Guardian Consent for Restrictive Practices in Residential Aged Care Settings

1. Purpose

Whenever possible, to prevent and minimise the use of restrictive practices. To ensure that people who are under guardianship receive best practice care, and that if restrictive practices are consented to, such restrictive practices are only used as a last resort and that appropriate checks and reviews have taken place.

2. Application

This Policy applies in situations where:

- a Guardian is appointed pursuant to the *Guardianship and Administration Act 1993(GAA)*; and
- if required, relevant orders made by the South Australian Civil & Administrative Tribunal (SACAT) pursuant to section 32(1) (a)(b) or (c) are in place.
- a person under Guardianship resides at a residential aged care facility.

This policy is for use by delegated Guardians of the Office of the Public Advocate when a client under the guardianship of the Public Advocate resides in a residential aged care facility. There is no requirement for private guardians or substitute decision makers to follow this policy, but it can be used as a guide.

3. Implementation

If a guardian is requested to consent to a restrictive practice the guardian will first

(1) **Prevent and avoid restraint.** Seek confirmation that all relevant behavioural prevention strategies to avoid restraint have either been attempted or seriously considered. The policy does not proscribe a particular approach but expects that a practitioner will consider, and where appropriate trial, restraint prevention strategies listed in best practice guideline such as the *Commonwealth Government's Decision Making Tool: Supporting a Restraint Free Environment*.

(2) **Specialist review if needed.** If any concerns remain that restrictive practices could be avoided or minimised, then a specialist review from a practitioner or service with skills in these areas will be requested (geriatrician, psychogeriatrician, Dementia Behavioural Management Advisory Service, or Older Persons Mental Health Services)

(3) **Confirmation that organisations policies are being followed.** Seek confirmation that the use of the restrictive practice is consistent with the aged care organisation's policy for the use of such practices, and any requirements for approval of the practice that the organisation has in place. Where no policy exists the Care Director/Manager of a facility will be requested to endorse that the restrictive practice is necessary, consistent with best practice, and that behaviour could not be managed through less restrictive means.

(4) **Consent subject to review.** The use of restrictive practices should be subject to regular review. A guardian, in conjunction with treating practitioners may wish to set a review date. Alternatively a guardian may wish to provide time limited consent to be extended on further request.

(5) **Emergency provisions.** Consent can be given to manage emergencies for up to 7 days, without the provider demonstrating that they have taken steps to prevent and avoid the use of restraint. This consent may be renewed for further 7 day periods, up to 28 days total, but it is expected that providers will then be in a position to comply with the requirements of this policy.

4. Background

Preventing limiting, and eliminating the use of restrictive practices in residential aged care facilities not only protects the rights, freedoms and inherent dignity of residents, but can reduce injury and death caused by preventable physical, chemical or mechanical restraint.

The Australian Institute of Health and Welfare report that 52% of permanent aged care residents experience dementia, and 26.3% a mental illness without dementia (AIHW, 2012). A key international systematic review suggests that 78% of those with a diagnosis of dementia in residential aged care will have behavioural and psychological symptoms (Seitz et al, 2012).

There is growing recognition that many psychological and behavioural symptoms can be managed ethically and effectively minimising restrictive practices - a particular focus has been the use of non-pharmacological approaches as an alternative to medication. Antipsychotic medications are used in nursing homes too often, for too long at too high doses and in dangerous combinations with other medications (Hilmer and Gnjidic, 2013).

The overall provision of mental health care in residential aged care is seen to need substantial improvement. The key to effective change will require interventions at a national level to improve such interventions (Looi and Macfarlane, 2014). Alzheimer's Australia have recommended the need for the Commonwealth Government to fund a multifaceted strategy to educate the workforce (Pesiah and Skladzien, 2014). The South Australian Public Advocate in its 2013 Annual Report has previously suggested that provisions aimed at reducing the use of restrictive practices in aged care be added to the User Rights Principles attached to the *Aged Care Act, 1997*.

