GB sets out other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency. The requirements outlined in new section 15GB ensure that approved providers are not absolved from complying with their legislative obligations in relation to the use of restrictive practices, including in an emergency.

The approved provider should be actively engaged in care recipient's behaviour support planning to reduce the risk and occurrence of emergencies use of restrictive practices. Approved providers are to consider escalation points for changed behaviours and how best to manage these behaviours to prevent an emergency in the care planning for care recipients.

<u>New Division 4 – Other responsibilities of approved providers relating to restrictive practices</u>
New Division 4 sets out the other responsibilities of approved providers for the purposes of paragraph 54-1(1)(h) of the Aged Care Act, including the responsibilities that must be met while restrictive practices are being used and the responsibilities that must be met following the emergency use of a restrictive practice.

New section 15G – Purpose of this Division

New section 15G provides that Division 4 specifies other responsibilities of an approved provider that provides aged care of a kind specified in section 15DA of the Quality of Care Principles to a care recipient. New section 15DA provides that the kinds of care that restrictive practice obligations apply to are residential care and flexible care in the form of short-term restorative care provided in a residential care setting.

New section 15GA – Responsibilities while restrictive practice being used

New section 15GA sets out the requirements approved providers must comply with while the restrictive practice is being used in relation to a care recipient.

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:

- the care recipient is monitored for:
    - signs of distress or harm, side effects and adverse events, changes in mood or behaviour, changes in well-being (including the care recipient's ability to engage in activities that enhance the quality of life and are meaningful and pleasurable), changes in the care recipient's ability to maintain independent function, and changes in the care recipient's ability to engage in activities of daily living; and
- the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and
- the effectiveness of the use and the effect of the changes in use of the restrictive practice are monitored; and
- that changes are made to the care recipient's environment to reduce or remove the need for the use of the restrictive practice; and
- if the restraint is a chemical restraint, that 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 (see paragraph 15FC(1)(a)).

This section seeks to provide clarity on how care recipients should be monitored while a restrictive practice is being used, including what matters should be monitored. This ensures changes and modifications to the application of a restrictive practice are responsive and the restrictive practice is applied in the least restrictive form, used for the shortest period of time possible and that the safety of care recipients is maintained while the practice or intervention is in use.

New Section 15GB - Responsibilities following emergency use of restrictive practice

New section 15GB sets out the requirements approved providers must comply with following the use of a restrictive practice if that restrictive practice was used in an emergency.

If an approved provider uses a restrictive practice in relation to a care recipient and the use of the restrictive practice in relation to the care recipient is necessary in an emergency, the approved provider must, as soon as practicable after the restrictive practice starts to be used:

- if the care recipient lacked capacity to consent to the use of the restrictive practice, the approved provider must inform the restrictive practices substitute decision-maker for the restrictive practice about the use of the restrictive practice; and
- ensure that the following matters are documented in the care and services plan for the care recipient:
    - the care recipient's behaviours that were relevant to the need for the use of the restrictive practice;
    - the alternative strategies that were considered or used (if any) before the use of the restrictive practice;
    - the reasons the use of the restrictive practice was necessary;
    - the care to be provided to the care recipient in relation to the care recipient's behaviour;
    - a record of the restrictive practices substitute decision-maker being informed about the use of the restrictive practice (assuming restrictive practices substitute decision-maker for the restrictive practice was informed about the use of the restrictive practice); and
- if the restrictive practice is not a chemical restraint, ensuring the assessments from an approved health practitioner are documented; and
- if the restrictive practice is a chemical restraint, ensuring that the assessments by the medical or nurse practitioners; practitioners' decisions to use the chemical restraint; care recipient behaviours that are relevant to the need for the chemical restraint; the reasons the chemical restraint is necessary, and information (if any) provided to the medical or nurse practitioner that informed their decision to prescribe the medication, are documented in the care and services plan for the care recipient.

If a restrictive practice is used in an emergency, approved providers are expected to review the behaviour that triggered the emergency and document this in the care recipient's care and services plan. From 1 September 2021, providers are required to document the review of the behaviour that triggered the emergency in the care recipient's behaviour support plan (see the amendments introduced by Schedule 2 to the Amending Principles). It is also expected that as part of this review approved providers consider and implement alternative behaviour support strategies to minimise the risk of an emergency reoccurring.

Item 10 - Subsection 15NA(1) (note 2)
Item 10 amends Note 2 to subsection 15NA(1) of the Quality of Care Principles by omitting the term 'physical restraint and chemical restraint' and substituting the words 'a restrictive practice'. This is a consequential amendment to reflect the new term 'restrictive practice' in section 54-9 of the Aged Care Act, and reflect the use of this term in the amendments introduced by the Amending Principles.

Item 11 - Subsection 15NB(2)
Item 11 repeals subsection 15NB(2) of the Quality of Care Principles and substitutes a new subsection 15NB(2). New subsection 15NB(2) provides that, despite paragraph 54-3(2)(g) of the Aged Care Act, the use of a restrictive practice in relation to a residential care recipient is not a reportable incident if:

- the use of the restrictive practice is in a transition care program in a residential care setting; and

- the use is in accordance with Part 4A of these principles (assuming that that Part applied to the residential care recipient in relation to that care).

This subsection states that any restrictive practice used in a transition care program in a residential care setting that is in accordance with Part 4A is not considered a reportable incident under paragraph 54-3(2)(g) of the Aged Care Act through the Serious Incident Response Scheme. Any use of a restrictive practice that is not in accordance with Part 4A is a reportable incident and must be reported to the Aged Care Quality and Safety Commission in accordance with the relevant provisions.

Item 12 - Subparagraph 8(3)(e)(ii) of Schedule 2
Item 12 amends subparagraph 8(3)(e)(ii) of Schedule 2 to the Quality of Care Principles (Standard 8 – Organisational governance, of the Aged Care Quality Standards) to omit the word 'restraint' and substitute the words 'restrictive practices'. This is a consequential amendment to reflect the new term 'restrictive practice' in section 54-9 of the Aged Care Act, and reflect the use of this term in the amendments introduced by the Amending Principles.

Part 2 – Technical Amendments (Staff Members)

User Rights Principles 2014

Item 13 - Section 4 (at the end of the note)
Item 13 amends the note to section 4 of the User Rights Principles, which sets out the defined terms for the purpose of those principles. In particular, the note to section 4 sets out terms that are defined in the Aged Care Act. The note is amended to add '(f) staff member.' The effect of this amendment makes clear that this term is defined in the Aged Care Act, and therefore does not need to be redefined in the User Rights Principles

Item 14 - Paragraph 11(3)(a)
Item 14 amends paragraph 11(3)(a) of the User Rights Principles to omit the words '(as defined in section 63-1AA of the Act)'. Paragraph 11(3)(a) makes reference to the definition of staff member in the Aged Care Act being defined in section 63-1AA. However, the *Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Act 2021* repealed section 63-1AA with effect from 1 April 2021. The definition of staff member is now defined in clause 1 of Schedule 1 to the Aged Care Act. As such, the reference in the User Rights Principles to section 63-1AA is no longer accurate and needed to be removed.

Item 15 - Subparagraphs 17(2)(f)(i) and (ii)
Item 15 amends subparagraphs 17(2)(f)(i) and (ii) of the User Rights Principles to omit the words '(as defined in section 63-1AA of the Act)'. Subparagraphs 17(2)(f)(i) and (ii) make reference to the definition of staff member in the Aged Care Act being defined in section 63-1AA. For the reasons as set out in Item 20 above, the reference in the User Rights Principles to section 63-1AA is no longer accurate and needed to be removed.

Item 16 - Paragraphs 20(3)(a), 23AE(3)(a) and 33(3)(a)
Item 16 amends paragraphs 20(3)(a), 23AE(3)(a) and 33(3)(a) of the User Rights Principles to omit the words '(as defined in section 63-1AA of the Act)'.
Paragraphs 20(3)(a), 23AE(3)(a) and 33(3)(a) make reference to the definition of staff member in the Aged Care Act being defined in section 63-1AA. For the reasons as set out in Item 20 above, the reference in the User Rights Principles to section 63-1AA is no longer accurate and needed to be removed.

Schedule 2 – Amendments commencing 1 September 2021

The amendments introduced by Schedule 2 to the Amending Principles relate to the introduction of a requirement for an approved provider to ensure that a behaviour support plan for a care recipient is included in the care and services plan for care recipients that require behaviour supports.

Items 1 to 8 of Schedule 2 to the Amending Principles amend provisions that are set out in Item 15 of Schedule 1 to the Amending Principles as set out above. As such, the descriptions of Items 1 to 8 assume that those provisions are in effect.

Quality of Care Principles 2014

Item 1 - Paragraph 15FA(1)(c)
Item 1 inserts 'in the behaviour support plan for the care recipient' after the word 'documented' in paragraph 15FA(1)(c) of the Quality of Care Principles.

