OPAN Older Persons Advocacy Network

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Australian Parliamentary Joint Committee on Human Rights

Older Persons Advocacy Network Statement to the Inquiry into the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

The Older Persons Advocacy Network thanks the Joint Committee for the opportunity to appear before the Inquiry into the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (the Amendment) and to submit our written statement.

OPAN consists of nine State and Territory member organisations providing the National Aged Care Advocacy Program (NACAP). We seek to assist older people and their families receiving aged care to understand and actively pursue their aged care rights. In 2018/19 OPAN members supported over 13,475 older people and their families through information and individual advocacy in relation to aged care. OPAN seeks to provide older people a voice, assist to self-advocate and to act at the direction of the older person to have their rights respected, upheld and promoted.

Recognising an individual older person's rights and autonomy is paramount. The Charter of Aged Care Rights[1] affirms the older person's right to 'high quality and safe care and services' and their right to 'live free of abuse and neglect' and to be 'involved in decisions which effect their care'.

In the past, restrictive practices were often a first response to behaviours that caused significant harm to the person or others. It is now recognised that restrictive practices can present serious human rights infringements. The emerging evidence of the impact on physical and mental health, level of functioning and reduced life span is compelling[2]
OPAN does recognise the Amendment provides a definition in the Quality of Care Principles of restraint which has OPAN believes has been previous lacking and a significant issue. However,

[1] https://agedcare.health.gov.au/quality/single-charter-of-aged-care-rights

OPAN does have concenrs the Ammendment does not provide sufficient safeguards for vulnerable older people in relation to these authroisation restrictive practices and in particular chemical restraint.

The Royal Commission into Aged Care Quality and Safety Background Paper No 4 is useful in summarising issues for consideration including Australia's human rights obligations[2]. There are risks of Australia breaching its human rights obligations without additional authorisation controls and independent monitoring.

The appeal of a case relating to South Australia Public Advocate and a person detained in a memory support unit highlights the need for supervisory controls over the powers of guardians in relation to the infringing of a vulnerable person personal liberty and restraining their freedom (e.g. by physical restraint).

The Appeal decision found:

"When it comes to the detention of a vulnerable person it is undoubtedly preferable, and consistent with the fundamental value the common law accords personal liberty, for the guardian to be required to make an application to the independent Tribunal[3] .

While this case refers to detention under the South Australia *Guardianship and Administration Act 1993* there is applicability to the consideration of the need for similar controls when authorising and implementing physical and chemical restraint in Residential Aged Care.

Restrictive practices should occur only in very limited and specific circumstances, as a last resort and utilising the least restrictive practice and for the shortest period of time possible under the circumstances. Restrictive practices should only be used intermittently, where they are proportionate and justified in order to protect the rights or safety of the person or others. OPAN's position is that this Amendment does not compel appropriate safety mechanisms, authorisation thresholds and monitoring controls to constrain and reduce physical and chemical restraint.

OPAN's position is that the respect for the older person's rights includes recognising the presumption of capacity for decision making, seeking a person's consent and participation in decision making (with support if necessary) prior to making a substitute decision on their behalf. Where the person is unable to consent due to capacity or cognitive decline engagement of the appropriate, informed decision maker with personal knowledge of the older person's needs and desires is appropriate. Where a decision must be made on behalf of a person, that substitute decision maker must give informed consent prior to any clinical practice, and in particular when recognised restrictive practice are to be utilised.

OPAN's position is the use of restrictive practices without informed consent and appropriate authorisation must be prohibited as occurs in other social care settings such as mental health, disability and child services. The use of physical and chemical constraint should be confirmed as

[2] Royal Commission into Aged Care Quality and Safety (2019). Background Paper 4 – Chemical and Physical Restraint (pages 71-72 https://agedcare.royalcommission.gov.au/publications/Pages/default.aspx

[3] http://www8.austlii.edu.au/cgi-bin/viewdoc/au/cases/sa/SASCFC//2019/58.html

a last resort in managing risks resulting from behaviours of concern as occurs in these other sectors.

Behaviours of Concern should be severe, persistent and have a clear demonstration of risk assessment and evidence of the likelihood of placing the individual or others at imminent harm. An emergent and rare crisis response would be the only exception and these should be deemed and reported externally to the Aged Care Quality and Safety Commission as a serious incident.

