PROCEDURE

RAC_Positive Behaviour Support & Restrictive Practice Procedure

Overview

- Changing in behaviour in older people can lead to behaviours of concern.
- The behaviours can be responsive to changes related 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).
- Behaviours of concern can generally be effectively managed with quality person centred care planning which should be captured in the resident's individualised behaviour support care plan.
- In some cases, non-restrictive practices are not enough to effectively manage behaviours of concern.
- A Behaviour support plan is required for any resident who requires or may require the use of restrictive practices as part of their care.
- This procedure outlines the process required for developing a behaviour support plan and requirements prior to implementing restrictive practices with the exception of an emergency.

RAC_Positive Behaviour Support & Restrictive Practice Procedure

Contents

1. Management of Behaviour(s) of Concern (BoC)

- In cases where a resident is expressing BoC, consideration should be given to the underlying cause of the behaviour(s). Consider areas of their day to day life where their needs may not be fully met. Addressing the underlying cause of the behaviour can be the most effective way to prevent the BoC.
- Whenever a resident has a history of behaviours of concern or is expressing a BoC, a Behaviour Support Plan (BSP) must be developed, and behaviour charting must commence.
- Residents who have a history on admission should have a BSP commenced soon after admission in consultation with the resident and those who know the resident.
- See section 2 for information on the development of BSPs.

1.1. Identify Cause of Behaviour of Concern

- Health conditions, e.g., constipation, pain, infection, delirium.
- Medical Diagnosis: Cognitive, Mental Health.
- Medication: Interactions, changes, polypharmacy.
- Environment: Noise, unfamiliar people place.
- Physical Needs: Thirst, hunger toileting.
- Sensory: Language, hearing, sight impairment.
- Social Relationships: interactions with others.

1.2. Investigate Behaviour of Concern

- Clinical Assessments to determine cause.
- Consult with MP/NP/ED transfer request further investigations. (clinical review, blood pathology, urine culture).
- Consider RMMR for medication review.
- Consultancy service referral: Geriatrician, Dementia Advisory Service, Older People Mental Health Service.

1.3. Documenting Behaviours of Concern

- A record of current behaviours of concern must be kept in the resident's BSP on eCase.
- Records of behaviour should be documented in the resident's ***eCase Behaviour Identifications and Interventions Chart*** and the ***eCase Progress Notes***. All residents who express behaviours of concern should have ongoing behaviour charting in order to properly monitor and track behaviours including changes in behaviour.
- When documenting in the behaviour chart, all sections of the chart must be completed.
- Please refer to the eCase QRG Completing Behaviour Identification and Interventions Chart. A video walk though of the process is available by clicking here. Please note, the ACFI requirements present in the video are no longer applicable.

1.4. Reporting Incidents Related to Behaviours of Concern

- Behaviours of concern can result in an incident occurring. For example, incidents of verbal/physical aggression directed at another person resulting in emotional/physical harm of any level.
- All resident incidents are to be documented in the ***eCase Resident Incident Register***. If the incident is reportable under the Serious Incident Response Scheme (SIRS), it must be reported to the ACQSC via the My Aged Care (MAC) Portal. Refer to ACQSC Decision Tool for guidance.
- For SIRS Incidents,
    - If the alleged offender is a resident, complete the ***eCase Resident Incident Register***.
    - For the alleged victim, complete the ***eCase SIRS Register***.
- If the incident related to the behaviour of concern results in the injury of an employee (both physical and psychological), the incident must be reported to My Safety.
- **For reporting and managing incidents, please refer to the RAC Incident Management System (IMS) Manual. All incidents related to behaviours of concern must follow the process outlines in the RAC IMS Manual.**
- **BoC and changes in behaviour must be escalated to the Care Manager or Residential Manager as soon as practicable.**

2. Behaviour Support Plan and When & What

The behaviour support plan should be individualised, current, relevant, and accessible.

It is recommended the BSP be developed with multidisciplinary input such as the resident, family, lifestyle staff and care team. The behaviour support plan in eCase should include:

2.1. A General BSP

A general BSP must be developed for any resident that demonstrates behaviours of concern even if the resident is not under any form of restraint.

The key elements of these are outlined below:

A. Information about the Person: Information and assessments about the person that help a provider to understand the person and their behaviour for example:

- Key relationships- family friends in current and past life.
- Resident background, culture, religious or spiritual, and language.
- Education, work background.
- Likes and Dislikes.
- Interests – sports, leisure, music, hobbies, travel.
- Trauma background or significant struggles/challenges.
- What is particularly important to the resident.

B. Information about the Behaviour: Information about the changed behaviour and for each occurrence of a new changed behaviour*:

- Time, date, duration.
- Any related incidents.
- Adverse consequences.
- Warning signs/triggers.

**A new changed behaviour includes a change in the type/ manifestation of behaviour; frequency/ intensity of behaviour; or response to existing strategies.*

- Assessments completed:
  - Delirium screen (eCase Delirium Screening Tool Chart), Depression screen (eCase Cornell Depression Scale), behaviour charts (eCase Behaviour Identification and Interventions Chart (BIIC)), pain charts (eCase Pain (Abbey) chart), vital signs.
  - Using Stop and Watch tool by carers for early identification of changes.

C. Consultation and Consent: A description of the consultation on use of the care strategies with the resident or representative. Additional external consultation (e.g. with DSA) may also be included who are the specialist(s) involved / consulted regarding the residents care.

- Advice from specialists, Dementia Australia, MP.
- Free text section in eCase Behaviour Essential can include names of those specialist who have been consulted in residents care.

D. Behaviour of Concern: Each behaviour of concern should be listed separately with the below information:

- What is the actual behaviour. Either known by family history or from review of the behaviour charts.
- What are the warnings/triggers/causes.
- What are the triggers for the behaviour (e.g. noise, people, pain).
- What are the setting events for the behaviour, including time of day and environment.
- What normally settles the behaviour, such as family, food, soothing, companionship, reassurance, activity. These are known as successful interventions.
- What interventions are unsuccessful in de-escalating the behaviour.
- What interventions are successful in preventing the behaviour(s) from occurring.
- What is the risk of the behaviour to the resident or others. (psychological / physical/ emotional).

E. Information about Care Strategies:

- Best practices strategies**.
- Other strategies used including information about their effectiveness and records of their monitoring and evaluation.
- Other strategies considered.

***Those that: 1) are best practice alternatives to the use of restrictive practices. 2) consider the person's preferences/ things that are meaningful to them. 3) improve quality of life/ engagement.*

Care plan strategies in the BSP should include information about how to address behaviours of concern, including:

- Setting events for behaviours.
- Effective strategies to prevent behaviour.
- Effective strategies to manage the behaviour(s) when they occur.
- Ineffective strategies to manage behaviour that have been trialled in the past.

