POLICY

RAC_Positive Behaviour Support & Restrictive Practice Policy

Consumer Statement

I am confident that Catholic Healthcare Limited (CHL) will ensure the care I am provided will focus on my safety, health, and wellbeing. If I require restrictive practice, this would only be used as a last resort to ensure my health and safety or for the safety of others. That I or my substitute decision maker is provided with the information to support me making an informed decision regarding its use.

Purpose

To provide policy, position and/or procedural information on Behaviour of Concern and Restrictive Practice which includes:

- CHL Residential Aged Care (RAC) specific and in line with the Mission and Values of the organisation.
- Consistent with State & Commonwealth Legislation & Aged Care Quality Standards.
- CHL's commitment to positive behaviour support and reducing/eliminating the use of Restrictive Practices.

CHL RAC Homes will:

- Provide person centred, evidence based care.
- Preserve the dignity, autonomy, safety, and human rights of the resident (consumer).
- Liaise with Medical Practitioners and allied health professionals as appropriate.
- Respond to resident's needs to effectively manage behaviours of concern and improve quality of life.
- Only use restrictive practices as a last resort, for the shortest time possible, and after exhausting all reasonable alternative strategies.

Applicability / Scope

This policy applies to Residential Aged Care employees of CHL, Contractors, Volunteers (including student clinical placements), Medical Practitioners, Nurse Practitioners and other healthcare providers that work with residents (consumers) in CHL RAC Homes.

Informed Consent for Restrictive Practices

- CHL recognises:
  - There are strict requirements regarding restrictive practice.
  - Informed consent is required by either the resident or a Restrictive Practices Substitute Decision Maker (RPSDM).
  - Restrictive Practice is only used with appropriate consent to protect the resident or others from risk of significant harm after alternative options have been exhausted.
  - There are legal avenues in QLD and NSW which need to be followed, for the consent of Restrictive Practice on behalf of a resident.
  - There are additional requirements for implementing a Restrictive Practice with a NDIS Participant Resident. Refer to RAC National Disability Insurance Scheme (NDIS) Policy Guideline for more information.

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Contents

Definitions

Approved Health Practitioner	An approved health practitioner is defined as a **Medical Practitioner**, **Nurse Practitioner or Registered Nurse.**
Enduring Guardian NSW Only	The person appointed to make **decisions relating to health and well-being** on their behalf. This can come into effect immediately or when the person loses capacity to make their own decisions, depending on what is written in the document. An Enduring Guardian's decision making is limited to the functions listed in their document. NOTE: the functions of the enduring guardian need to be set out in the instrument. **Restrictive practice's function needs to be stated, specifically**. It is not assumed. *(NSW Guardianship Act 1987 & NSW Guardianship Regulation 2010)*
National Disability Insurance Scheme (NDIS)	The National Disability Insurance Scheme (NDIS) is an Australia-wide scheme designed to support people with permanent and significant disability live their lives to their full potential.
Restrictive Practice (RP)	As defined by the Aged Care Act (1997), A restrictive practice in relation to a care recipient is any practice or intervention that has the effect of restricting the rights or freedom of movement of the care recipient.
Restrictive Practices Substitute Decision Maker (PRSDM)	A restrictive practice substitute decision make (RPSDM) is a person or body, that under the law of the state or territory, can give informed consent to the restrictive practice if the resident lacks the capacity to do so. In QLD, a restrictive practices guardian appointed by QCAT (QLD) is required. In NSW, a guardian by NCAT(NSW) with a restrictive practices function is required or an Enduring Guardian with restrictive practices functions is required. Refer to Restrictive practices in aged care – a last resort | Australian Government Department of Health and Aged Care.

1. Positive Behaviour Support & Care Planning Process

Changes in behaviour can be common as a person ages. This may be due to health conditions (such as pain, infections, constipation, delirium), medical diagnosis (such as dementia), the person's environment, medication interactions, physical needs, social relationships, and barriers to communication or sensory deficits (such as language or hearing/sight impairments).