This insertion clarifies that the details that must be documented by an approved provider in relation to the use of alternative behaviour supports and restrictive practices must be documented in a behaviour support plan after 1 September 2021.

Item 2 - Paragraph 15FA(1)(g)
Item 2 amends paragraph 15FA(1)(g) of the Quality of Care Principles to omit the phrase "relevant provisions of the care and services plan for the care recipient", and substitute "provisions of the behaviour support plan for the care recipient that relate to the use of the restrictive practice". This is to reflect the new requirements for a behaviour support plan introduced by the amendments in Item 9 of Schedule 2 below.

Item 3 - Paragraph 15FB(1)(b)
Item 3 repeals paragraph 15FB(1)(b) and substitutes a new paragraph 15FB(1)(b). Section 15FB relates to the additional requirements for the use of restrictive practices other than chemical restraint. New paragraph 15FB(1)(b) provides that approved providers are required to document the following matters in the behaviour support plan for the care recipient:

- the assessments of an approved health practitioner (see paragraph 15FB(1)(a));
- a description of any engagement with persons other than the approved health practitioner in relation to the assessments;
- a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments.

Item 4 - Paragraph 15FC(1)(b)
Item 4 amends paragraph 15FC(1)(b) of the Quality of Care Principles to omit the phrase "care and services plan", and substitute "behaviour support plan". This is to reflect the new requirements for a behaviour support plan introduced by the amendments in Item 9 of Schedule 2 below.

Item 5 - At the end of paragraph 15FC(1)(b)
Item 5 adds two new subparagraphs at the end of paragraph 15FC(1)(b) of the Quality of Care Principles. Section 15FC relates to the additional requirements for the use of restrictive practices that are chemical restraint. The two new subparagraphs to paragraph 15FC(1)(b) provide that approved providers are also required to document the following matters in the behaviour support plan for the care recipient:

- a description of any engagement with persons other than the practitioner in relation to the use of the chemical restraint;
- a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments.

This addition recognises the importance of multi-disciplinary teams in care planning and assessment of care needs for a care recipient. For example, this may include dementia support specialists available through the Dementia Behaviour Management Advisory Service. These specialists provide support to staff in residential aged care including expertise, advice and short-term case management interventions. They also provide ongoing support and guidance to implement recommendations that are specifically tailored to the individual.

Support is also available through the Severe Behaviour Response Teams, which is a mobile service for people with dementia who are experiencing severe behaviours and psychological symptoms of dementia. This service provides support through advice, strategies and written recommendations tailed specifically to the individual and ongoing support and guidance to implement these recommendations.

Item 6 - Paragraph 15GB(b)
Item 6 amends paragraph 15GB(b) of the Quality of Care Principles to omit the phrase "care and services plan", and substitute "behaviour support plan". This is to reflect the new requirements for a behaviour support plan introduced by the amendments in Item 9 of Schedule 2 below.

Item 7 - Paragraph 15GB(c)
Item 7 inserts 'in the behaviour support plan for the care recipient' after the word 'documented' in paragraph 15GB(c) of the Quality of Care Principles.

This clarifies that the details that must be documented by an approved provider in relation to the use of a restrictive practice that is not chemical restraint in an emergency must be documented in a behaviour support plan after 1 September 2021.

Item 8 - Paragraph 15GB(d)
Item 8 amends paragraph 15GB(d) of the Quality of Care Principles to omit the phrase "care and services plan", and substitute "behaviour support plan". This is to reflect the new requirements for a behaviour support plan introduced by the amendments in Item 9 of Schedule 2 below, and clarifies that the details that must be

documented by an approved provider in relation to the use of a restrictive practice that is chemical restraint in an emergency must be documented in a behaviour support plan after 1 September 2021.

Item 9 - At the end of Part 4A
Item 9 adds new Division 5 - Other responsibilities of approved providers relating to behaviour support plans, at the end of Part 4A of the Quality of Care Principles.

New Division 5 - Other responsibilities of approved providers relating to behaviour support plans
New Division 5 introduces new responsibilities for approved providers in relation to implementing behaviour support plans from 1 September 2021. New Division 5 provides that behaviour support plans must be developed for any care recipient that requires behaviour support.

The new provisions set out in Division 5 detail what the approved provider must include in a behaviour support plan. This is expected to include best practice behaviour support strategies that are responsive to the care recipient's needs that seek to reduce or eliminate the need for the use of restrictive practices. These supports should be individualised and address the underlying causes of concern, while safeguarding the quality of life of care recipients.

Behaviour support plans should be developed in consultation with the care recipient, their nominated representative, any relevant health practitioners, and their restrictive practice substitute decision-maker if the care recipient lacks the capacity to provide informed consent.

Relevant health practitioners may include dementia specialists or health practitioners required to support an assessment for mobility, injury or illness or mental health, alcohol or drug misuse.

New Section 15H - Purpose of this Division
New section 15H provides that Division 5 specifies other responsibilities of an approved provider that provides aged care of a kind specified in section 15DA of the Quality of Care Principles for the purposes of paragraph 54-1(1)(h) of the Aged Care Act. Relevantly, the kinds of aged care set out in section 15DA are approved providers of residential care and flexible care in the form of short-term restorative care provided in a residential care setting.

New Section 15HA - Responsibilities relating to behaviour support plans
New subsection 15HA(1) provides that, if an approved provider provides aged care to a care recipient and behaviour support is needed for the care recipient, the approved provider must ensure that a behaviour support plan is included in the care and services plan for the care recipient. These behaviour supports are expected to be individualised to best address the changed behaviour, and the underlying causes and/or triggers for the behaviour.

Given the number of care recipients with dementia or cognitive decline is increasing, approved providers need to continue to build their behaviour support capability and

ensure they are equipped to manage behaviours of concern that ensures the rights of care recipients and promotes quality of life for care recipients.

New subsection 15HA(2) provides that the approved provider must ensure that the behaviour support plans are prepared, reviewed and revised in accordance with this Division and set out matters as required by this Division and Divisions 3 and 4 of Part 4A of the Quality of Care Principles (see the amendments introduced by Item 15 of Schedule 1 to the Amending Principles).

New subsection 15HA(3) provides that the approved provider must consider any previous assessments of the care recipient that are available to the approved provider when preparing the behaviour support plan. These assessments are not limited to behaviour assessments. They can include any assessment of the care recipient that may provide insight into the causes or triggers of their changed behaviours such as assessments for pain, mobility or illness, injury or trauma.

New Section 15HB - Matters to be set out in behaviour support plans—alternative strategies for addressing behaviours of concern

New section 15HB sets out the information that is required to be documented in a behaviour support plan in relation to alternative strategies for care recipients with behaviours of concern. The behaviour support plan for a care recipient must set out the following:

- information about the care recipient to assist with understanding their behaviour, such as information about the care recipient's past experience and background. Other examples may be information about a care recipient's, habits or routines, likes or dislikes, hobbies, trauma, illness, injury, loss of close friends or family;
- any assessment of the care recipient that is relevant to understanding the behaviour – for example, assessments for pain, mobility, injury or illness, post-surgery, dementia, mental health, alcohol or drug misuse;
- information about the behaviours of concern for which the care recipient may need support – for example, assistance with activities and emotional supports;
- information about each occurrence of behaviours of concern for which the care recipient has needed support, including the date, time and duration of the occurrence, any adverse consequences for the care recipient or other persons, any related incidents, and any warning signs for, or triggers or causes of, the occurrence (including trauma, injury illness or unmet pain needs, boredom or loneliness);
- alternative strategies for addressing the behaviours of concern that are best practice alternatives to the use of restrictive practices in relation to the care recipient, and take into account the care recipient's preferences (including preferences in relation to care delivery) and matters that might be meaningful or of interest to the care recipient, and aim to improve the care recipient's quality of life and engagement;
- any alternative strategies that have been considered for use, or have been used, in relation to the care recipient;
- for any alternative strategy that has been used in relation to the care recipient, the effectiveness of the strategy in addressing the behaviours of concern and records of the monitoring and evaluation of the strategies;

- a description of the consultation that has been undertaken by the approved provider about the use of alternative strategies with the care recipient or the care recipient's representative.

The intention of this provision is to ensure the approved provider takes a more preventative approach in relation to the use of restrictive practices by considering alternative strategies in the first instance, while examining and seeking to understand the cause of the behaviours. The approved provider should consider any past events or experiences that led to behaviours of concern to help prevent future behaviours of concern occurring that may be related to these causes or triggers.
Approved providers are encouraged to engage with care recipients, family, friends, health practitioners, and anyone else that has known the care recipient to understand the individual care recipient's experiences and preferences. This helps to ensure the care recipient can have the best quality of life possible while in residential care and are supported with person-centred strategies that consider their rights and preferences.