2.2. A BSPs for Residents for Whom Use of Restrictive Practices

A BSPs for residents for whom use of restrictive practices is assessed as necessary (s15HC of QoCPs), restrictive practices are used (s15HD); or a review of the use of the restrictive practices indicates on ongoing need for the restrictive practices (s15HE).

All aspects of General BSP (outlined above) along with additional criteria outlined below:

A. Additional Information about the Behaviour and Care Strategies:

Additional information about the behaviour that is relevant to use of the restrictive practices and about best-practice alternative strategies that must be used, or any other actions that were taken, before the use of the restrictive practices.

B. Information about the Restrictive Practices:

Information about the restrictive practices including how it is to be used, when the restrictive practices began to be used, its duration, frequency and intended outcome of use (and whether that was achieved).

C. Additional Information Regarding Consultation and Consent:

A description of the consultation about the use, or ongoing use of the restrictive practices with, and a record of consent by, the resident or the 'restrictive practices substitute decision-maker' (as per state and territory government requirements). Also include consultation with external services (e.g. DSA) about use of restrictive practices.

D. Monitoring and Escalating the Restrictive Practices:

Information about how the restrictive practices or ongoing use of the restrictive practices is monitored and escalated (considering the nature of the restrictive practices and any care needs that arise out of use of restrictive practices).

E. Reviewing the Restrictive Practices:

Information about how use of restrictive practices/ ongoing use of restrictive practices, will be reviewed including:

- whether the intended outcome of its use was achieved;
- alternative strategies could have been used to address the changed behaviour;
- a less restrictive form of restrictive practices could have been used to address the changed behaviour;
- there is an ongoing need for use of the restrictive practices; and
- if chemical restraint, whether the medication that is the restrictive practices, can or should be reduced or stopped.

F. Other Assessments/ Documentation***

This includes any assessments, documentation or consultation that led the medical practitioner or nurse practitioner (for chemical restraint only) to be satisfied that the use of the restrictive practices was necessary.

****These must be included if the restrictive practices are assessed as necessary, in accordance with s 15FB or 15FC of the Quality of Care Principles (QoCPs) 2014.*

2.3. Additional Items that must be Documented in A BSP Where A Resident is Under Chemical Restraint

Along with the criteria outlined above, except in an emergency, the following must be documented in BSP where an RP being chemical restraint is to be used:

- The assessments.
- The practitioner's decision to use the chemical restraint.
- The care recipient's behaviours that re relevant to the need for the chemical restraint.
- The reasons why the chemical restraint is necessary.
- The information(if any) provided to the practitioner that informed the decision to prescribe the medication for the purpose of using the chemical restraint.
- That the approved provider is satisfied with the practitioner obtained informed consent to the prescribing of the medication.
- The details of the prescription.
- A description of the prescribed medication, including its name, dosage and when it may be used.
- A description of any engagement with external support services (e.g. dementia support specialists) in relation to the assessments.
- That the use of the medication for the purpose of chemical restraint is in accordance with the prescription (QoCPs 15 FC (2)).

The consultation requirements above continue to apply.

Where an RP (being chemical restraint) is used in an emergency, as soon as possible after the emergency, the BSP must be updated/created to state:

- The care recipient's behaviours that were relevant to the need for RP.
- The alternate strategies that were considered or used (if any) before the use of the RP.
- The reasons why the RP was necessary.
- The care to be provided to the care recipient in relation to their behaviour.
- If the RSPM was informed about the emergency use of the RP, a record of the conversation.
- Ensure that assessments in the BSP are either updated or created as appropriate.
- The practitioner's decision to use the restraint.
- The information provided to the practitioner.

A description of any engagement with external support services (e.g. dementia support specialists) (QoCPs 15FG (b), (d)).

2.4. BSPs for Residents Requiring the Use of Restrictive Practices in An Emergency

All of the criteria outlined above continue to apply along with additional criteria outlined below:

- Where an RP is used in an emergency, as soon as possible after the emergency, the BSP must be updated/created to state:
  - The care recipient's behaviours that were relevant to the need for RP.
  - The alternate strategies that were considered or used (if any) before the use of the RP.
  - The reasons why the RP was necessary.
  - The care to be provided to the care recipient in relation to their behaviour.
  - If the RSPM was informed about the emergency use of the RP, a record of the conversation.
  - Ensure that assessments in the BSP are either updated or created as appropriate.
  - The practitioner's decision to use the restraint.
  - The information provided to the practitioner.
- A description of any engagement with external support services (e.g. dementia support specialists) (QoCPs 15FG (b), (d)).

NDIS Residents ONLY:

If an NDIS resident is expressing behaviour(s) of concern, please contact your Regional Manager and CHL's NDIS Coordinator immediately. There are additional legal requirements related to NDIS Residents who demonstrate behaviour(s) of concern.

3. Implementing a Restrictive Practice (RP)

The steps to implement the use of one or more RPs are:

1. Assess alternative strategies to the RP and consider whether the BoC can be managed with these alternative strategies. All strategies trialled, including both effective and ineffective, should be documented in eCase Progress Notes, Behaviour Chart, and noted in the BSP.
2. Assess the potential consequences of the RP (both positive and negative) and consider if the RP will be effective in achieving its desired outcome.
3. Assess if the RP is necessary to prevent harm to the resident, other residents, employees, visitors, or anyone else on CHL Premises. RP should only be used as a last resort, be the least restrictive option, and used for the shortest time possible.
4. Develop BSP in accordance with *the Quality of Care Principles (QoCPs) 2014*.
5. Gain consent for the Practice. If the resident cannot consent, ensure there is an appropriately appointed RPSDM (Refer to Session 6: Consent for Restrictive Practices).
6. Ensure the RP is listed in the resident's Alerts on eCase.

3.1. Implementing an RP with a NDIS Resident

NDIS Residents are dual RAC/NDIS Residents, meaning CHL must comply with both NDIS & Aged Care Laws. Therefore, the above steps 1 – 3 and 6, in Section 3 apply in addition to the below:

1. Obtain a BSP from an NDIS Registered Behaviour Support Practitioner. The Home cannot write a BSP that contains the use of an RP with an NDIS Resident.
2. If the resident cannot consent, ensure the person consenting is legally empowered to do so, i.e. they have a restrictive practices function detailed in their Guardianship Order or Guardianship documentation.
3. Obtain authorisation in accordance with State/Territory Requirements. This is through the Department of Communities and Justice (DCJ) in NSW.

If an NDIS Resident requires a BSP, immediately contact CHL's NDIS Coordinator.

4. Identifying Restrictive Practices (RP)

In some cases, RP are used to manage BoC. Categories of RPs include chemical restraint, mechanical restraint, physical restraint, environmental restraint, or seclusion. Please see RAC_Positive Behaviour Support and Restrictive Practice Policy for more information, including definitions of the mentioned RPs.