Changes in behaviour can, at times, lead to behaviours of concern, such as

- Verbal or physical aggression.
- Verbal or physical agitation.
- Wandering or intrusiveness or trying to get into inappropriate places.
- Resistance to care or services.
- Socially inappropriate behaviour.
- Sexually inappropriate behaviours.
- Substance misuse/abuse.
- Or any other behaviours or reactions related to psychological symptoms, such as anxiety, depressive mood, hallucinations, delusions.

Behaviours of concern can be effectively managed with quality, person centred care planning. The behaviour care planning process is broken into 3 stages:

Stage 1: Commences at the pre-admission stage with initial screening and gathering of relevant information before the resident enters care with primary focus on:

- on completing assessments to understand care needs.
- to understand who the resident is including their likes, dislikes, family, friends, and their social history.
- thorough consultation with the resident and their family, to seek out any other information about the resident's life story that will enable the home to tailor care and understand, connect, and build a strong relationship with the resident.

Stage 2: Shortly after admission if resident is identified with behaviours of concern requiring support then the focus during this stage is to:

- Begin the behaviour support process.
- Identify the behaviour.
- Assess the ABCs (Antecedent, Behaviour, Consequence).
- Plan, implement and evaluate the Behaviour Support Plan.
- Get to know the resident and continue to gather information about the resident to inform more effective care strategies.

Stage 3: Focus is on ongoing monitoring and evaluation that is required to support new or changed behaviours.

- Use assessment tools to monitor and evaluate the Behaviour Support Plan.
- Tweak strategies if they are not effective by using what you know about the resident (e.g. their personality, previous work, old hobbies, old relationships), care assessments and discussions with partners in care (friends, family, and others).
- For new or changed behaviour repeat the behaviour support process.

The key principles of an effective Behaviour Support Process are based on identifying a change in behaviour, assessment of the level of risk and impact on the resident and other around them, developing and implementing an effective behaviour support plan and monitoring for effectiveness.

2. Behaviour Support Plans (BSP)

Effective behaviour support planning and robust behaviour support plans (BSPs) help to address responsive behaviours, reduce, and eliminate the inappropriate use of restrictive practices, ensuring they are only used as a last resort. These requirements are set out in detail in the Quality of Care Principles 2014.

The BSP brings together important information about a person's background, preferences, and behaviours. It also helps to identify when changes are required in order to meet the needs of residents to optimise their wellbeing, safety, and quality of life.

Effective behaviour support care planning should:

- Focus on developing individualised best practice strategies that are responsive to the resident's needs, in a way that reduces and/or eliminates the need for the use of restrictive practices.
- Address underlying causes of concern.
- Respond to the resident's needs.
- Safeguard and optimise the dignity, safety, and quality of life of residents who require specialist behaviour support and of others around them.

For information about what type of BSP a resident needs, refer to the RAC_Positive Behaviour Support and Restrictive Practice Procedure.

3. Restrictive Practices

In some cases, non-restrictive measures are not enough to effectively manage behaviour(s) of concern. A restrictive practice may need to be implemented to protect the dignity and safety of the resident and, at times, the safety of other residents and staff.

A restrictive practice is any action that restricts the rights freedom of movement of a resident.

- Chemical Restraint
- Environmental restraint
- Mechanical Restraint
- Physical Restraint
- Seclusion

3.1 Chemical Restraint

Chemical Restraint is the practice or intervention that is, or that involves, the use of medication or a **chemical substance** for the **primary purpose of influencing a resident's behaviour**, but does not include the use of medication prescribed for:

a) the treatment of, or to enable the treatment of, the resident for:

   (i) a diagnosed mental disorder; or

   (ii) a physical illness; or

   (iii) a physical condition; or

b) end of life care for the resident.

Most common chemical restraints are psychotropic medications. Psychotropic medications include drugs that are capable of affecting the mind, emotions, and behaviour. Three main classes include: Antidepressants, Anxiolytic/Hypnotics, Antipsychotics, and Anticonvulsants (See Appendix1: Psychotropic Medications.