New Section 15HC - Matters to be set out in behaviour support plans—if use of restrictive practice assessed as necessary
New section 15HC sets out the information required to be documented in a behaviour support plan if the use of a restrictive practice has been assessed as necessary in accordance with section 15FB or 15FC of the Quality of Care Principles. In these circumstances, the behaviour support plan for a care recipient must set out the following:

- the care recipients behaviours of concerns that are relevant to the need for the use of the restrictive practice;
- what the restrictive practice is and how it is to be used, including its duration, frequency and intended outcome;
- the best practice alternative strategies that must be used before using the restrictive practice;
- how the use of the restrictive practice will be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that may arise from the use of the restrictive practice;
- how the use of the restrictive practice is to be reviewed, including consideration of the following:
    - the outcome of its use and whether the intended outcome was achieved;
    - whether an alternative strategy could be used to address the care recipient's behaviours of concern;
    - whether a less restrictive form of the restrictive practice could be used to address the care recipient's behaviours of concern;
    - whether there is an ongoing need for its use;
    - if the restrictive practice is chemical restraint, whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;
- a description of the approved provider's consultation about the use of the restrictive practice with the care recipient or, if the care recipient lacks capacity to give informed consent to the use of the restrictive practice, their restrictive practice substitute decision-maker;

- a record of the informed consent from the care recipient, or if the care recipient lacks capacity to give that consent, consent from their restrictive practice substitute decision-maker.

This section provides further requirements of approved providers when a restrictive practice is assessed as necessary, noting that the section 15HD outlines the requirements that must be met if a restrictive practice is used. While approved health practitioners (a medical practitioner, nurse practitioner or registered nurse) may assess a restrictive practice as necessary, it is important to note that comprehensive behaviour support planning and management is intended to reduce the use of restrictive practices.
This section also clarifies that the approved provider must document, in the behaviour support plan, how the restrictive practice is to be monitored and reviewed. This ensures the care recipient, their nominated representative, aged care staff and relevant health professionals all understand the conditions of the use of the restrictive practice.

If a behaviour support plan includes a restrictive practice that has been assessed as necessary, any use of a restrictive practice must be reviewed regularly or as soon as practicable after any change in the care recipient's circumstances (see new section 15HF). This includes any circumstance where a restrictive practice is used in an emergency. Any changes in behaviour should mean that the use of the restrictive practice should be reconsidered and reduced or stopped as soon as practicably possible.

The note following new section 15HC clarifies that assessments mentioned in sections 15FB and 15FC of the Quality of Care Principles must also be documented in the behaviour support plan.

New Section 15HD - Matters to be set out in behaviour support plans—if restrictive practice used
New section 15HD sets out the information that is required to be included in a behaviour support plan if a restrictive practice has been used in relation to a care recipient. The behaviour support plan for the care recipient must set out the following:

- the restrictive practice being used and how it was used, including when it began to be used, the duration of each use, the frequency of its use, the outcome of its use and whether the intended outcome was achieved;
- if, under the plan, the restrictive practice is to be used only on an as-needed basis in response to particular behaviour, or in particular circumstances: the care recipient's behaviours of concern that led to the use of the restrictive practice and the actions (if any) taken leading up to the use of the restrictive practice, including any alternative strategies that were used before the restrictive practice was used;
- details of the persons involved in the use of the restrictive practice;
- a description of any engagement with external support services in relation to the use of the restrictive practice;
- details of the monitoring of the use of the restrictive practice as required by the plan;
- the outcome of the review of the use of the restrictive practice as required by the plan.

Note 1 to section 15HD directs the reader, in relation to paragraphs 15HD(e) and (f), to paragraphs 15HC(d) and (e) as those provisions set out the requirements for a behaviour support plan for a care recipient to require monitoring and review of the use of a restrictive practice in relation to the care recipient.

Note 2 to section 15HD provides that if the use of a restrictive practice in relation to a care recipient is necessary in an emergency, other matters in section 15GB must also be documented in the behaviour support plan for the care recipient.

The use of a restrictive practice must be continually monitored, reviewed and documented. If there is a change to a care recipient's circumstances or behaviour, a review should be completed to understand what has changed and whether the existing strategies remain best practice for the care recipient. This includes any circumstance where a restrictive practice is used in an emergency.

If these strategies are no longer effective, new strategies need to be considered and trialled, noting that care needs change over time and can be affected by other factors in the residential care setting.

Approved providers must seek to ensure the least restrictive form of a restrictive practice is being applied and that it is used for the shortest time possible. Approved providers must also continually seek to consider whether an alternative strategy can be used and whether the restrictive practice can be reduced or stopped. These requirements are intended to ensure the use of restrictive practices are reduced and the inappropriate use of restrictive practices are eliminated.

New Section 15HE - Matters to be set out in behaviour support plans—if need for ongoing use of restrictive practice indicated

New section 15HE sets out the information that is required to be included in a behaviour support plan if a review of the use of a restrictive practice has indicated the need for the ongoing use of the restrictive practice. In these circumstances, the behaviour support plan for the care recipient must set out the following:

- the restrictive practice and how it was used, including its duration, frequency and intended outcome;
- how the ongoing use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;
- how the ongoing use of the restrictive practice is to be reviewed, including consideration of the following:
    - the outcome of the ongoing use of the restrictive practice and whether the intended outcome is being achieved;
    - whether an alternative strategy could be used to address the care recipient's behaviours of concern;
    - whether a less restrictive form of the restrictive practice could be used to address the care recipient's behaviours of concern;
    - whether there continues to be need for the ongoing use of the restrictive practice;

    - if the restrictive practice is chemical restraint, whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;
- a description of the consultation about the ongoing use of the restrictive practice with the care recipient or, if the care recipient lacks the capacity to give informed consent to the ongoing use of the restrictive practice, the restrictive practices substitute decision-maker;
- a record of informed consent from the care recipient or, if the care recipient lacks capacity to give that consent, consent from their restrictive practice substitute decision-maker.

If the ongoing use of a restrictive practice is assessed as necessary, informed consent for the ongoing use of the practice is required. Perpetual or ongoing approval cannot be given to the use of a restrictive practice. The care recipient or their restrictive practice substitute decision maker may withdraw their consent at any time. Therefore, the approved provider should take steps to regularly communicate with the care recipient or their restrictive practices substitute decision-maker, and obtain informed consent contemporaneously.

Approved providers are required to regularly monitor and review the use of a restrictive practice approved on an ongoing basis and should continually explore alternative strategies to manage behaviours of concern.

Additionally, any use of a restrictive practice on an ongoing basis must be applied in the least restrictive form possible to prevent harm to the care recipient or other persons and must consider the impact of the use of the restrictive practice on the care recipient.

New Section 15HF - Reviewing and revising behaviour support plans

New section 15HF sets out that an approved provider must review a behaviour support plan for a care recipient and make any necessary revisions:

- on a regular basis; and
- as soon as practicable after any change in the care recipient's circumstances.

The care needs of older people in residential aged care are dynamic and may change rapidly. Changes in the care needs of older people require timely and responsive review by medical practitioners, nurse practitioners and registered nurses with day-to-day knowledge of the care recipient.

Any behaviours of concern, including where this occurs in an emergency, must be reviewed. Additionally, if a behaviour support plan includes a restrictive practice that has been assessed as necessary, the behaviour support plan must be regularly reviewed to determine if the restrictive practice can be reduced or stopped. If a chemical restraint is used, a medication review is also recommended to ensure that any medication is regularly reviewed and updated to ensure medication that is no longer required or can be reduced or stopped.

Arrangements under the National Disability Insurance Scheme require any behaviour support plan that includes a restrictive practice to be reviewed every 12 months or earlier if the participant's circumstances change.

It is expected that a care recipient will need their behaviour support plan to be reviewed significantly more frequently than every 12 months. This is due to the dynamic nature of care needs of older people. Conversely, the care needs of people with a disability are generally more stable.

In the event a care recipient's behaviour support needs are stable and do not change over a 12-month period, a review must be completed within the 12 months. However, it is not expected that an aged care recipient with a behaviour support plan in place would not have any changes in their behaviour or care needs in a 12-month period. It is expected that care needs of an older person in residential aged care would change more frequently and would therefore require more frequent review and amendment of their behaviour support plans.

New Section 15HG - Consulting on behaviour support plans

New subsection 15HG(1) that in preparing, reviewing or revising a behaviour support plan for a care recipient, an approved provider must consult the following:

- the care recipient and any other person nominated by the care recipient (unless the care recipient lacks the capacity to be consulted);
- if the care recipient lacks capacity to be consulted, a person or body able to make decisions about the care of the care recipient under the law of the State or Territory in which the care recipient is provided with aged care;
- any health practitioners with expertise relevant to the care recipient's behaviours of concern.