What is a Restrictive Practice and how is it defined:

- Restrictive practice limits the rights of a person that may stop a resident doing what they want to do.
- Restrictive practice refers to practices, interventions, medications, or chemical substances that are used to restrict a consumer's free movement, restrict access to their environment, and or influence their behaviour.

Please see decision trees showing each RP to guide you in making a determination if a practice is an RP in Annexure A. RAC staff should consult their Regional Manager, Regional Support Manager, or Regional Quality Manager if they have any questions or concerns about any RP being used, or potentially being used with residents in the Home.

Note: Decision trees in Annexure A are a guide only and dependant on individual situations. Please contact your regional support manager, regional quality manager, or regional manager if you have further questions regarding the outcome of the decision tree.

5. Inappropriate use of RP

Inappropriate use of RP is considered a reportable incident under the SIRS. For information about inappropriate use of RP and how to report to the ACQSC via the MAC Portal, please refer to the IMS Manual. The ACQSC has developed a sample response to assist you in reporting the inappropriate use of RP.

5.1. NDIS Unauthorised Use of RP

- There are **significant differences** in the rules and legislation around restrictive practices involving NDIS Residents.
- Please refer to the RAC National Disability Insurance Scheme (NDIS) Policy Guideline and the RAC IMS Manual for more information.
- The **Regional Manager and CHL's NDIS Coordinator must be notified of any NDIS Residents with a RP**. They must also be notified of any changes to an NDIS Resident's RP.

If you are unsure of your reporting requirements, please contact your Regional Manager or Regional Support Manager.

6. Consent for Restrictive Practices

6.1. Who can Consent to a Restrictive Practice?

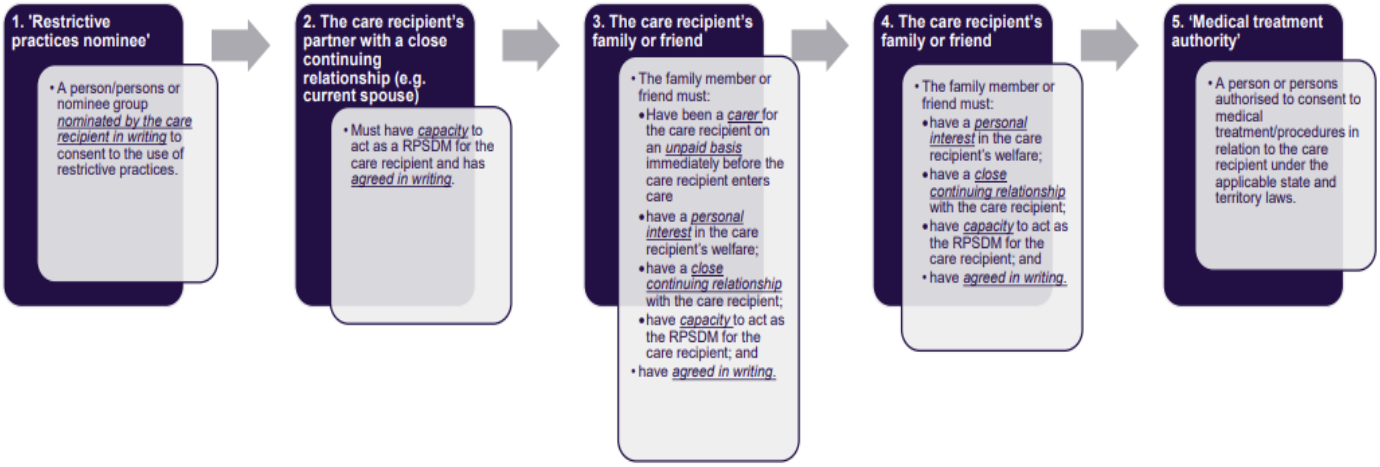
- A resident is only able to provide consent for a RP if they have capacity to do so.
- If the resident does not have capacity to provide consent, a RPSDM must be appointed.
    - A RPSDM is a person that is legally empowered to make decisions about RPs. This means:
        - In NSW: the Guardian has a Guardianship Order or an Enduring Guardianship Document that contains a Restrictive Practices Function detailed in the Order/Document.
        - In QLD: The Guardian has a Guardianship Order that contains a Restrictive Practices Power detailed in the Order.

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

Until 1 December 2024, consent for a RP can be provided by someone who is not a legally appointed RPSDM if an application has been submitted to NCAT/QCAT.

The person providing consent under this transitional arrangement must meet one or more of the below requirements:

- Restrictive practices nominee- an individual person/people nominated by the resident ***in writing*** to provide consent to restrictive practices on their behalf.
- Partner who has a close continuing relationship with resident and has *agreed* ***in writing*** to act as RPSDM.
- Relative/friend who was a carer - on unpaid basis immediately before resident entered care, has a close relationship and personal interest in the welfare of the resident and has *agreed* ***in writing*** to act as RPSDM.
- Relative/ friend who was not the carer who has a personal interest in the welfare of the resident and has *agreed* ***in writing*** to act as RPSDM.
- Medical treatment authority- an individual or body appointed ***in writing*** under law, who can give consent to provide medical treatment to the resident if the resident lacks capacity to give that consent.



During the transitional timeframe one of the following forms should be signed to ensure we meet the consent requirements.

A CHL restrictive practice nomination form must be signed if restrictive practice is used while a resident of RAC.

I. RAC Restrictive Practice Resident Self-Nomination Form

RAC Restrictive Practice Resident Self-Nomination Form should be signed by a resident, who has the capacity to consent, to the use of restrictive practices in accordance with their behaviour support plan. The type of restrictive practice will be clearly described and there will have been consultation on the use and possible impact.

II. RAC Restrictive Practice Substitute Decision Maker Nomination Form

RAC Restrictive Practice Substitute Decision Maker Nomination Form should be signed by a person who has been appointed as a RPSDM for a resident while waiting for the Guardianship Application to be approved or in NSW has an Enduring Guardian with RP function. The type of restrictive practice will be clearly described and there will have been consultation on the use and possible impact. This should be in accordance with the resident behaviour support plan.

The nomination form and any other forms associated with tribunal application and appointments should be uploaded into the *eCase gallery under "Legal Documents - Consents or Other."*

6.3. Restrictive Practice Consents - In Addition to the Above Forms

I. Psychotropics and Chemical Restrictive Practice Consent Form

Medical Practitioner / Nurse Practitioner is required to obtain **written informed consent** on the commencement of **new psychotropics** and **following changes in psychotropics**.