Prescribing Psychotropic medications requires informed consent regarding the options, risks, and benefits. When psychotropic medications are used to manage behaviour it may be classed as a chemical restraint.

Hormonal Chemical Restraint - Hormonal agents such as cyproterone are not psychotropic medications however when used due to their anti-androgen effects to manage behaviours, are chemical restraint.

In NSW they are categorized as **"Experimental special medical treatment to which Tribunal may consent"** and require application to the NSW Civil and Administrative Tribunal (NCAT), regardless of whether or not the person responsible for the resident consents to the treatment.

3.2 Environmental Restraint

Environmental Restraint is the practice or intervention that restricts, or that involves restricting, a resident's **free access to all parts** of the resident's environment, including items and activities, for the **primary purpose of influencing a resident's behaviour.**

Some examples include but are not limited to:

- Residents living in MSU with wandering behaviours.
- Limiting the number of cigarettes a resident that smokes excessively and cannot manage a budget due to cognition.

Environmental Restraint does not include limiting access to the home's kitchen, medication room, or staff room, as these areas do not form part of the resident's environment.

3.3 Mechanical Restraint

Mechanical Restraint is the practice or intervention that is, or that involves, the **use of a device** to prevent, restrict or subdue a resident's movement for the **primary purpose of influencing a resident's behaviour**. It **does not** include the use of a device for therapeutic or non-behavioural purposes in relation to the resident.

Some examples include, but are not limited to:

- Resident attempts to get out of bed and wander into other resident's rooms. Bedrails are put in place to prevent this from happening.
- A resident in a wheelchair attempts to stand up without assistance. A lap belt is used to prevent this behaviour.

3.4 Physical Restraint

Physical Restraint is the practice or intervention that:

- is, or that involves, the use of **physical force** to prevent, restrict or subdue movement of a resident's body, or part of a resident's body, for the **primary purpose of influencing a resident's behaviour**; but
- **does not** include the use of a hands-on technique in a reflexive way to guide or redirect the resident away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the resident.

Some examples include, but are not limited to:

- Holding a resident down to administer medication.
- A resident always wants to stay in the courtyard. Most nights, staff members have to lead them back to their room while holding their hands/arms. The resident always resists.

3.5 Seclusion

Seclusion is a practice or intervention that is, or that involves, the **solitary confinement** of a resident in a room or a physical space at any hour of the day or night where:

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

for the **primary purpose of influencing a resident's behaviour**.

Some examples include, but are not limited to:

- An aggressive resident is brought to their room to calm down during an aggressive episode. Care workers bring the resident to their room and close the door. In this case, it is implied that exit is not permitted.

4. Circumstances In Which A Restrictive Practice Can Be Used

4.1 Except In An Emergency, A Restrictive Practice Can Only Be Used:

- As a last resort to prevent harm to the resident or other persons.
- After consideration of the likely impact of the use of the restrictive practice on the resident.
- To the extent possible, when best practice alternative strategies have been used before the RP is used.
- After alternatives have been trialled and documented in the resident's BSP.
- The practice is proportionate to the level of harm.
- The RP is being used in the least restrictive form, and for the shortest time necessary to prevent harm to the resident, other residents, employees, and visitors.
- Informed consent to the use of the RP and to how it is to be used, is given by the RPSDM or the resident (if they have capacity to do so).
- The use of the RP is in accordance with the consent of the resident or RSPDM.
- The RP must be documented in, and be used in accordance with, a behaviour support plan.
- The use of the RP is consistent with the Charter of Aged Care Rights.
- The use of the RP meets the requirements of the law of the State or Territory in which the RP is used.

4.2 Except In An Emergency, the Following Additional Requirements Apply to the Use of Restrictive Practices – Chemical Restraints:

The approved provider is satisfied the medical practitioner or nurse practitioner has:

- Assessed the resident as posing a risk of harm to the resident or any other person, and
- Assessed that the use of chemical restraint is necessary, and
- Prescribed medication for the purpose of using the chemical restraint, and
- Obtained the information consent to the prescribing of the medication for the purpose of using the medication as chemical restraint, and
- The requirements relating to BSP have all been met.