New subsection 15HG(2) provides that if the use of a restrictive practice in relation to the care recipient is assessed as necessary as mentioned in section 15FB or 15FC of the Quality of Care Principles, the approved provider must also consult the following in preparing, reviewing or revising the behaviour support plan:

- the approved health practitioner (medical practitioner, nurse practitioner or registered nurse) that made that assessment;
- if the care recipient lacks capacity to be consulted, their restrictive practice substitute decision-maker for the restrictive practice.

New subsection 15HG(3) provides that, if consulting under this section, the approved provider must provide the behaviour support plan or revised behaviour support plan, and any associated information, to those persons that are being consulted to support and facilitate the consultation process. The behaviour support plan and any associated materials must be provided in an appropriately accessible format to the persons that are being consulted.

This ensures the delivery of person-centred care and the inclusion of the care recipient in the care planning and decision making process. During this process, the care recipient should be supported or assisted to make their own decisions. This includes communicating with them in a way they can understand and they should be given the opportunity to discuss their concerns and expectations.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021

This legislative instrument is compatible with human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*

Overview of instrument

The purpose of the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021* (Amending Principles) is to amend the Quality of Care Principles 2014 (Quality of Care Principles). The Amending Principles also make consequential amendments to the *User Rights Principles 2014* (User Rights Principles) and repeal the *Committee Principles 2014* (Committee Principles).

These amendments are in response to the recommendations of the Royal Commission into Aged Care Quality and Safety (Royal Commission), and the Independent Review of the Legislation Provisions Governing the use of Restraint in Residential Aged Care (Restraint Review). These amendments deliver the first stage of aged care reform developed in response to the Royal Commission's Final Report.

Both the Royal Commission and the Restraint Review recommended that the legislation be strengthened and that approved providers' responsibilities on the use of restrictive practices be clarified.

The Amending Principles strengthen and clarify the responsibilities on approved providers who deliver residential aged care and short-term restorative care in a residential setting, by including enhanced safeguards and conditions on the use of restrictive practices. The Amending Principles outlined the requirements approved providers are to comply with prior to, during, and after the use of restrictive practices.

Human rights implications

The instrument engages the following human rights:

- the right to not be subjected to torture or to cruel, inhuman or degrading treatment or punishment - Article 7 of the *International Covenant on Civil and Political Rights* (ICCPR), Articles 1 and 2 of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

(CAT), and Article 15 of the *Convention on the Rights of Persons with Disabilities* (CRPD)

- the right to liberty and security of person - Article 9 of the ICCPR and Article 14 of the CRPD
- the right to an adequate standard of living – Article 11(1) of the *International Covenant on Economic Social and Cultural Rights* (ICESCR) and Article 28 of the CRPD
- the right to protection from exploitation, violence and abuse –Article 16 CRPD
- the right to health – Article 12 of the IESCR and Article 25 of the CRPD
- the right to privacy – Article 17 of the ICCPR.

Right not to be subjected to cruel, inhuman or degrading treatment

This Amending Principles engage the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment found in Article 7 of the (ICCPR) and Article 15 of the (CRPD) by imposing responsibilities in relation to the use of restrictive practices. These obligations ensure that appropriate consideration is given by approved providers to the personal rights and liberties of care recipients prior to administering restrictive practices, and will act to prevent inhuman treatment and aim to positively engage the care recipient in the process.

Specifically, the Amending Principles ensure approved providers understand and use restrictive practices only:

- the restrictive practice is used only as a last resort to prevent harm to the care recipient or other persons
- the restrictive practice is used only after consideration of the likely impact of the use of the restrictive practice on a care recipient
- to the extent possible, best practice alternative strategies have been used before the restrictive practice is used
- the alternative strategies that have been considered or used have been documented
- 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;
- 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;
- informed consent to the use of the restrictive practice has been given by the care recipient or if the care recipient lacks capacity their restrictive practice substitute decision maker
- the use of the restrictive practice complies with any relevant provisions of the care and services plan for the care recipient;
- the use of the restrictive practice complies with the Aged Care Quality Standards
- the use of the restrictive practice is not inconsistent with the Charter of Aged Care Rights
- 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.

These requirements will ensure that restrictive practices are only used as a necessary and proportionate response to the circumstances and ensures the rights of care recipients are given primary consideration and protection.

Right to liberty and security of person

Article 9 of the ICCPR and Article 14 of the CRPD provide for the right to personal liberty, which requires that an individual not be subject to arrest and detention, except as provided for by law, and provided that the law itself and the manner of its execution are not arbitrary. The Amending Principles supports the right to liberty through providing for adequate safeguards to be put in place to ensure that the use of restrictive practices is not exercised in an arbitrary manner.

In alignment with section 6 of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, the Amending Principles define restrictive practices as seclusion, chemical restraint, mechanical restraint, physical restraint, and environmental restraint. Clarity of the definitions of each of the five types of restrictive practice will prevent arbitrary use and ensure care recipients' rights and liberties are at the forefront of the decision making process.

Right to an adequate standard of living

The Amending Principles engage the right to an adequate standard of living under Article 11(1) of ICESCR and Article 28 of the CRPD. The Amending Principles strengthens the regulation of restrictive practices and promotes the right to an adequate standard of living by taking steps to reduce the instance of inappropriate use of restrictive practices occurring in aged care.

As recommended by the Royal Commission, civil penalties will be applied for approved providers who fail to comply with a written notice produced by the Aged Care Quality and Safety Commissioner (Commissioner) in relation to their restrictive practice obligations as specified in these Amending Principles. This will ensure that compliance action can be taken against approved providers who unlawfully use restrictive practices, thereby adding an additional layer to the protections for aged care recipients and providing improvement of living conditions, where applicable.

Protection from exploitation, violence and abuse

The Amending Principles ensure appropriate measures are implemented to prevent the exploitation and abuse of aged care recipients, in line with Article 16 of the CRPD. The Amending Principles promote this right by ensuring procedures in place require the effective monitoring of the safety and wellbeing of care recipients, and emphasising restrictive practices are to be a last resort, with appropriate consideration given to the likely impact of the restrictive practice on the care recipient.

Additionally, the Amending Principles acknowledge there may be limited situations where it is appropriate to use restrictive practices to ensure the safety of the care recipient and others in the workplace, such as staff and volunteers, or the safety of other aged care recipients. Where restrictive practices are used, approved providers must ensure they only use them as a last resort and only following the employment of alternative behaviour supports, unless the use of a restrictive practice is necessary in an emergency.

In the event a restrictive practice is assessed as necessary in an emergency, the approved provider must monitor and review the necessity for the continued use of the restrictive practice. If a restrictive practice is required to be continued after an

emergency situation has passed, approved providers will be required to comply with all legislative requirements relating to the use of restrictive practices, including obtaining informed consent for ongoing use of a restrictive practice.

It is expected that approved providers will be actively engaged in care recipient's behaviour support planning and that this will reduce any occurrence of emergencies. This should include consideration of any escalation points for any changed behaviours and how best to manage behaviours to prevent an emergency in the care planning for care recipients.

Right to health

The Amending Principles also engage the right to health under Article 12 of the ICESCR and Article 25 of the CRPD. These articles refer to the right of individuals to the highest attainable standard of physical and mental health. The Amending Principles promotes the right to health by providing greater protections to the physical and mental health of individuals receiving aged care of kind specified in the Quality of Care Principles. It does this by providing for strengthened regulation of restrictive practices in accordance with the Quality of Care Principles, and by specifying the practice must only be used as a last resort, except in the case of an emergency.

Right to privacy

The protection against arbitrary or unlawful interference with privacy is contained in Article 17 of the ICCPR. Article 17 provides that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation, and that everyone has the right to the protection of the law against such interference or attacks.

Although the United Nations Human Rights Committee has not defined 'privacy', it should be understood to comprise freedom from unwarranted and unreasonable intrusions into activities that society recognises as falling within the sphere of individual autonomy.

The right to privacy under Article 17 can be permissibly limited in order to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term 'unlawful' in Article 17 of the ICCPR means that no interference can take place except as authorised under domestic law. Additionally, the term 'arbitrary' in Article 17(1) of the ICCPR means that any interference with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances. The Committee has interpreted 'reasonableness' to mean that any limitation must be proportionate and necessary in the circumstances.

The requirements under the Amending Principles require approved providers of residential aged care and short-term restorative care delivered in a residential setting to document information about care recipients including behaviours of concern and the use of behaviour supports and restrictive practices. If a restrictive practice has been applied in a circumstance that is inconsistent with the Amending Principles they will be required to report information about that event to the Aged Care Quality and Safety Commissioner (Commissioner) as per the reportable incident obligations as stated in the Aged Care Act. The Commissioner may review and store information

they are notified of and may also access information collected by approved providers for the purpose of their compliance and monitoring functions. Article 17 of the ICCPR states that no person should be subject to interference with their privacy.