The MP/NP must review, consider a reduction of medications used for **Chemical Restraints every 3 months.** Chemical restraints must be formally approved by the Restrictive Practice Substitute Decision Maker or legally approved Guardian at **commencement of and following changes** in medication with minimum annual using written consent.

RPSDM should be kept informed and updated on the resident's condition, any changes which could be related to the medication.

II. RAC Restrictive Practice Consent Form – Excluding Chemical

RAC Restrictive Practice Consent Form – Excluding Chemical should be completed by an approved health practitioner is defined as a Medical Practitioner, Nurse Practitioner or Registered nurse and the RPSDM who has assessed and determined the requirement for restrictive practice. (Environmental, Mechanical, or other)

The RPSDM is required to authorise and sign the consent, prior to the use of restrictive practice which should be reviewed on a regular basis and resigned at least **annually**.

The behaviour support plan is also reviewed and updated **every 4 months** as part of the monitoring procedure for all restrictive practices.

Restrictive Practice Consents - should be uploaded into the *eCase Gallery under 'Legal Documents-Consents.'*

7. Application for Guardianship to NCAT / QCAT

A Guardianship application is required for restrictive practice when the resident no longer has capacity to make an informed decision regarding their care needs.

1. Consult with the resident and friends/family about the need for a RPSDM. Allow them to nominate a person that would be the best person(s) for the role.
    a. If the resident does not have any friends/family, speak to the resident about the need for a RPSDM and explain that an application to NCAT/QCAT will have to be made.
2. Explain to the resident and the nominated person the need for an NCAT/QCAT application for a RPSDM to be appointed. Refer to your Regional Manager if you are receiving strong objections from family/friends/resident.
3. Draft a NCAT/QCAT application for a Guardian with a RP Function.
    a. For NSW, the Guardianship orders form can be found here.
    b. For QLD, the Application for administration/guardianship appointment or review - Guardianship and Administration Act 2000 form can be found here.
4. Gather supporting documents for the application.
    a. You must demonstrate that:
        i. The resident lacks capacity to make their own decisions (this could be a letter from the MP).
        ii. There is a need for a guardian, i.e., there are current decisions that need to be made that cannot be made informally.
5. Forward the application with supporting documents to your Regional Manager, who will then consult with the Legal Team or other relevant stakeholders.
6. Speak to the nominated RPSDM and the resident the application is about to explain that you are submitting the guardianship application to NCAT/QCAT.
7. Once approval is received from your Regional Manager, submit the application per the instructions on the form.
8. Provide a copy of the application to the resident and proposed RPSDM.
9. Wait to receive a Notice of Hearing from NCAT/QCAT. This could take a few weeks.
10. Once Notice of Hearing is received, set up a calendar invite to all involved with details of how to attend the meeting.
11. Attend the meeting on the Hearing date. After the hearing, you will receive a formal notice of the outcome, which will include the Guardianship Order.
12. Once the Guardianship order is received, ensure it is uploaded to *eCase gallery under "Legal Documents Other"*.

Note – a Guardianship Order will suspend other Guardianship Orders, including Enduring Guardianships. If the enduring guardianship document has additional powers that are still required, ensure that they are included in the NCAT/QCAT Application.

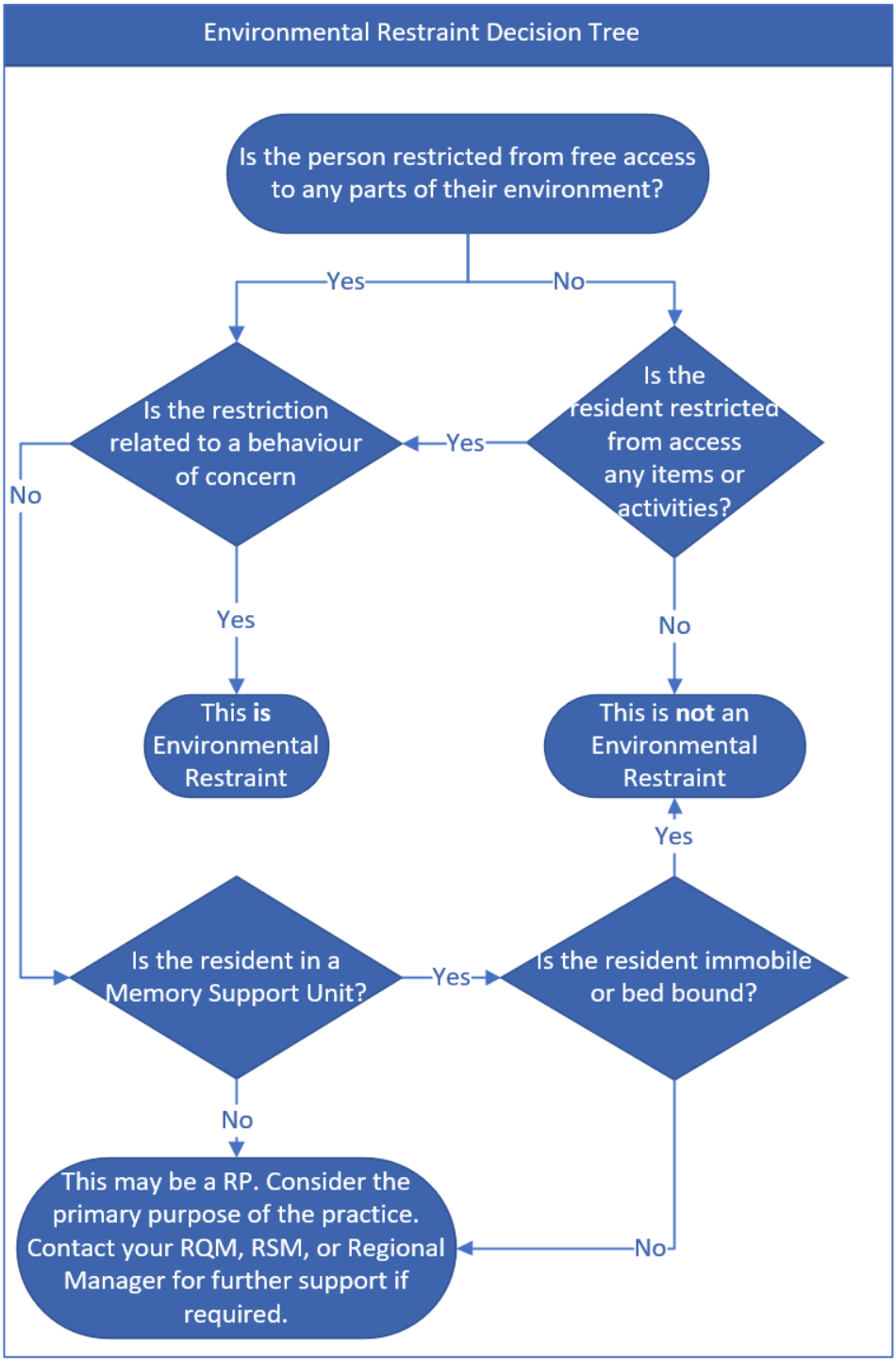
8. Other Resources

For further information about positive behaviour support, please refer to the Dementia Support Australia Website.