4.3 Requirements while RP are Being Used

While a RP is being used, the approved provide must monitor the resident for the following:

- Signs of harm or distress.
- Side effects and adverse events.
- Changes in mood or behaviour.
- Changes in well-being, including the resident's ability to engage in activities that enhance quality of life and are meaningful and pleasurable.
- Changes in the resident's ability to engage in activities of daily living (to the extent possible).

4.4 The Approved Provider Must Also:

- Ensure that the necessity for the RP is regularly monitored, reviewed, and documented.
- The effectiveness of the RP and the effect of changes in the use of the RP are monitored.
- To the extent possible, changes are made to the resident's environment to reduce or remove the need for RP.
- If the RP is chemical restraint, information about the effects and use of the chemical restraint is provided to the medical practitioner/nurse practitioner who prescribed the medication as Chemical Restraint.

If a restrictive practice is being used and the practice does not meet the above requirements, it is considered a reportable incident under SIRS. If this occurs, the incident must be escalated to the residential manager or the care manager as soon as practicable.

Refer to the RAC National Disability Insurance Scheme (NDIS) Policy Guideline when implementing Restrictive Practices with an NDIS Participant Resident.

4.5 Emergency Use of Restrictive Practices

In emergency use of a RP is required, the Home must:

- Demonstrate that the RP was required and necessary to prevent harm.
- The RP was used as a last resort.
- Inform the RPSDM in cases where the resident cannot consent to the practice.
- Update the resident's BSP.
- Inform the MP.
- Monitor the resident for signs of distress, adverse side effects/events, changes in wellbeing, and changes in ability to complete ADLs.

5. Inappropriate Use of RP

The inappropriate use of restrictive Practice is reportable under Serious Incident Reporting Scheme (SIRS).

- This includes when RP is used without prior consent or without notifying the consumer's representative as soon as practicable.
- where a restrictive practice is used in a non-emergency situation, or
- when a provider issues a drug to a consumer to influence their behaviour as a form of restrictive practice.

6. Responsibilities and Accountabilities

6.1 All Employees

In relation to Restrictive Practices, employees have the responsibility to:

- Work in accordance with CHL's Mission & Values.
- Know their resident's likes, dislikes, and preferences to provide person centred care.
- Identify and report on changes in behaviour, day to day care needs, health, cognition, pain, and changes in mood.
- Work in accordance with care plans, including behaviour support plans.
- Notify relevant employees if a care plan needs to be reviewed if a resident's care needs change.
- Report incidents of inappropriate use of restrictive practice(s).
- Complete mandatory training requirements as part of their role.

6.2 Registered Nurse (RN)

In relation to Restrictive Practices, Registered Nurses have the responsibility to:

- Meet the above expectations listed for all employees, and;
- Make the appropriate assessments, investigations, and referrals when there is a change in the resident's behaviour, health, and/or condition.
- Ensure restrictive practices are being used in accordance with the Quality of Care Principles 2014. This includes BSP and consent requirements listed in the above section, titled Circumstances in which a Restrictive Practice can be used.
- Review/implement relevant charting, in particular, behaviour charting.
- Comply with the requirements of the RAC_Positive Behaviour Support and Restrictive Practices Procedure.
- Undertake regular reviews of the BSP and update it every four months, or as required if the resident's condition changes.

6.3 Care Manager (CM)

In relation to Restrictive Practices, Care Managers have the responsibility to:

- Meet the above expectations listed for all employees and Registered Nurses.
- Comply with the RAC_Positive Behaviour Support and Restrictive Practices Procedure.
- Ensuring the RPSDM is legally empowered to make decisions about restrictive practices if the resident cannot provide consent.
- Ensuring the BSP and Restrictive Practices are compliant with the Quality of Care Principles 2014.
- Maintains the psychotropic register which includes residents with chemical restraint.
- Regularly reviews and updates the psychotropic register as medications change, to ensure residents are monitored and BSP updated.
- Conduct trend analysis of use of RP within the Home and aim towards minimising and eliminating the use or RP.
- Report trends and data of use of RPs at meetings as required.
- Make any mandatory reports within the required timeframes, including National Quality Indicators Data, reporting to ACQSC via SIRS, and reporting to NDIS Commission as required.