In limited circumstances, and only as a last resort, a restrictive practice, following assessment and authorisation, could be used as part of a behaviour support plan, to address a behaviour that poses a risk of harm to the person or others. In other sectors, such as the disability sector and under the NDIS quality and safety framework, where a restrictive practice is deemed necessary as part of a behaviour support plan, these practices are subject to rigorous approval, authorisation and monitoring.

Unlike in Aged Care, the Disability sector has much tighter controls than outlined in the current Amendment with restrictive practices subject to much greater regulation. These include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint[4].

The National Disability Insurance Scheme regulations state:

> *(a) the use (other than a single emergency use) of the regulated restrictive practice in relation to the person with disability must be authorised in accordance with the authorisation process;*
>
> *(b) the provider must lodge with the Commissioner evidence that the use is so authorised as soon as reasonably practicable after the use of the practice in relation to the person.* [5]

The controls in place within aged care are not equivalent and OPAN believes these breach the older people's rights in aged care. The Amendment requires strengthening to a similar level of protection to individual rights, minimisation of restrictive practice and appropriate transparency and monitoring when utilised as a last resort.

OPAN has a number of concerns and suggestions regarding the Amendment, including:

1. ***Lack of a high authorisation threshold, the need for external authorisation and the lack of transparent monitoring and reporting mechanisms***

The Amendment currently does not compel approved providers to seek any higher form of authorisation than for prescribing of other regular and non-restrictive medications. The system, and legislation should compel a higher level of rigour in assessment to ensure restrictive practices are used as a practice of last resort once other behaviour supports have been trialled and a behaviours support plan exists.

[4] https://www.ndiscommission.gov.au/regulated-restrictive-practices
[5] *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*

The Disability sector has much tighter external controls to protect and monitor the people's rights when the use of restrictive practice is deemed necessary. Strict external authorisation policies and procedures prior to use of a restrictive practice occurs at the State and Territory level by an external government or guardianship agency provides appropriate checks and balances. It also allows review of documentation around alternate approaches to restraint, prevalence monitoring and constraint on use. The requirement for detailed assessment and behaviour support plans is a minimum requirement.

Similar external controls are not enabled by the Amendment. OPAN supports an external independent authorisation and monitoring function as part of reducing and increasing transparency over restrictive practices in aged care.

There is some requirement to report restrictive practice use in aged care to the Aged Care Quality and Safety Commission but this is retrospective, occurs quarterly and OPAN believes is unlikely to change culture and practice in relation to frontline use and governance of physical and chemical restraint. The need to achieve external authorisation is required, at a minimum similar to authority prescriptions, with recording of key data items regarding behavioural assessment, support planning, review, evaluation, informed consent, and the controls/limitations surrounding the prescribed restrictive practice.
These controls may increase workload and provider responsibilities but should be a reasonable minimum threshold for a provider prior to seeking to infringe an older person's rights and autonomy.

2. ***Lack of compulsion to adhere to nationally consistent policies and protocols***

The explanatory memorandum mentions the framework for reduction of use of restrictive practices but the Amendment makes no requirement to follow any practice guidelines or policy in the Amendment. This should be rectified.

There are detailed behaviour assessment, planning, informed consent and independent authorisation processes within disability and mental health sectors, *prior* to the use of any restrictive practice. The legislative Amendment should place additional controls and approval processes to drive restrictive practice reduction. Other than some minor requirements it does not compel any additional controls or safety mechanisms to reduce the frequency or improve the monitoring of the use of restrictive practices.

NSW procedures on restrictive practice approval notes the use of restrictive practice without *"not properly authorised and/or does not have validity or does not adhere to requisite protocols and approvals"* is deemed unauthorised and is prohibited. Other state and territory polices state similar to NSW with using restrictive practice without planned positive behaviour support practices, and without following the operational procedures outlined in the Restrictive Practice Approval Policy is a breach and is prohibited.

3. ***No concordance between consent for chemical versus physical restraint, and a lack of any informed consent required for chemical restraint***

The Amendment only requires substitute consent for physical, not chemical restraint and this is not acceptable. The requirement is only that the representative be 'informed' of use of chemical restraint and not that consent be obtained by the medical/nursing practitioner, or confirmed that it has been obtained by the aged care provider. This should be urgently addressed, given the gravity and extent of the problems now known with this practice.