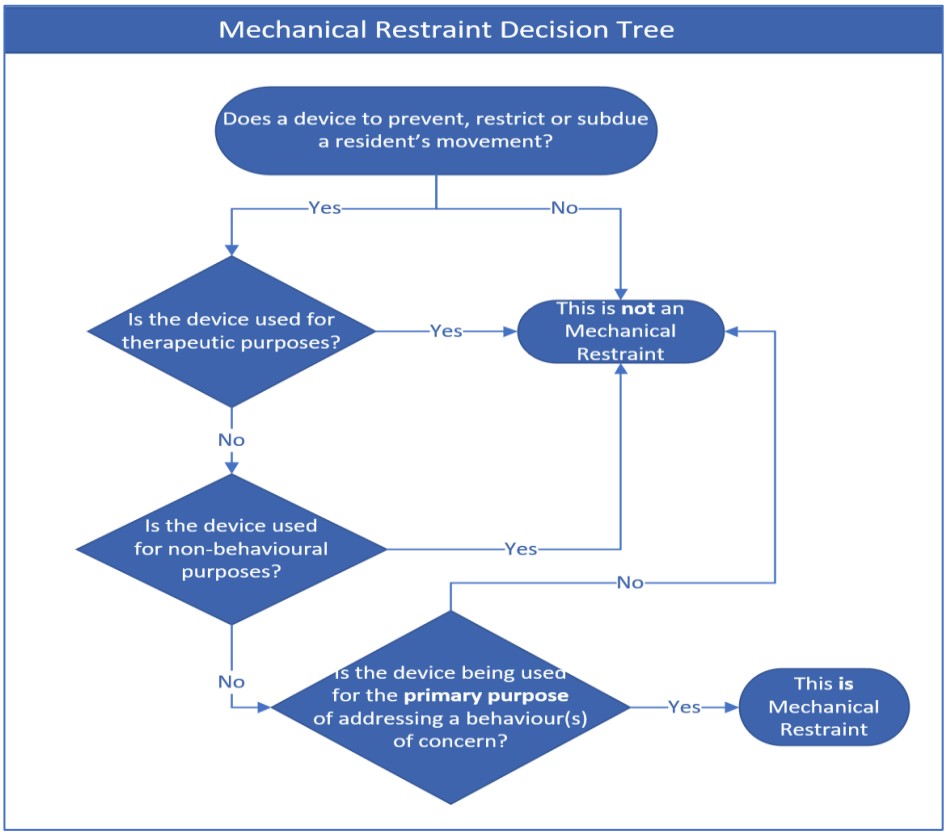
Annexure A: RP Decision Support Trees

Note: Use as a guide only. RP should be assessed on a case by case basis. Contact your regional support manager, regional quality manager, or your regional manager for further clarification.