6.4 Medical Practitioner (MP) / Nurse Practitioner (NP) (Chemical Restraint Only)

In relation to Restrictive Practices, Medical Practitioners / Nurse Practitioners have the responsibility to:

- Clinical assessments and documenting changes in medication.
- Ensuring alternative treatment options are exhausted prior to prescribing a Chemical RP.
- Indication for medication is correctly documented. If psychotropic medication is being used to treat a medical condition, the diagnosis must be listed in the resident's diagnosis list on eCase.
- Regularly review and evaluate the requirement for the Chemical restraint, reduce and deprescribe where possible.
- Comply with Quality of Care Principles 2014.

6.5 Residential Manager (RM)

In relation to Restrictive Practices, Residential Managers have the responsibility to:

- Residential manager is responsible and accountable for ensuring the Home complies with the Age Care Act and Quality of Care Principles.
- Liaising with MP/NP, AR, and the resident regarding the implementation of a restrictive practice, including consent requirements.
- In cases where the resident cannot consent and there is no RPSDM, approaching the Guardianship Division of NSW Civil and Administrative Tribunal (NCAT) or the Guardianship Division of Queensland Civil and Administrative Tribunal (QCAT).
- Conduct trend analysis of use of RP within the Home and aim towards minimising and eliminating the use or RP.
- Report trends and data of use of RPs at meetings as required.
- Updating relevant data tools and reports of RP's in the Home.
- Report to relevant regulatory bodies as required when the use of a RP is unauthorised or inappropriate.
- Provide the resident and family with information that enables an informed decision regarding restrictive practice including potential consequences for having or not having restrictive practices in place. The potential side effects of medications such as psychotropic's used in the treatment of medical conditions used for behaviour management.
- Residents and relatives have been provided Fact sheets in relation to restrictive practice, consent, and legislation around restrictive practice in aged care.

6.6 Regional Manager

In relation to Restrictive Practices, Regional Managers have the responsibility to:

- Support Homes in their region are complying with Quality of Care Principles and the Aged Care Act.
- Identify gaps in knowledge/practice and address those gaps as they arise.
- Ensure the home has an active Medication Advisory Committee that reviews the use of high risk Medications and the use of Restrictive Practice in the home.

6.7 Clinical Governance and Safe Care (CGSC) Team

In relation to Restrictive Practices, CGSC Team have the responsibility to:

- Monitor and reviews the Residential Aged Care Homes for compliance in the use of restrictive Practice. Analyse Trends for the use of polypharmacy, high risk medications including psychotropic's and Chemical restrictive practice across the organisation.
- Review incidents to identify trends, including any SIRS, related to restrictive practice and reviews National Quality Indictor data to identify opportunities for improvement.
- Provide reports to the Quality and Safety Committee.

6.8 Legal Team

In relation to Restrictive Practices, CGSC Team have the responsibility to:

- Provide support in the NCAT or QCAT applications.
- Ensure CHL is informed of the changes in legislation and is supported in the implementation of the new requirements.

7. Consent Requirements

Refer to the RAC_Positive Behaviour Support and Restrictive Practices Procedure for frequency of consent requirements.

Restrictive Practice can only be used where informed consent has been given by the resident themselves or if the resident lacks capacity, the restrictive practice decision maker (RPSDM). A RPSDM is a legally appointed guardian that has a Restrictive Practices function detailed in their Guardianship Order.

If no-one is authorised as the RPSDM an application is required to the Guardianship Division of NCAT or to the Guardianship Division of to appoint a RPSDM.

7.1 Transitional Arrangements for Residents that Do Not Have Capacity to Consent for A RP:

A person can act as a RPSDM in cases where no one is legally appointed RPSDM and an application to NCAT/QCAT has been submitted seeking a Guardian with a Restrictive Practices Function. This is a temporary arrangement until 1 December 2024.