To the extent that handling of personal information under the Amending Principles may limit this right, existing arrangements protect this right by ensuring personal information acquired is protected. Personal information is subject to the protection of information provisions in Part 6.2 of the Aged Care Act, and the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act. The existing penalties for misuse of protected information will protect and ensure the safe handling of the personal information that is collected. Approved providers also have a responsibility to protect a care recipient's personal information under section 62-1 of the Aged Care Act.

The measure contains protections to ensure personal information is being collected in an appropriate and non-invasive manner to achieve the legitimate aims and objectives of reporting on the use of a restrictive practice that is inconsistent with the Amending Principles. The collection and use of personal information under the Amending Principles is reasonable, necessary and proportionate.

The personal information collected under these Amending Principles is to be used by approved providers to identify where restrictive practices are inconsistently applied. This in turn further promotes the right to health, the right not to be subjected to cruel, inhuman or degrading treatment, and the right to protection from exploitation, violence and abuse by reducing in instance of abuse and neglect of vulnerable older Australians. The Commissioner will also use the information received though notifications, complaints, reports of serious incidents, investigations and monitoring to intervene in circumstances to protect individuals from the misuse of restrictive practices.

Conclusion
The Amending Principles are consistent with human rights as they advance protections for older Australians and strengthen the protection of care recipients by implementing measures to ensure greater protections from exploitation, violence, abuse and cruel, inhuman or degrading treatment.

The Amending Principles also engage rights to privacy for the legitimate objective of providing advice that will assist in the provision of quality aged care services, and is reasonable, necessary and proportionate in the particular circumstances to achieving that objective.

Senator the Hon Richard Colbeck
Minister for Senior Australians and Aged Care Services

ADVICE TO THE SENATE STANDING COMMITTEE FOR THE SCRUTINY OF DELEGATED LEGISLATION – AGED CARE LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE NO. 1) PRINCIPLES 2021 [F2021L00222]

Specific training and experience delegates of the Commissioner are required to possess in exercising relevant powers and functions to determine whether an emergency occurred, and to otherwise review and monitor providers' compliance with the emergency use of restrictive practices

The current and preceding legislative requirements around the use of restrictive practices contained both the concept of an emergency, and the mechanism for some provider responsibilities to be deferred for a limited period when an emergency occurs. Critical to the definition of an emergency are the criteria: unforeseen, sudden, and urgent.

When the Aged Care Quality and Safety Commission (Commission) is considering matters relating to the use of restrictive practices in what a provider has defined as an emergency, officers would have regard to whether these criteria were present. As with the majority of the Commission's work, officers need to overlay an understanding of the legislation with contextual information about a specific occurrence or system of practice in a service.

If officers have a concern that a provider was using the emergency provisions inappropriately, they would have regard to the context, the provider's posture and the real or likely impact of the non-compliance on care recipients to guide their response and the further action they might take. Should the provider be found to be non-compliant with their responsibilities, including those relating to the use of restrictive practices, the Commission may take further enforceable regulatory action. The Commission's Regulatory Strategy and Compliance and Enforcement Policy (available on the Commission's website at: www.agedcarequality.gov.au/sites/default/files/media/regulatory_strategy_jan_1_2020_v2.1.pdf and www.agedcarequality.gov.au/sites/default/files/media/compliance-and-enforcement-policy-14-july-2021.pdf respectively) address this process.

The Commission specifically recruits and then develops officers to have a range of critical skills, including a sound knowledge of the aged care system and the varied needs of aged care consumers, skills to interpret clinical and care related information, and the ability to understand and interpret legislative requirements. The Commission does this through its recruitment practices, induction and ongoing training programs, on-the-job training through engagement with supervisors and peers, and extensive policy and procedural guidance. Successful completion of the Commission's mandatory Quality Assessor Training Program is a requirement for registration as a quality assessor. The program is designed to provide trainee assessors with the underpinning knowledge, skills and practical workplace competency to undertake assessments against the Aged Care Quality Standards. Ongoing employment as a quality assessor is subject to completion of mandatory training, a minimum of 15 hours annual continuous professional development, and satisfactory work performance.

Commission staff have access to, and are encouraged to use, clinical, legal and decision-support advice to support sound and consistent practice and decision making. The Chief Clinical Advisor also regularly provides delegated decision makers and other officers with training and advice to support their exercise of this regulatory oversight. The onboarding of the Senior Practitioner, Restrictive Practices, will further enhance this oversight, providing additional support, training and advice to Commission decision makers and officers, and externally to the sector.

The Commission will continue to monitor providers' use of restrictive practices through complaints handling processes, responding to notifications made under the Serious Incident Response Scheme, and as part of quality assessment and monitoring activities including accreditation site audits. Where there is evidence that insufficient action has been taken by a provider to avoid emergency use of restrictive practices for a care recipient, the Commission may take further regulatory action where it is deemed appropriate and proportionate to risk, to require the provider to address any non-compliance.

Further regulatory action may include (inter alia) issuing a Compliance Notice specifically connected to a failure to meet the restrictive practices requirements in the Quality of Care Principles 2014. A Compliance Notice allows the Commission to require a provider to take a certain action or refrain from taking certain actions. This is of particular relevance where the Commission is concerned that a provider has inappropriately relied on the emergency provisions outlined in section 15FA of the Quality of Care Principles 2014 and has not met all the pre-conditions before using restrictive practices.

Following from this, if an approved provider fails to comply with a Compliance Notice, there are multiple possible responses which the Commission would consider based on all available evidence, including imposing a sanction, issuing an infringement notice, or seeking a civil penalty from a court. Commission delegates are supported to make these decisions with internal instructional material.

THE HON JOSH FRYDENBERG MP
TREASURER

Ref: MS21-002372

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2913

Dear Senator Fierravanti-Wells

Thank you for your correspondence of 30 September 2021, on behalf of the Senate Standing Committee for the Scrutiny of Delegated Legislation (the Committee) regarding the *Financial Sector Reform (Hayne Royal Commission Response) (Hawking of Financial Products) Regulations 2021* (the Regulations).

The Committee has sought my advice as to:

- why it is considered necessary and appropriate to use delegated legislation, rather than primary legislation, to introduce these measures;
- whether the *Corporations Regulations 2001* can be amended to provide that the exceptions set out in the instrument cease to operate three years after they commence; and
- whether there is any intention to conduct a review of the relevant provisions to determine if they remain necessary and appropriate, including whether it is appropriate to include the provisions in delegated legislation.

Use of delegated legislation

The Regulations set out a number of exemptions from the prohibition on hawking of financial products in section 992A of the *Corporations Act 2001*. These exemptions apply to types of financial products which already have robust rules and requirements which apply when making offers to sell or issue those products to consumers or where the consumer is expected to have a better understanding of the products and has an increased ability to assess the suitability of the product at the time the offer to sell or issue the product is made.

Each of the exemptions in the Regulations apply in relation to the offer to issue or sell specific financial products and do not apply to persons who are making the offer to issue or sell financial

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products at large. Due to the specific nature of these exemptions, and the fact that they do not apply to all persons who are offering to sell or issue financial products, it is necessary and appropriate for them to be contained in delegated legislation. I note that the exemptions which have broader application across financial products, such as the exemption for persons providing financial advice, are contained in the primary law.

Cessation of provisions after 3 years

The Committee have also requested my advice in relation to whether the *Corporations Regulations 2001* can be amended to provide that the exemptions will cease to operate three years after they commence. In my view it would not be appropriate for the provisions to cease to have effect after three years, as they are made under a specifically delegated power rather than a general exemption or modification power. If they ceased to operate, the hawking prohibitions would no longer give effect to the policy intent, that is the hawking prohibitions would no longer apply only in situations where there is a risk of consumer harm.

Additionally, if the provisions were to cease after three years this would create considerable uncertainty for businesses that are relying on the exemptions. The cessation of the exemptions could give rise to significant commercial risks and increase compliance costs for affected businesses, which may need to make significant changes to their internal compliance processes and IT systems to ensure that they were meeting the additional requirements in the primary law.

Review of the provisions

The Committee has also asked for my advice as to whether there is an intention to conduct a review of the provisions, including a review as to whether it is appropriate to include the exemptions in delegated legislation. As you may be aware the Australian Law Reform Commission (ALRC) has undertaken to conduct a review of, and produce a report on, the potential reframing and restructuring of Chapter 7 of the *Corporations Act 2001*. I expect that the framing and structure of these provisions, including whether it is appropriate for these provisions to be included in delegated legislation, will be considered as part of this process. The ALRC is scheduled to release its interim report on Chapter 7 by 25 August 2023, with the final report due by 30 November 2023.