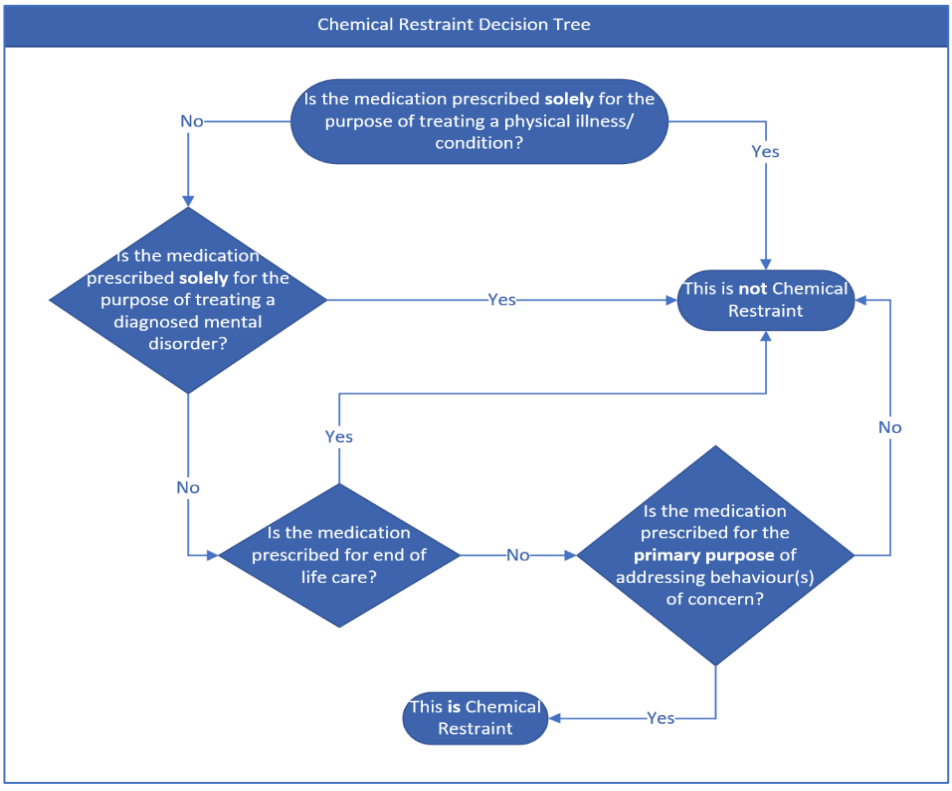
Environmental Restraint Decision Tree



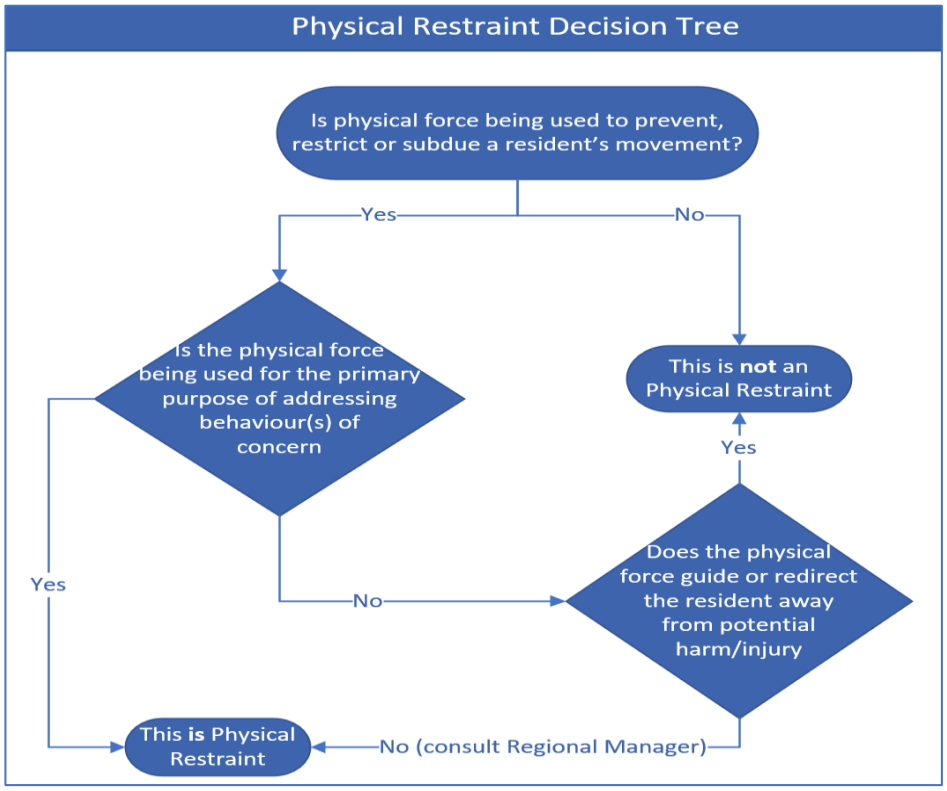
Mechanical Restraint Decision Tree



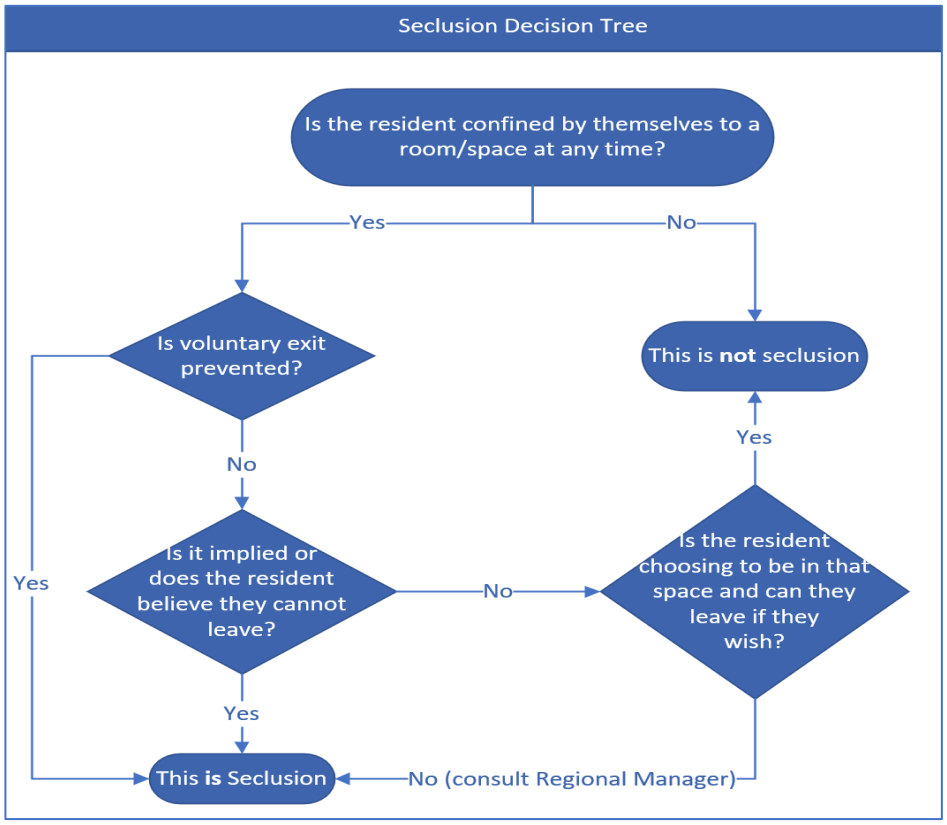
Chemical Restraint Decision Tree



Physical Restraint Decision Tree



Seclusion Decision Tree



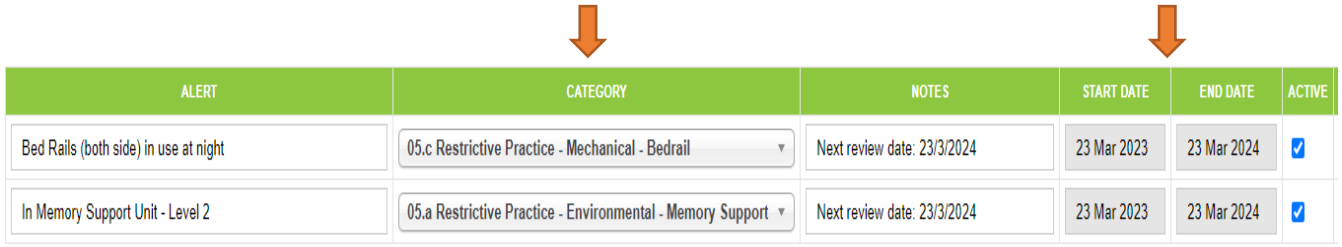
Annexure B: Documentation and Process Map for Behaviour Assessment & Care Planning

Step	Documentation	Role Responsibility
1. Determine the Resident's Needs and Choices	• New admission resident - review National Screening and Assessment Form (NSAF)/Aged Care Client Record (ACCR). • Review the Resident's BIIC. • Assess the risk to self and others- does the Resident require emergency treatment. • Consult with care staff, family, Authorised Representatives, Medical Practitioners, NDIS support coordinator, and other Allied Health Professionals where possible to establish a life history and to identify current effective person-centred strategies. • Complete the ***eCase PAS – CIS Assessment (Generated Behaviour Care Plan)*** and ***Cornell Depression Scale Assessment.***	RN/EN/ Management
2. Investigate the Cause of the Behaviour	Investigation: • Behavioural disturbances may be a result of several factors including but not limited to: o Health conditions e.g.: constipation, pain, infections, delirium. o Medical diagnosis (Cognitive/Mental Health). o Person environment, e.g.: noise, unfamiliar environment. o Activities of daily living e.g.: resistive to care provision. o Medication interactions e.g.: polypharmacy, medication changes. o Social relationships, e.g.: interactions with other people. o Communication and sensory, e.g.: language barriers, hearing/vision impairment. o Physical needs, e.g.: hunger, thirst. o Chemical imbalances. Recommendation: • Consult with the Medical Practitioner and undertake blood tests / urinalysis as required • Consult with the Medical Practitioner and Pharmacist to check medication interactions as required • Consult with the Allied Health Professionals and/or refer to Specialist Services as appropriate. For example: Dementia Support Australia (DSA) resources to assist with Behavioural and Psychological Symptoms of Dementia (BPSD) and Older People Mental Health service (OPMH).	RN/EN/ Management