Refer to RAC_Positive Behaviour Support and Restrictive Practice Procedure.

Appendix 1: Psychotropic Medications Include but are not Limited To:

Drug Class	Example: Generic (Brand) Names
Antipsychotics	1. Aripiprazole (Abilify, Abyraz) 2. Chlorpromazine (Largactil) 3. Clozapine (Clozaril) 4. Haloperidol (Serenace) 5. Olanzapine (Zyprexa, Lanzek, Zypine) 6. Periciazine (Neulactil) 7. Quetiapine (Seroquel, Delucon, Quetia) 8. Risperidone (Risperdal, Rispa, Rixadonel) 9. Trifluoperazine (Stelazine) 10. Ziprasidone (Zeldox)
Antidepressants	1. Agomelatine (Valdoxan) 2. Amitriptyline (Endep) 3. Citalopram (Celapram, Talam, Cipramil) 4. Clomipramine (Anafranil) 5. Desvenlafaxine (Desfax, Pristiq) 6. Dothiepin (Dothep) 7. Doxepin (Sinequan, Deptran) 8. Duloxetine (Andepra, Drulox, Cymbalta) 9. Escitalopram (Cilopam, Lexam, Lexapro) 10. Fluoxetine (Zactin, Lovan, Prozac) 11. Fluvoxamine (Faverin, Luvox) 12. Imipramine (Tofranil) 13. Mirtazapine (Mirtazon, Avanza, Axit, Remeron) 14. Moclobemide (Aurorix, Amira) 15. Nortriptyline (Allegron) 16. Paroxetine (Paxtine, Aropax) 17. Reboxetine (Edronax) 18. Sertraline (Xydep, Eleva, Sertra, Zoloft) 19. Venlafaxine (Efexor, Elaxine, Enlafax) 20. Vortioxetine (Brintellix)
Anxiolytics (for Anxiety) & Sedatives/Hypnotics (for Sleep)	1. Alprazolam (Kalma, Alprax, Xanax) 2. Clonazepam (Paxam, Rivotril) 3. Diazepam (Antenex, Valpam, Valium) 4. Lorazepam (Ativan) 5. Oxazepam (Alepam, Serepax, Murelax) 6. Nitrazepam (Alodorm, Mogadon) 7. Zolpidem (Stildem, Stilnox) 8. Zopiclone (Imrest, Imovane) 9. Temazepam (Temtabs, Temaze, Normison)
Anticonvulsants	1. Carbamazepine (Teril, Tegretol) 2. Gabapentin (Gabacor, Neurontin) 3. Lamotrigine (Lamictal, Lamitan) 4. Phenytoin (Dilantin) 5. Pregabalin (Lyrica, Lypralin) 6. Sodium valproate (Epilim, Valprease, Valpro)
Mood Stabilisers	1. Lithium Carbonate (Lithicarb, Quilonum)
Anti-Dementia medications	1. Cholinesterase inhibitors: a. Donepezil (Aricept, Arizil) b. Galantamine (Galantyl, Gamine, Reminyl) c. Rivastigmine (Exelon, Rivastigmelon) 2. Memantine: a. Memantine (Ebixa, Memanxa, Namenda)
Opioids	1. Buprenorphine (Temgesic, Norspan) 2. Codeine (codeine phosphate, codeine linctus) 3. Methadone (Physeptone, Biodone Forte) 4. Fentanyl (Abstral, Fentora, Actiq, Durogesic) 5. Tapentadol (Palexia) 6. Tramadol (Tramal, Zydol) 7. Oxycodone/Naloxone (Targin) 8. Hydromorphone (Dilaudid, Jurnista) 9. Morphine (Ordine, MS Contin, Kapanol, Contin) 10. Oxycodone (Endone, OxyContin, OxyNorm)
Other	1. Melatonin 2. Cannabis Oil CBD