Thank you for bringing the Committee's concerns to my attention. I trust that this information will be of assistance to the Committee

Yours sincerely

THE HON JOSH FRYDENBERG MP

22 / 6 /2021

THE HON SUSSAN LEY MP
MINISTER FOR THE ENVIRONMENT
MEMBER FOR FARRER

MC21-085657

12 OCT 2021

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

Dear Chair Dear Connie

Thank you for your letter of 30 September 2021 concerning (Senate Standing Committee for the Scrutiny of Delegated Legislation, Senator Fierravanti-Wells) - Great Barrier Reef Marine Park Amendment (No-Anchoring Areas) Regulations 2021 (Amending Regulations).

I note the Committee's concern, in particular, about 'no-anchoring areas' under the Great Barrier Reef Marine Park Regulations 2019 (Principal Regulations) being declared by notifiable instrument, rather than by legislative instrument.

These notifiable instruments are being brought forward by the Australian Government following regulations that were made in February 2019 to deliver:

- better environmental management;
- more sensitive and appropriate approaches to applying penalties in the Marine Park such as penalty infringement notices; and
- an overall lower cost burden for both the Government and Great Barrier Reef Marine Park (Marine Park) users.

Decisions to declare no-anchoring areas under the Principal Regulations are made by the Great Barrier Reef Marine Park Authority (Authority). As your letter mentions, the position of the Authority is that these decisions are appropriately made by notifiable instrument because they are administrative in character, and not legislative. While I acknowledge that the Committee appears to have taken a different view, the Authority's position reflects my own.

No anchoring areas have been declared only where it is considered necessary for the protection of sensitive habitats such as coral communities from anchor damage. Declaring this via a notifiable instrument facilitates appropriate regulation of activities in the Marine Park. The inclusion of maps in these notifiable instruments better support Marine Park users in understanding their location when on the water.

I would also point out that the mechanism of no-anchoring areas being declared by notifiable instrument was present in the Principal Regulations before the Amending Regulations were made. Moreover, anchoring in a no-anchoring area was already a strict liability offence by operation of s 234 of the Principal Regulations in combination with the Plans of Management for the Cairns, Hinchinbrook and Whitsunday Planning Areas. The Amending Regulations have simply improved the existing mechanism by enabling:

- no-anchoring areas to be declared in other parts of the Great Barrier Reef Marine Park; and
- all of the no-anchoring areas to be included in a single instrument (see the Great Barrier Reef Marine Park (Declaration of No-Anchoring Areas – Townsville/Whitsunday Management Area) Notifiable Instrument 2021).

If the Amending Regulations were disallowed this would not have the effect of requiring no-anchoring areas in the future to be declared by legislative instrument. Instead, the mechanism of no-anchoring areas being declared by notifiable instrument would remain, but without the improvements introduced by the Amending Regulations.

I respect greatly the views and expertise of the Senate Standing Committee for the Scrutiny of Delegated Legislation, however I do note that the better opportunity to debate the spectrum of legal instruments and their application would have been in 2019 when the Principal Regulations were made. To deny these particular administrative instruments from proceeding would also deny the Government's aspirations to lessen regulatory burden and deliver a better suite of regulatory experiences for the Australian community.

I would be happy to arrange a more detailed background discussion for you through the Authority. This may provide greater clarity on the positive intentions and administrative appropriateness of these instruments.

Thank you for bringing your concerns to my attention.

Yours sincerely

SUSSAN LEY

THE HON ANGUS TAYLOR MP
MINISTER FOR INDUSTRY, ENERGY AND EMISSIONS REDUCTION

MC21-007052

Senator the Hon Concetta Fierravanti-Wells
Chair, Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

Dear Senator Connie

Thank you for your letter of 30 September 2021 regarding five instruments made under section 33 of the *Industry Research and Development Act 1986* (the Act). I appreciate the time you have taken to bring this matter to my attention.

The instruments you referred to in your letter are:

- Industry Research and Development (Boosting Australia's Diesel Fuel Storage Program) Instrument 2021 (F2021L00610);
- Industry Research and Development (Growing Australia's Cyber Skills Program) Instrument 2021 (F2021L00536);
- Industry Research and Development (Modern Manufacturing Initiative Program) Instrument 2021 (F2021L00539);
- Industry Research and Development (Carbon Capture, Use and Storage Program) Instrument 2021 (F2021L00547); and
- Industry Research and Development (Beetaloo Cooperative Drilling Program) Instrument 2021 (F2021L00567).

Your letter of 30 September responded to a letter dated 26 August 2021 from the former Minister for Industry, Science and Technology, the Hon Christian Porter MP. The former Minister's letter was written in response to your earlier letter of 4 August 2021.

I welcome the committee's proactive and constructive engagement with my Department on these instruments. I recognise the important role the committee plays in scrutinising instruments and their supporting explanatory statements to ensure that the Parliament is properly informed about the instruments that come before it. I agree entirely that those documents need to provide sufficient information for parliamentarians to decide whether or not to support the instruments.

In this instance, I share the former minister's view that the legislative instruments and explanatory statements as currently drafted strike a suitable balance between discharging relevant requirements in an economical and flexible way, while also providing suitable transparency and parliamentary oversight of Government programs and spending activities. I note also that the programs are subject to further parliamentary oversight through the Budget and Estimates processes and through parliamentary questions, and will continue to be so.

Specification of eligibility criteria

Your letters of 4 August and 30 September asked whether details of eligibility criteria should be included in explanatory statements, as opposed to being set out in grant guidelines.

The legislative instruments and their explanatory statements in their current form do address fundamental eligibility criteria where they are relevant, for example:

- The Industry Research and Development (Boosting Australia's Diesel Fuel Storage Program) Instrument 2021 states that the eligibility criteria for the program include that the applicants must be trading or financial corporations formed within the Commonwealth.
- The Industry Research and Development (Carbon Capture Use and Storage Program) Instrument 2021 provides that the eligibility criteria include that the applicant is a constitutional corporation, State or Territory agency, authority or instrumentality of a State or Territory, or an authority of the Commonwealth.
- The Explanatory Statement to the Industry Research and Development (Modern Manufacturing Initiative Program) Instrument 2021 sets out that constitutional corporations will be eligible for funding, and that eligibility is limited to projects that show potential to expand or promote interstate or international trade.
- The Explanatory Statement to the Industry Research and Development (Beetaloo Cooperative Drilling Program) Instrument 2021 sets out that the funding is intended to support activities in the Beetaloo sub-basin, which is wholly located in the Northern Territory. The Grant Opportunity Guidelines for the Program include that the project must be delivered in the Beetaloo sub-basin.
- The Industry Research and Development (Growing Australia's Cyber Skills Program) Instrument 2021 states that the purpose of the program is to establish the Cyber Security Skills Partnership Innovation Fund and to fund programs run by Questacon for the benefit of students. The Explanatory Statement provides detail of the Fund and examples of activities that may be eligible for funding.

To further assist the Committee's understanding of the five instruments under consideration and why including further detail would not be suitable, I attach the current publicly available guidelines for these programs. The guidelines are quite detailed in relation to eligibility, expanding on the base criteria in the instrument and providing additional operational detail. For example, guidelines provide criteria for assessing whether or not an applicant is a trading corporation, and set out further detail of eligible activities to ensure that they fall within the scope and purpose of each program.

Providing substantial further information in the instruments and explanatory statements about eligibility criteria that are not relevant to legislative authority would not sit well with the primary purpose of section 33 of the Act, which is to establish a simple and efficient mechanism to provide that authority. Requiring this would often be inconsistent with the underlying intent of the provisions, and would create additional administrative burden because it would require information available in guidelines to be duplicated in explanatory statements. Duplication of this nature may detract from the agility and responsiveness that is intended to be achieved by prescribing programs under section 33 of the Act.

Further, addressing eligibility criteria comprehensively in explanatory statements would, in many cases, cause confusion for program participants in the event that criteria change. It is preferable for the published program guidelines to act as the comprehensive and up-to-date source of information for applicants and the wider public.

I recognise, however, the Committee's desire to ensure that instruments and explanatory statements contain sufficient information to provide for effective scrutiny as best practice, and I will continue to bear this in mind in the development of any future instruments made under the Act and the publication of supporting information to explain the programs that they prescribe.

Scope of the Modern Manufacturing Initiative

In your letter of 30 September you also requested that further details as to the scope of the Modern Manufacturing Initiative Program be set out in the Industry Research and Development (Modern Manufacturing Initiative Program) Instrument 2021.

I recognise that this is a significant program and that it is important that the Parliament has sufficient information before it when the instrument to authorise the program expenditure is tabled. I agree that parliamentary oversight is particularly important in relation to programs that involve significant expenditure. However, the detail in the instrument is based on what is necessary to provide clearly delineated authority for program expenditure. I consider that the instrument and explanatory statement in this case provides a substantial explanation of the purpose of the program and that this should be sufficient for the Parliament to determine whether or not to permit the authorisation of the expenditure.