This anomaly suggests that chemical restraint warrants a lower substitute consent standard, perhaps related to a presumption about medical decision-making in the context of therapeutic use. The same argument could be applied in disability that the responsibility for consent lies with the registered health practitioner who holds and exercises their prescribing rights. That is, it is the prescribers responsibility to gain consent. However, currently there is no compulsion on the health professional as medication administrator (Registered Nurse, Enrolled Nurse or other through dose administration aid) to even confirm with the prescriber that informed consent from the resident or their authorised representative has been obtained. External authorisation for restrictive practices at the state/territory level assist in reducing the risk of chemical restraint without informed substitute consent.

It is OPAN's position that a professional and ethical responsibility lies on all parts of the system to follow and confirm informed consent when using the restrictive practice of chemical restraint. The role of various health professionals in the quality and safe use of medications and the medication cycle do not allow one health professional to negate their responsibilities to deliver safe practice and in line with legal and ethical responsibilities.

There should be, at a minimum, a requirement for the information provided and process undertaken by *ALL* members of the clinical and support team to be documented in details prior to chemical restraint. This should include documenting the details involved in support planning, obtaining consent, confirming consent and implementing any restrictive practice, including chemical restraint. This should occur for the aged care providers staff and those providing clinical services on a visiting basis. The position that 'a doctor prescribed this and so I have to give it' does not cut it. Neither is the aged care provider suggesting the employment model or independent nature of GPs means they have no responsibility for safe and high-quality practice.

4. Lax controls and timeframes surrounding chemical restraint.

From 1 July 2019, it will be mandatory for residential aged care service providers to provide data on three quality indicators, including use of physical restraint, to the Department of Health. Resources have been developed to assist residential services to collect and report quality indicator data.[6] However, there is no similar requirement to report the authorisation or use of chemical restraint within the Amendment and this should be rectified.

Utilising medications for side effects rather than their intended approved effects could occur intentionally or inadvertently by the administrator of the medication even with a valid order from the prescriber. The Amendment does little to minimise, control, or at least provide for external monitoring of this practice as occurs in the disability sector.

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[6] Australian Government Department of Health, *Quality indicators in residential aged care*, 2019, https://agedcare.health.gov.au/ensuring-quality/quality-indicators-for-aged-care.

The NSW Restrictive Practices Authorisation Policy clearly indicates the misuse of any medication is a prohibited practice that would never receive authorisation from the independent authorising agency. The Policy details medication misuse as:

"Administration of medication prescribed for the purpose of influencing behaviour, mood or level of arousal, contrary to the instructions of the prescribing general practitioner, psychiatrist or paediatrician".

The policy goes on to provides examples of prohibited practice:

- *'Use of any medication as a convenience."*
- *"Using a small amount of an antipsychotic medication with a sedative effect in the evening to assist a person to get to sleep, when it is only prescribed for administration in the morning to treat schizophrenia."*[i].

There are continued risks of this continuing to occur in Aged Care under the current Ammendment. There also limited controls for the off-label prescribing of anti-psychotic or other medications or multiple medications which had synergistic restraint or sedative effects. There should be deterrents for this type of off-label prescribing where little of no clinical evidence exists or in fact possible health risks The 'independence' of the prescriber from the administrator of the medication or the service provider is not seen as a defence for this practice, but the lack of these controls within aged care will not minimise these practices

In addition, the Amendment as it stands implies the use of chemical restraint can be used indefinitely and does not compel medical or Authorisation be given to use a restrictive practice for a time-limited period only. The decision to authorise a restrictive practice must be regularly reviewed and information analysed within agreed time frames.

5. A need to strengthen and control 'emergency' exceptions to consent

There is an exception in 'emergency' circumstances to obtaining consent for physical restraint from the resident/representative and this may be appropriate in rare circumstances. This arises from practical constraints on timely consent in genuinely emergent scenarios.

However, the Act doesn't define 'emergency'. Some parameters around what 'emergency' means, and who gets to decide when an event constitutes an emergency would limit possible abuses of this clause. At its most minimal, a definition of 'emergency' might include safeguarding from *serious and imminent harm* to *the resident, or others*, given occasional resident-to-resident violence. In addition, a requirement that a senior Nurse Practitioner or doctor is overseeing such an emergency would be appropriate, given the gravity of the proposed intervention.