End of Policy

Review History

Version Number	Date of update	Version Number	Date of update
		Version 15	29 Nov 2021
		Version 14	01 July 2021
		Version 13	08 Feb 2021
Version 19	28 Apr 2023	Version 12	11 Feb 2020
Version 18	13 Feb 2023	Version 11	30 Oct 2019
Version 17	10 May 2022	Version 10	27 Aug 2019
Version 16	18 Mar 2022	Version 9	22 Jun 2019

Reference & Related Documents

References	• Bedrails – Adult Inpatient Use, South-Eastern Sydney Illawarra NSW Health, 2020. • Bed Rails Clinical Considerations for Prescribers, Government of South Australia, 2015. • Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia, AHPRA. • Consent to medical or dental treatment fact sheet, NCAT Guardianship Division. • Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care, Australian Government Department of Health and Aged Care 2012. • Frequently asked questions about consent, Aged Care Quality and Safety Commission. • Good Medical Practice: A Code of Conduct for Doctors in Australia, Australian Medical Council. • New consumers and restrictive practices fact sheet, Aged Care Quality and Safety Commission. • Overview of restrictive practices, Aged Care Quality and Safety Commission. • Prescribing psychotropic medications to people in aged care – information and resources, Australian Government Department of Health and Aged Care. • Psychotropic medications used in Australia information for aged care, Aged Care Quality and Safety Commission. • Restrictive practices in aged care – a last resort, Australian Government Department of Health and Aged Care. • Restrictive Practices and Guardianship fact sheet, NSW Civil and Administrative Tribunal (NCAT). • Restrictive practices, Queensland Civil and Administrative Tribunal (QCAT). • Safe use of bed rails, Government of South Australia, 2015. • Safe use of bed rails, Medicines and Healthcare Products Regulatory Agency (UK), 2013. • What Nurses Need to Know, Environmental Health Unit, QLD Health, 2008
Related Policies, Procedures & Guidelines	• eCase Quick Reference Guide (QRG): ○ Completing eCase Documentation for Case Conferences • RAC National Disability Insurance Scheme (NDIS) Policy Guideline • RAC_Positive Behaviour Support and Restrictive Practice Procedure

Related Documents & Forms	Documents: • RAC Auditing Documentation eCase Assessment: • Cornell Depression Scale Assessment • Medication Assessment • Mobility and Transfers Assessment • PAS – CIS Assessment (Generated Behaviour Care Plan) • Risk Assessment • Sleep Assessment eCase Care Planning: • Behaviour Care Plan • Medication Care Plan • Mobility and Transfers Care Plan • Risk Care Plan • Sleep Care Plan eCase Chart and Work Log ONLY Activities: • Behaviour Identification and Interventions Chart • Case Conference Chart • Complex Health Care Procedure Chart • Falls Risk Assessment Tool (FRAT) Form • RAC Psychotropic and Chemical Restrictive Practice Consent Form • RAC Restrictive Practice Consent Form – Excluding Chemical • RAC Restrictive Practice Resident Self-Nomination Form • RAC Restrictive Practice Substitute Decision Maker Nomination Form • SOM – Clinical Directive Register
Aged Care Quality Standards & NDIS	This policy may impact on the following Aged Care Quality Standards and NDIS: • Standard 1 – Consumer dignity and choice • Standard 2 – Ongoing assessment and planning with consumers. • Standard 3 – Personal care and clinical care • Standard 8 – Organisational governance • NDIS Practice Standards and Quality Indicators
Legislation & Rules:	This policy is guided by the following legislation & rules: • Aged Care Act 1997 • National Disability Insurance Scheme Act 2013 • National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 • NDIS Quality and Safeguarding Framework • NSW Guardianship Act 1987 • NSW Guardianship Regulation 2010 • QLD Guardianship Administration Act 2000 • Quality of Care Principles 2014 • User Rights Principles 2014 - Charter of Care Recipients' Rights and Responsibilities

Key words for search

Restraint, Physical, Environmental, Aversive, Authorised Representative, Bedrails, Concave Mattresses, Lap Belts, Seat Belts, Pelvic Belts, Risk, Fact Sheet; Low Bed; Special Care Unit, Bed against Wall, Restrictive Practice, Mechanical Restraint, Seclusion