Step	Documentation	Role Responsibility
3. Develop a Person-Centered Behaviour Support Plan. That meets the quality of care principals.	• Work with Multidisciplinary team including **resident and/or authorised representative (RPSDM/ guardian /NDIS support coordinator**). • Clearly established care planning goals with consideration to the resident's needs, preferences, and choices: o The Residents background individual's preferences & choices – cross reference to lifestyle care plan. o The pattern of the behaviour of concern, triggers and how to prevent the trigger? o Recent incidents and the impact of the behaviours of concern. o What are the risks of behaviour. o What actions/care plan goals are required to manage the behaviour of concern. o Care Plan strategies and how often a review and evaluation are required. o Restrictive Practice should be clearly documented as a last resort. o If RP is prescribed, under what circumstances is it used, duration and type. o Who consented and prescribed the Restrictive Practice.	RN/EN
4. Evaluate the Care Plan	• Consult with the resident, authorised representative, multidisciplinary team and review the care plan **every four months** or after each responsive behaviour episode to ensure that triggers to behaviours and strategies are to be reviewed for effectiveness in managing behaviour. • If resources are required, report to Manager.	RN

Annexure C: Documentation and Process Map for Restrictive Practice – Excluding Chemical

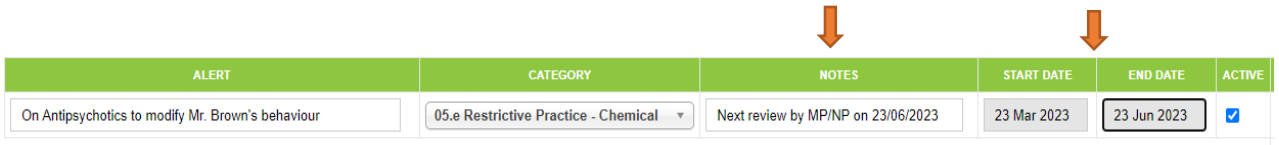
Step 1 Prior to Use of Restrictive Practice	Documentation	Role Responsibility
a. Assessment by an Approved Health Practitioner & Alternatives to the Use of the Restrictive Practice	• Document on eCase Progress Notes (select ***MP – Consult or Nurse Practitioner (NP) Review or RN Review***). • Review eCase Behaviour Identification and Interventions Chart and Pain chart. • Review eCase Mobility & Transfer, FRAT, Sleep and Medication Assessment. • Referral to specialist services as required.	MP/NP/RN/EN/ RAO/PCA/ Management
b. Risk Assessment & Least Restrictive Form of Practice	• Complete or Review the ***eCase Risk Assessment and Care Plan***.	RN/Management
c. Communication, explanation of risks, alternative strategies explored	• Document on eCase Conference Chart if required. • Document on eCase Progress Notes (select ***Case Conference***).	RN/Management
Step 2 Use of Restrictive Practice *(Last Resort)*	**Documentation, Upload to eCase Gallery (under Legal Documents)**	**Role Responsibility**
a. Legal Authority	• RAC Restrictive Practice Resident Self-Nomination Form should be signed by a resident, who has the capacity to consent, to the use of restrictive practices in accordance with their behaviour support plan. The type of restrictive practice will be clearly described and there will have been consultation on the use and possible impact. • Application to the NCAT/QCAT is required if the residents is unable to authorise consent. • Copies of NCAT/QCAT applications should be uploaded in the ***eCase Gallery under Legal Documents – Other.*** • While waiting approval from NCAT /QCAT a *RAC Restrictive Practice Substitute Decision Maker Nomination Form* must be signed by the RPSDM and upload to ***eCase Gallery under Legal Documents – Consent.*** • **Note:** a *RAC Restrictive Practice Substitute Decision Maker Nomination Form* should be signed by a person who has been appointed as a RPSDM for a resident to make decisions regarding restrictive practice on the residents' behalf.	Management/ Resident/ RPSDM / Guardian
b. Informed Consent	• Complete the *RAC Restrictive Practice Consent Form – Excluding Chemical* update the **behaviour care plan** and upload to ***eCase Gallery under Legal Documents – Consent.*** **Note: The consent form signed by MP/ NP, and Resident/ RPSDM/ Guardian and updated at least annually.** • Document on eCase Progress Notes (select ***Non Chemical Restrictive Practice Decision - Last Resort***). • Manager or as delegated to maintain and update *SOM – Clinical Directive Register*.	MP/NP/RN/ Management/ Resident/ RPSDM / Guardian

Step 2 Use of Restrictive Practice (*Last Resort*)	Documentation, Upload to eCase Gallery (under Legal Documents)	Role Responsibility
c. Document eCase Alert	• Document in ***eCase Alerts tab***, select appropriate type of Restrictive Practice from 05.a – 05.e and record the ***START and END*** date according to review timeframe ***(at least annually or as required)*** on *RAC Restrictive Practice Consent Form – Excluding Chemical*.  	RN/Management
Step 3 Regular Monitoring and Reviewing	**Frequency for Review & Consent**	**Role Responsibility**
• **Any devices, equipment, furniture, secured spaces, or actions for the primary purpose of influencing resident's behaviour,** e.g., Bedrails, Low Bed or Lo Lo Bed, Concave Mattress, Chairs with locked tables, Seatbelts, Bed against a Wall, Memory Support Units, Perimeter Alarms/Keypad on Entry/Exit	• eCase Behaviour Support Plan within Behaviour Care Plan review 4 monthly or as required. • The *RAC Restrictive Practice Consent Form – Excluding Chemical* need to be reviewed **at least annually or as required by MP/NP** and consultation with **Resident / RPSDM / Guardian**. **Note: The consent form signed by MP/ NP, and Resident/ RPSDM/ Guardian and updated at least annually.** • Upload to ***eCase Gallery under Legal Documents - Consent***. • Document on eCase Progress Notes (select ***Restrictive Practice - Authorisation Review & Renewed***) • Update in ***eCase Alerts tab***, select appropriate type of Restrictive Practice from 05.a – 05.e and record the ***START and END*** date according to review timeframe on *RAC Restrictive Practice Consent Form – Excluding Chemical*. • Case conference conducted annually and as required with Resident and/or RPSDM/ Guardian.	MP/NP/RN/ Management/ Resident/ RPSDM / Guardian