The instrument provides significant detail about the types of projects that would be supported by the three streams of the program:

- The Collaboration Stream supports large projects that bring together businesses, researchers and investors to build economies of scale and allow businesses to better compete in international markets.
- The Translation Stream supports projects aimed at translating research into commercial solutions.
- The Integration Stream supports projects that target the integration of Australian businesses into domestic and global value chains.
- All three streams have the purposes set out in the instrument of addressing barriers to scale and competitiveness for Australian manufacturing, and building manufacturing capabilities and networks, lift productivity, create jobs and boost the export potential and global competitiveness of Australian businesses.

The explanatory statement to the instrument provides further detail of the policy objectives of each of these streams.

I consider the level of detail in the instrument and accompanying explanatory statement to be suitable to meet the requirement of the Act, to inform Parliament about the purpose of the spending and to support parliamentary oversight of the program. In this instance, I would note that the instrument does not establish significant elements of a regulatory scheme, impose taxes or levies, contain penalties, modify primary legislation, or substantially impact on personal

rights or liberties, as outlined in the Committee's official guidance on the application of Scrutiny Principle (j).

I thank the Committee for their engagement to date and would welcome further consultation should the Committee have further questions on these instruments.

I trust this is of assistance.

Yours sincerely

ANGUS TAYLOR

Enc
CC: The Hon Melissa Price MP, Minister for Science and Technology
The Hon Keith Pitt MP, Minister Water and Resources

Senator the Hon Michaelia Cash
Attorney-General
Minister for Industrial Relations
Deputy Leader of the Government in the Senate

Reference: MC21-045260

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

By email: sdlc.sen@aph.gov.au

Dear Senator Concetta

Thank you for your letter of 30 September 2021 regarding the Senate Standing Committee for the Scrutiny of Delegated Legislation's consideration of the *Civil Dispute Resolution Regulations 2021* (the Regulations). Set out below is my advice on each of the issues raised by the Committee.

Why it is considered necessary and appropriate to use delegated legislation, rather than primary legislation, to prescribe proceedings which are excluded from the requirements of the *Civil Dispute Resolution Act 2011*

The *Civil Dispute Resolution Act 2011* (the Act) requires that, as far as possible, parties take 'genuine steps' to resolve a civil dispute before proceedings are commenced in the Federal Court of Australia or the Federal Circuit and Family Court of Australia.

Where a regulation is made under section 17 of the Act, the proceedings listed in the regulation are exempted from the requirements in the Act. This regulation making power is a necessary and appropriate use of delegated legislation as it ensures that the requirement to undertake dispute resolution prior to civil proceedings applies only in appropriate circumstances. Not all legal proceedings otherwise captured by the Act lend themselves to dispute resolution, and sections 15 and 16 of the Act have been drafted to expressly exclude a range of proceedings from its application.

The regulation making power was included in the Act because, at the timing of drafting, it was not possible to anticipate all of the circumstances in which the Act may not be applicable.

If a proceeding is identified as not being one that should be subject to the dispute resolution requirements in the Act, a regulation can be made that responds quickly to this need for exclusion. This means that the Act can operate flexibly, which was clearly Parliament's intention when it was enacted in 2011.

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When a regulation is being developed, it will go through a consultation process. Since regulations are tabled in Parliament and are subject to disallowance processes, they are still subject to necessary parliamentary scrutiny. To date, there have been a small number of proceedings listed in regulations made under section 17 of the Act. This suggests that the overarching intention of the Act, to encourage the use of dispute resolution before civil proceedings, is being achieved and that the regulation making power in section 17 of the Act is not undermining the Act's operation.

Whether the instrument can be amended to provide that the measures cease within three years after commencement

To address the Committee's concerns, I will make an amending regulation which will re-set the sunset date to allow for a three (3) year sunsetting period from the date of commencement. I propose the Regulations will be amended by 31 December 2021. This will allow time for the Office of Parliamentary Council to draft and for the Federal Executive Council to consider the amending regulation.

Whether there is any intention to conduct a review of the relevant provisions to determine if they remain necessary and appropriate, including whether it is appropriate to include the provisions in delegated legislation.

The relevant provisions were reviewed, prior to the Regulation being made. The policy decision to exempt the proceedings listed in the Regulations has been developed having regard to the nature of the proceedings and impact on the parties, further balanced with consideration of public interest and access to justice. This justification is also outlined in the Regulation's accompanying Explanatory Statement.

I trust this information is of assistance.

Yours sincerely

Senator the Hon Michaelia Cash

14/12/2021

The Hon Alan Tudge MP

Minister for Education and Youth

Ref: MS21-001201

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
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By email: sdlc.sen@aph.gov.au

Dear Chair Connie

Thank you for your letter of 30 September 2021 in which you raise the scrutiny concerns of the Senate Standing Committee for the Scrutiny of Delegated Legislation (the Committee) in relation to the Education Services for Overseas Students (Exempt Courses) Instrument 2021 (the Instrument). I provide the following advice in response to the Committee.

Compliance with the Legislation Act 2003 - incorporation
The Instrument is made under subsection 5AA(3) of the *Education Services for Overseas Students Act 2000* (the Act) and determines that various courses of education or training are not 'courses' for the purposes of the Act. Section 5 of the Instrument relevantly determines the following courses for this purpose:

- Vocational Education and Training (VET) courses specified in Part 2 of Schedule 1
- VET Courses where the requirements of the course only consist of one or a combination of any of the units of competency specified in Part 1 of Schedule 1 to the Instrument and where the course does not lead to a qualification recognised under the Australian Qualifications Framework.

Part 1 and Part 2 of Schedule 1 of the Instrument prescribe 21 named units of competency and two named VET courses, respectively. In addition to those named units and courses, the Instrument also specifies in Parts 1 and 2 any unit or course (respectively) 'identified in the National Register referred to in section 216 of the *National Vocational and Training Regulator Act 2011* as a later version of, or a superseding [unit or course]' of the units or courses named.

This additional specification is a specification by class in accordance with subsection 13(3) of the *Legislation Act 2003*. That provision relevantly provides that if enabling legislation confers on a person a power to prescribe a matter, the person may identify the matter by referring to a class or classes of matters. The note in subsection 5AA(3) of the Act contemplates that specification by class may be used for the purposes of the subsection.

The purpose of prescribing these classes of courses and units is to preserve the effect of the Instrument in relation to units and courses that supersede the units and courses specified. Determining the scope of the class by reference to an objectively ascertainable criterion, such as the way units and courses are described in the National Register, avoids the ambiguity that may result if a more general specification of superseding units or courses is used.

The Hon Alan Tudge MP
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To provide a simple example of this, the reference is intended to ensure that, where a first aid course with a new unit code is devised to cover the same skills associated with the unit of competency described at item 5 in the table in Part 1 of Schedule 1, that first aid course will remain exempt, even though the 'unit code' may technically differ from the code initially specified. Without referring to a superseded unit in this way, the Instrument would need to be immediately updated in the event that a new unit code is applied to a first aid course, with providers at risk of requiring registration under the Act in the event of any delay in updating the Instrument. In this light, the Instrument intends to operate by clarifying that first aid courses are exempt, and the reference to the National Register is made to indicate the current unit code, providing additional certainty around which units or courses fall within this class.

The reference to the National Register serves only as a manner of describing a class that is prescribed by the Instrument, in the same way that other units and courses specified by the Instrument are described by their name and unit or course code. To this end the Explanatory Statement provides information that the National Register may be accessed at https://training.gov.au/Home/Tga.

While it is correct that reference to the National Register is required in order to determine whether courses or units fall within the class specified, no part of the National Register is applied, adopted or incorporated by the Instrument.

I will amend the Explanatory Statement for the Instrument in due course to reflect the above advice. I also commit to monitoring the superseding of the relevant units or courses and where, as a result of such superseding, the reference in the Instrument becomes ambiguous or otherwise unclear, I will amend the Instrument by referring directly to the new unit or course codes, as relevant.

I trust this information is of assistance.

Yours sincerely

Alan Tudge

13 / 4 / 2021

Senator the Hon Bridget McKenzie

Minister for Emergency Management and National Recovery and Resilience
Minister for Regionalisation, Regional Communications and Regional Education
Leader of the Nationals in the Senate
Senator for Victoria

Ref No: MC21-008607

Senator Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

Dear Senator Connie,

Thank you for your letter of 30 September 2021 in relation to the *Industry Research and Development (Regional Decentralisation Agenda—Securing Raw Materials Program) Instrument 2021* [F2021L00973] (the Instrument).

The Senate Standing Committee for the Scrutiny of Delegated Legislation (the Committee) has asked for advice on the following two matters in relation to the Instrument:

- whether the Instrument could be amended to set out the eligibility criteria for the program, or at a minimum, whether the explanatory statement could be amended to include this detail; and
- the constitutional validity of the Instrument, including how the Instrument is a law with respect to trading or financial corporations.