Even without national initiatives, dramatic results in the reduction of the reliance on chemical restraint can be achieved through local change management. For example O' Sullivan (2011) has reported the elimination of psychotropic drug use in two New Zealand secure dementia units achieved using a combination of person centred care, providing adequate occupational and leisure activities to residents, making readily achievable environmental changes, and providing sensory stimulation.

Avoiding restraint

This Policy of the Office of the Public Advocate for aged care, is based on the same approach used in the Office's policy on Consenting for Restrictive Practices in Disability Settings since 2011, which expects an appropriate assessment and the development of a positive behavioural support plan. In the aged care setting there is a similar expectation that provider organisations will use a recognised approach to reduce and eliminate where possible the use of restrictive practices, and the guardian will check that such approaches have been attempted or seriously considered prior to providing consent to that practice.

We should not and cannot be proscriptive as to what restraint minimisation approach is used, but expect careful consideration of preventative options such as those described in the Commonwealth Government's 2012 publication, a *Decision Making Tool: Supporting A Restraint Free Environment in*

Residential Aged Care, be considered. An alternative resource is another Commonwealth Government document, the more comprehensive guide *Behaviour Management: A Guide to Good Practice*, released jointly by the Dementia Collaborative Resource Centres and the Dementia Behaviour Advisory Service. These publications can be accessed on the web links in the references to this policy.

Examples of restraint free options are attached to this policy in Appendix A.

If the need for ongoing restraint is in doubt, specialist referral to either a geriatrician, psychogeriatrician, the DBMAS, or older persons mental health service will be requested by the guardian.

Ongoing review of restrictive practices

The use of a restrictive practice should be subject to regular and ongoing review. If detention or restraint are used to manage behaviours associated with an exacerbation of mental illness, then it would be expected that such interventions would no longer be required when a person's condition has improved. Similarly because of the progressive nature of many dementia, restrictive practices used at a particular time in the course of a dementia (eg chemical restraint) are likely to not be required at some future time.

If there are situations where a restrictive practice has been commenced in the past without consent (for example the administration of chemical restraint) then the first question to consider is whether the practice can be stopped. If not, a guardian can be asked to consent on a temporary basis for an intervention to continue for a brief period of time, so that practitioners can undertake necessary assessments and properly consider the use of other options that do not involve restraint.

Medical specialists consulted in the preparation of this policy recommended that withdrawing chemical restraint be considered if symptoms of concern have settled, if the patient develops intolerable side effects to the medication, if the medication appears to have no beneficial effect, or if none of these circumstances apply then every three months.

Use of this policy by private guardians and substitute decision makers

There is no legal requirement for private guardians appointed by SACAT or substitute decision makers appointed through an Advance Care Directive to follow this policy. However private guardians and substitute decision makers may wish to use this document as a guide.

The Office of the Public Advocate's Enquiry Service can provide information and advice to private guardians and substitute decision makers about the use of their powers, including the consent and/or refusal of consent for the use of restrictive practices.

Preventing and Eliminating Restrictive Practices in Acute Hospitals

The policy in its present form is limited to Aged Care settings regulated by the *Aged Care Act 1997* and not acute hospitals. This is because the policy describes Decision Making tools used in the aged care sector, and the consultation with specialist services that visit residential aged care. However the same general principles apply across settings.

Preventing and Eliminating Restrictive Practices in Community Aged Care

Similarly this policy applies to consent for practices in residential aged care, and not community aged care as it refers to services and approaches available in residential care. However the application of law is the same, and practice principles are similar. The Commonwealth Decision Making Tool for use in Community Aged Care is included in the reference list for reference.

5. Definitions

The following definitions apply in this, the 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings' policy document,.

GAA. *Guardianship and Administration Act 1993*

Guardian means an enduring guardian or a guardian appointed under a guardianship order pursuant to the GAA.

Practitioner means a health or aged care professional

Restrictive practices mean detention, seclusion, chemical restraint, physical restraint and mechanical restraint as defined in this document.

Detention means a situation where a person is unable to physically leave the place where he or she receives aged care services. The means of detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent the person from exercising freedom of movement. "Detain" and "detained" have corresponding meanings[1].