NSW Restrictive Practice Authorisation procedures note that occasionally there may be the need for a crisis response where there is a clear and immediate risk of harm linked to behaviour(s). Immediate intervention may be considered necessary under the service provider's duty of care in order to manage the risk. They state:

"The crisis response should involve the minimum amount of restriction or force necessary, the least intrusion and be applied only for as long as is necessary to manage the risk. A crisis response should never be used as a de facto routine behaviour support strategy"

Other than in the aged care sector this is deemed to be unauthorised and a serious and reportable incident to the NDIS Commission. A similar threshold should apply to authorised aged care providers. OPAN supports the inclusion of unauthorised (or non-consent) chemical restraint being included within the Serious Incident Response Scheme and required to be reported as a serious incident by service providers for each time this practice occurs. This standard for reporting could assist in raising the profile of chemical or physical restraint, especially without explicit and informed consent, as a practice to be avoided and deterred.

The allowance for administration of chemical restraint in an emergency without consent and then notification 'if practicable' is of great concern. Consent should be sought first and then if delayed senior oversight obtained to administer without consent.

In addition, the notification or 'informing' of the authorised representative should be mandatory, as close to the emergency use of chemical restraint and should have maximum time limits by which this should occur (e.g. 24 – 48 hours).

6. *Lack of emphasis in the Amendment on compelling the use of alternatives to restraint prior to restrictive practice*

The Explanatory Statement does stipulate that 'alternatives to restraint [should] have been used for the consumer to the extent possible'. However, there is not a strong enough emphasis on these alternative interventions in the Amendment.

Clause 15 (F) (2 c) (ii) and 15 (G) (2) (ii) requires ***documentation*** of *'the alternatives to restraint that have been used (if any)".* This implies alternatives to restraint are optional and allows for restrictive practices to be utilised as a first rather than last resort.

OPAN believes these clauses must be amended. To reduce restrictive practices providers should be compelled within the Amendment to trial alternatives prior to authorisation and use of restrictive practices.

7. *The need for the Amendment to further support skilled behavioural assessment and documentation prior to authorisation of restrictive practices*

As part of this documentation, details of the informed consent process should be required to form part of a behavioural management plan. This documentation at the service provider level should include explicit confirmation that consent for chemical restraint has been obtained by the prescriber before other health professionals administer or implement physical and chemical restraint being administered. Prior documentation, consent and review of the behavioural support plan must be the requirement in all but emergency cases. In addition OPAN is concerned that:

- There is no requirement of face to face/telehealth based assessment of the resident prior to use of chemical restraint

- The use of terms relating to the assessment and documentation such as 'if any', and '(if known by the approved provider)' in documentation regarding the planning and use of physical and chemical restraint should be removed. These should be seen as minimum requirements and the required level of assessment and documentation required by an approved provider in considering or requesting authorisation for restrictive practices.

- Behaviours of concern can often be managed by implementing positive behaviour support strategies. Therefore, demonstration and documentation of the planning, trialling and outcome of behaviour support strategies must occur prior to any use of restrictive practice. The current Amendment does not compel or require this, rather suggests with the term 'if any' that this is optional.

A structured national consent form and procedure to assist residential aged care staff and aged care providers to navigate the process and documentation requirements is advisable. The documentation and a national consent form for use of restraints has been recommended by Australian Commission for Quality and Safety in Health Care in 2018. This would be a useful clinical support and provide a nationally consistent mechanism for assessment. It would also be more easily identifying in case notes and flagged where restrictive practices had been implemented.

8. The need for increased individual advocacy to support all older people placed under restrictive practices, including physical and chemical restraint

OPAN's position is that all older people who are compelled to receive chemical or physical restraint without their personal consent should be considered vulnerable, at risk of harm and requiring additional safe guards to secure quality and safe care. The very nature of restrictive practices, even when authorised, infringes on a person's human rights, even if the intended benefit is to reduce risk of harm to self or others.

Therefore, additional supports are required to ensure the voice of the older person (and their family) is maintained when their freedom of movement and communication is constrained by the restrictive practices of physical and chemical restraint.

The National Aged Care Advocacy Program should be expanded to ensure all older people prescribed and under a restrictive practice in residential care have access to an aged care advocate. OPAN should be funded to provide enhanced individual advocacy support for this vulnerable cohort of older people as this is a right under the Charter of Aged Care Rights. This investment would protect and enhance the rights of older people.

Submitted on behalf of the Older Persons Advoacy Network

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