The Instrument, which is made under section 33 of the *Industry Research and Development Act 1986* (IR&D Act), prescribes the Regional Decentralisation Agenda – Securing Raw Materials Program (the Program) giving authority to the Commonwealth to make, vary or administer arrangements in relation to activities under the prescribed program.

Including the eligibility criteria in the Instrument or explanatory statement

The Instrument details the activities the Program provides funding for the purposes of the Program, and general eligibility criteria relating to the Program. The explanatory statement provides the supporting explanation of these provisions, and provides additional information such as eligible activities, administration of the program and grant amounts. As such, the Instrument and its explanatory statement include sufficient information to support parliamentary oversight and scrutiny of Government programs and spending activities, and strike an appropriate balance between flexibility and transparency.

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Further, the purpose of section 33 of the IR&D Act is to provide a simple and efficient mechanism to give legislative authority to the Commonwealth to make, vary or administer arrangements in relation to industry, innovation, science or research programs. The Instrument gives this authority in relation to the Program. Providing further detailed and specific eligibility criteria in the Instrument or explanatory statement would be inconsistent with the primary purpose of section 33 and the Instrument, as that information is not relevant to legislative authority to administer the Program.

Specifying the expected detailed eligibility criteria at the inception of the program in the explanatory statement could result in the explanatory statement becoming out of date or misleading and give rise to confusion in the event that those criteria change as the program evolves. For this reason, it is preferable for the published guidelines to act as the comprehensive and up-to-date source of information for applicants and the wider public on eligibility to participate in the Program rather than the explanatory statement. As noted in the explanatory statement, those guidelines include relevant eligibility and merit criteria and are publicly available, including to the Committee, on the GrantConnect website.

For these reasons, on balance, it is not necessary or desirable to amend the Instrument or explanatory statement. Further, the Program is, and remains, subject to the appropriate level of parliamentary oversight through the Budget and Estimates processes and through parliamentary questions.

Constitutional validity

The Committee has also requested advice on the constitutional validity of this Instrument, including now the Instrument is a law with respect to trading or financial corporations.

The Commonwealth generally does not disclose its constitutional legal advice. However, the comments below may be of assistance to the Committee. These comments are not intended to waive legal professional privilege.

Section 51(xx) of the Constitution empowers the Parliament to make laws with respect to 'foreign corporations, and trading or financial corporations formed within the limits of the Commonwealth', (together, constitutional corporations).

In *Williams v Commonwealth* (2014) 252 CLR 416 (*Williams No 2*), the High Court, considering section 32B of the *Financial Management and Accountability Act 1997* (the FMA Act), held (at [50]) that:

> A law which gives the Commonwealth the authority to make an agreement or payment of that kind is not a law with respect to trading or financial corporations. The law makes no provision regulating or permitting any act by or on behalf of any corporation.

However, the relevant provisions of the IR&D Act are substantially different to the provisions considered by the High Court in *Williams No 2*. Section 34 of the IR&D Act corresponds to section 32B of the FMA Act considered by the High Court in *Williams No 2*. However, the FMA Act contained no provision in terms equivalent to those of section 35 of the IR&D Act.

Subsection 35(2) of the IR&D Act limits the arrangements made under section 34 so that, where a party to an arrangement made under section 34 is a constitutional corporation, the arrangement must be subject to a written agreement containing terms and conditions under which money is payable by the Commonwealth. The corporation must comply with the terms and conditions. The activities of the corporation are therefore regulated through the terms and conditions made under each agreement pursuant to subsection 35(2).

Further, subsection 35(3) provides that the agreement must provide for circumstances in which the corporation must repay amounts to the Commonwealth.

Parliamentary oversight and scrutiny of delegated legislation is important, and the Committee plays an important role in that regard. The Department of Infrastructure, Transport, Regional Development and Communications has noted the Committee's preference that instruments and explanatory statements contain sufficient information to provide for effective scrutiny of the Parliament. I have asked that the Department ensure these preferences are reflected in the preparation of future instruments made under the IR&D Act.

Thank you for bringing your concerns to my attention and I trust this is of assistance.

Yours sincerely

Bridget McKenzi

25 OCT 2021

THE HON ANGUS TAYLOR MP
MINISTER FOR INDUSTRY, ENERGY AND EMISSIONS REDUCTION

MC21-007943

Senator the Hon Concetta Fierravanti-Wells
Chair, Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
CANBERRA ACT 2600

Dear Senator Fierravanti-Wells

Thank you for your letter of 28 October 2021 regarding five instruments made under section 33 of the *Industry Research and Development Act 1986*. I appreciate the opportunity for further engagement with the Committee on this matter.

Industry Research and Development (Modern Manufacturing Initiative Program) Instrument 2021

In your letter, you requested that the instrument authorising the Modern Manufacturing Initiative Program be amended to include reference to the National Manufacturing Priorities.

I accept your suggested amendment in this case and undertake to make it. As you are aware, the program is already operating within these priorities.

I trust that this is sufficient to resolve your concerns about the instrument.

Specification of eligibility criteria

In your letter, you also requested that the explanatory statements for the five listed instruments be amended to include high-level eligibility criteria for the programs.

I note your advice that the Committee considers that Parliament should be informed of the key, enduring criteria. High-level eligibility criteria for the programs are set out in the instruments or explanatory statements where they are relevant to legislative authority. I set out how the instruments and explanatory statements identify those criteria in my letter of 21 October 2021. Further, each of the explanatory statements provide some additional detail about the scope and policy objectives of the programs. The publicly available guidelines then provide the specific detail that is applied in the assessment of applications.

In my view, the content and detail contained in the instruments and explanatory statements, taken together, strike an appropriate balance between the need to support Parliamentary oversight of delegated legislation and the efficiency that section 33 is intended to provide.

However, I will continue to bear in mind the Committee's view that further information is desirable when making instruments in the future.

Yours sincerely

ANGUS TAYLOR

Enc

CC: The Hon Melissa Price, Minister for Science and Technology
The Hon Keith Pitt, Minister for Resources and Water

THE HON ALEX HAWKE MP
MINISTER FOR IMMIGRATION, CITIZENSHIP, MIGRANT SERVICES AND MULTICULTURAL AFFAIRS

Ref No: MC21-046789

Senator Concetta Fierravanti-Wells
Secretary
Senate Regulations and Ordinances Committee Secretariat
Parliament House
CANBERRA ACT 2600

Dear Senator Fierravanti-Wells

Thank you for your correspondence of 21 October 2021 regarding the *Migration Amendment (Subclass 417 and Subclass 462 Visas) Regulations 2021* [F2021L01030] and the concerns of the Senate Standing Committee for the Scrutiny of Delegated Legislation in relation to procedural fairness.

I note the Committee's view that procedural fairness would be better protected if the *Migration Regulations 1994* (the Regulations) expressly provide that employers may make submissions prior to being listed in a legislative instrument. I accept that recommendation and advise that amendments to the Regulations will be prepared as soon as possible.

On the issue of 'how common law procedural fairness will apply to the listing of excluded employers in future legislative instruments', please be assured that until such time as the requirements under the Regulations are amended, any employer I may consider for exclusion will be afforded procedural fairness under policy.

The precise form of the amendments to the Regulations will be subject to discussions with the Office of Parliamentary Counsel.

Thank you for raising this matter.

Yours sincerely

ALEX HAWKE

11 / 11 / 2021

PARLIAMENT OF AUSTRALIA • HOUSE OF REPRESENTATIVES

PAUL FLETCHER MP

Federal Member for Bradfield
Minister for Communications,
Urban Infrastructure,
Cities & the Arts

MS21-002170

Senator the Hon Concetta Fierravanti-Wells
Chair
Senate Standing Committee for the Scrutiny of Delegated Legislation
Parliament House
Canberra ACT 2600

Dear Senator Fierravanti-Wells

Thank you for your letter of 30 September 2021 concerning the *Telecommunications (Statutory Infrastructure Providers—Circumstances for Exceptions to Connection and Supply Obligations) Determination 2021* (the Instrument). The Committee has sought my advice on whether the explanatory statement to the Instrument can be amended to provide justification for including the exceptions in delegated rather than primary legislation, and whether the Instrument can be amended so that it ceases within three years from commencement.

As requested by the Committee, I will arrange for the explanatory statement to be amended. The replacement explanatory statement will set out the reasons for including exceptions in delegated legislation, as per the explanation I provided to the Committee in my letter of 24 August 2021. I anticipate this will be made available to the public shortly.

In relation to the Committee's second question, I have commenced a process to consult stakeholders on amending the Instrument so that it ceases three years after the date of commencement. Unless there are significant stakeholder concerns with that approach, I envisage making a final decision on the amendment in November 2021.

Yours sincerely

Paul Fletcher

29/10/2021

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