Seclusion means the sole confinement of a person at any hours of the day or night in any room or area in the premises in which that person is detained. (It should be noted that seclusion is very rarely used in residential aged care settings. Information about seclusion is included in this policy for completeness.)

Chemical restraint. If the primary purpose of administering medication is to subdue or control the behaviour of a person, then the use of the medication is a chemical restraint. Likewise, the use of medication when needed (ie, 'PRN'), for the primary purpose of controlling behaviour, is a restraint. If information regarding the primary purpose of administering the medication is not available, the intervention should be considered a chemical restraint. If the medication is used to treat a person's illness (psychiatric or physical), then it is not viewed as a restraint but as a treatment[2].

Physical restraint means the use of any part of another person's body to restrict the free movement of a person with the aim of controlling that person's behaviour. (It should be noted that physical restraint is very rarely used in residential aged care settings. Information about physical restraint is included in this policy for completeness.)

Mechanical restraint means the use of a device to restrict the free movement of a person or to prevent or reduce self-injurious behaviour. It does not include the use of devices for therapeutic purposes or to enable the safe transportation of that person.

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[1] Detention and Keypad Operated Doors. Aged care facilities frequently have keypad operated doors, sometime with the keypad code on display. If a person lives in a locked area, and is able to operate the keypad that person is not detained. If a person lives in a locked area, and cannot operate the keypad, or alternatively cannot ask to have the doors opened on request, and have this request granted, then the person is detained.

[2] BPSD and Chemical Restraint. There is debate in medical practice as to whether the Behavioural and Psychological Symptoms of Dementia, commonly abbreviated to "BPSD" should be considered a psychiatric disorder. Following this argument if BPSD is considered a disorder, the use of medication to treat behaviours associated with BPSD would be treatment and not considered a chemical restraint. The OPA does not take this view. BPSD is a broad term and encompasses both behavioural and psychological symptoms. For the purpose of this policy, when medication is prescribed to a patient with BPSD to manage behaviour it is a chemical restraint. However if a person develops significant psychological symptoms secondary to dementia (such as psychosis characteristically presenting with hallucinations, and or delusions, depression or an anxiety disorder) then the prescription of medication to treat these psychological symptoms would not be considered to be a restraint, and would be considered treatment.

Cross reference to Commonwealth Department of Social Security Publications.

This document uses definitions to describe restrictive practices commonly in use in the disability, mental health and acute sectors.

Language used in aged care has developed in parallel to that in other sectors. The principles are identical however.

Term used in this policy (and generally in other sectors)	Equivalent Term used in the Department of Social Security Decision Making Tool.
Restrictive Practice	Restraint
Detention	Environmental Restraint
Seclusion	Environmental Restraint (also considered a form of Extreme Restraint)
Chemical Restraint	Chemical Restraint
Mechanical Restraint	Physical Restraint
Physical Restraint	Person to Person Restraint Physical Restraint

Where to send feedback about this policy: opasa@opa.sa.gov.au.

Enquiries about Consent and the Use of this Policy can be directed to the OPA Information Service on 8342 8200.

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Attachment:

Recommendation and Consent for Restrictive Practices in Aged Care Setting

This table is intended to be used as a reference, indicating who has the legal authority to consent for a restrictive practice, and gives examples of who might recommend the use of such a practice after an assessment.

Form of restrictive intervention	Practitioner Recommendation as per Aged Care provider's own policy	Management Endorsement as per Aged Care provider's policy	Consent
Detention	Eg. Treating Health Professional	Eg. Care Director/Manager	An appropriate authority (a guardian or substitute decision maker) expressly authorised by SACAT under s.32(1)(b) to detain the protected person in the place in which he or she will so reside but only to the extent authorised by SACAT.
Seclusion	Eg. Treating health professional. It is expected that seclusion will rarely, if ever, be used in aged care settings.	Eg. Care Director/Manager	An appropriate authority (a guardian or substitute decision maker) expressly authorised by SACAT under s.32(1)(b) to detain the protected person in the place in which he or she will so reside.
Physical restraint	Eg. Treating Health Professional	Eg. Care Director/Manager involved in the care of the protected person, expressly authorised by SACAT under s.32(1)(c) to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person but only to the extent authorised by SACAT.	An appropriate authority (a guardian or substitute decision maker).

Form of restrictive intervention	Practitioner Recommendation as per Aged Care provider's own policy	Management Endorsement as per Aged Care provider's policy	Consent
Mechanical Restraint	Eg. Treating Health Professionals This includes the use of lap belts designed to prevent movement, tabletops designed to stop a person standing, posey restraints, bed rails put in place to stop a person getting out of bed (as opposed to accidentally falling out) and deep chairs from which a person cannot stand unassisted. Individual analysis of each person's situation is likely to be necessary to determine if a mechanical device is being used only for safety purposes or is being used to restrain a person's behaviour.	Eg. Care Director/Manager involved in the care of the protected person, expressly authorised by SACAT under s.32(1)(c) to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to day care and well-being of the person but only to the extent authorised by SACAT.	An appropriate authority (a guardian or substitute decision maker).

Form of restrictive intervention	Practitioner Recommendation as per Aged Care provider's own policy	Management Endorsement as per Aged Care provider's policy	Consent
Chemical Restraint (of behaviour <u>not</u> due to a mental illness) ***Not requiring the use of force to administer medication.***	Prescriber: Medical officer, GP or psychiatrist	Eg. Care Director/Manager	A substitute decision maker appointed under an advance care directive (*ACD Act 2013*) subject to any instructions and directions in the Advance Care Directive (see *ACD Act 2013* s.35). A person responsible for a patient (*Consent Act*) which means (in hierarchical order): Guardian for healthcare appointed under the GAA, s.29, subject to any conditions or limitations (s.29(6)). A prescribed relative of the patient who has a close and continuing relationship. An adult friend who has a close and continuing relationship. SACAT. *Please note: Although a person overseeing ongoing day to day supervision, care and wellbeing of a patient can provide health consent generally, the ACD Regulations forbid such a person providing consent to chemical restraint.*
Chemical Restraint (of behaviour <u>not</u> due to a mental illness) ***Requiring the use of force to administer medication.***	Medical officer, GP or psychiatrist	Eg. Care Director/Manager involved in the care of the protected person, expressly authorised by SACAT under s.32(1)(c) to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to day care and well-being of the person but only to the extent authorised by SACAT.	A substitute decision maker appointed under an advance care directive (*ACD Act 2013*)) subject to any instructions and directions in the Advance Care Directive (see *ACD Act 2013* s.35). Guardian for healthcare appointed under the GAA, s.29, subject to any conditions or limitations (s.29(6)). Guardian for healthcare appointed under the GAA, s.29, subject to any conditions or limitations (s.29(6)).

Form of restrictive intervention	Practitioner Recommendation as per Aged Care provider's own policy	Management Endorsement as per Aged Care provider's policy	Consent
Psychiatric treatment (medication prescribed for treatment of a mental illness administered on an involuntary basis)	Medical practitioner, authorised health professional, SACAT (*Mental Health Act 2009*) This includes the prescription of medication to treat psychiatric symptoms secondary to an underlying organic disorder. (eg psychotic symptoms secondary to dementia)	Not applicable.	Not applicable. Not applicable. A guardian or substitute decision maker should not consent for involuntary psychiatric treatment, but defer to the provisions of the *Mental Health Act 2009*, for such treatment. In this situation a *Community Treatment Order* would be made subject to the provisions of the *Mental Health Act 2009.*

6. References

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Pesiah C and Skladzien E (2014) The Use of Restraints and Psychotropic Medications in People with Dementia, http://www.fightdementia.org.au/media/alzheimers-australia-report-shows-misuse-of-psychotropic-medications-in-people-with-dementia.aspx

Seitz D, Purandare N and Conn D (2010) Prevalence of psychiatric disorders amongst older adults in long-term care homes: a systematic review, *International Psychogeriatrics*, 22:1025-1039.

7. ENDORSEMENT

Signed by John Brayley

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Public Advocate

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Restraint Free Options (Commonwealth Government Decision Making Tool)