Step 4 Application and Release of Restrictive Practice	Frequency for Review	Role Responsibility
• Mechanical Restraint, e.g., Chairs with locked tables, Seatbelts - Must be released at least **every two (2) hours** for a period not less than **ten (10) minutes.**	• During the release period the Resident should be toileted, and/or their position changed. Such intervention does not preclude the need to provide person-centred care to the Resident at other times. • eCase Complex Health Procedures Chart: ***Restrictive Practice - Mechanical - Record each occasion when Restrictive Practice is used (start and end),*** must be recorded each time the restrictive practice device is applied and released, and this record must be attended to at the time.	RN/EN/PCA
• Bedrails • Concave Mattress • Low Bed or Lo Lo Bed	• Checked **every two (2) hours,** there is no need to release bedrails if the Resident is safe and comfortable. • eCase Work Log Activity: ***Restrictive Practice - Mechanical - Safety and comfort check or Safety and comfort check (Work Log ONLY).***	RN/EN/PCA
Step 5: Restrictive Practice Ceased	**Documentation**	**Role Responsibility**
• A **Resident or RPSDM/ Guardian** decline ongoing consent. **OR** • If the need for restrictive practice is no longer required.	• Restrictive practice **MUST** be removed or ceased. • Document on eCase Progress Notes (select ***Restrictive Practice – Ceased/No Longer required).*** • Update eCase Behaviour Support Plan within Behaviour Care Plan. • **Inactivate** relevant eCase Alert. • Manager or as delegated to **remove** resident from the *SOM – Clinical Directive Register.*	RN/Management

Annexure D: Documentation Map for Psychotropic Medication & Restrictive Practice - Chemical Restraint

Step	Documentation	Role Responsibility
Step 1: Prior to Psychotropic Medication Commenced		
a. Implementation of psychosocial supports such as redirection, engagement with others in the home, other therapies.	• Document on eCase Social Activity Chart. • Review about me, life history and leisure.	RN/RAO/PCA/ Management
b. Review and implementation of behaviour management charts & documentation.	• Review eCase Behaviour Identification and Interventions Chart. • Review eCase Pain Chart. • Review medical history and diagnosis.	RN
Residents with BPSD, e.g., agitation, aggression, restlessness, depression, wandering, disinhibited, delirium, sundowning		
c. Consultation with Dementia Support Australia (DSA), Geriatrician, Psychogeriatrician.	• Upload to eCase Gallery (under ***Clinician Correspondence***). • Document on eCase Progress Notes (select ***Behaviour - Specialist Team Review***). • Review eCase Care Plan.	RN/ Management
d. One to one nursing care	• Document on eCase Progress Notes (select ***Behaviour - – 1:1 Specialised Nursing***).	Management/ Regional Manager
e. Case conference	• Document on eCase Case Conference Chart. • Document on eCase Progress Notes (select ***Case Conference***).	RN/RAO/PCA/ Management/MP
Step 2 Decision to Commence Psychotropic Medication and/or Considered Chemical Restraint (Last Resort) **Note: The use of an antipsychotic, benzodiazepine, and anticonvulsant to treat behaviours and psychological symptoms of dementia (BPSD) is a chemical restraint.**		
a. Assessment by a Medical Practitioner or Nurse Practitioner.	• Upload to eCase Gallery (under ***Clinician Correspondence***). • Document on eCase Progress Notes (select ***MP – Consult or Nurse Practitioner (NP) Review)***	MP/NP

Step	Documentation	Role Responsibility
Step 2 Decision to Commence Psychotropic Medication and/or Considered Chemical Restraint (Last Resort) **Note: The use of an antipsychotic, benzodiazepine, and anticonvulsant to treat behaviours and psychological symptoms of dementia (BPSD) is a chemical restraint.**		
b. Discussion with **Resident / RPSDM / Guardian** and must be obtained for all prescribed psychotropic medications ***on admission*** to the Home, with commencement of a ***new*** psychotropic, and at ***change*** in psychotropic medication.	• Document on eCase Case Conference Chart. • Document on eCase Progress Notes (select ***Resident / Family Contact / Discussion - Authorised Representative Contact / Discussion***). • Complete the *RAC Psychotropic and Chemical Restrictive Practice Consent Form*. **Notes:** The consent form signed by **MP/ NP**, and **Resident / RPSDM / Guardian at least annually**. ***Chemical Restraints require MP/NP review every 3 months and sign in the consent form.*** • A new *RAC Psychotropic and Chemical Restrictive Practice Consent Form* is required when commencement of a **new** psychotropic and at **change** in psychotropic medication. • Upload to eCase Gallery (under ***Legal Documents - Consent***).	MP/NP/RN/ Management/ Resident/ RPSDM / Guardian
c. Complete documentation	• Review the Medication chart. • Update the eCase Risk Assessment and Care Plan and Medication Assessment and Care Plan. • If **commenced on a Psychotropic Medication,** document in the *eCase Progress Notes (select **Medication Management - Psychotropic Medication Commenced***). • If considered a **Chemical Restraint**, document in the *eCase Progress Notes* (select ***Restrictive Practice - Chemical -Decision to Use as Last Resort***) and **Behaviour support Plan** within Behaviour care plan. • Manager or as delegated to maintain and update *Psychotropic Medication Register* & *SOM – Clinical Directive Register.*	MP/NP/RN/ Management
d. Document **eCase Alert**	• If the Home uses a restrictive practice such as **chemical restraint** on a Resident, document in ***eCase Alerts tab***, select appropriate type of Restrictive Practice from 05.a – 05.e and record the ***START and END*** date according to review timeframe - **every 3 months by MP/NP.**  	RN

Step	Documentation	Role Responsibility
Step 3 Continued to Use of Psychotropic Medication and/or Chemical Restraint		
a. Regular monitoring and reviewing	• The psychotropic medications and *RAC Psychotropic and Chemical Restrictive Practice Consent Form* need to be reviewed **at least annually or as required by MP/NP** and consultation with **Resident/ RPSDM/ Guardian**. **Note: The consent form signed by MP/ NP, and Resident/ RPSDM/ Guardian and updated at least annually.** • ***Chemical Restraints** require **MP/NP review every 3 months** and sign in the **RAC Psychotropic and Chemical Restrictive Practice Consent Form**.* • Upload to eCase Gallery (under ***Legal Documents - Consent***). • If **ongoing on a Psychotropic Medication**, document in the *eCase Progress Notes (select **Medication Management - Psychotropic Medication Reviewed***). • If ongoing a **Chemical Restraint**, document in the *eCase Progress Notes* (select ***Restrictive Practice - Authorisation Renewed***). • Review eCase Behaviour Care Plan **every 4 months** or more often as required. • Pathology as per MP/ NP directive.	MP/NP/RN/ Management/ Resident/ RPSDM / Guardian
b. PRN Psychotropic Medication use	• Document on eCase Progress Notes (select ***Medication Management – PRN Psychotropic Medication Use***).	RN/Management
Step 4: Restrictive Practice: Chemical Restraint Ceased		
• If the need for chemical restraint is no longer required after consulting with the Resident/ RPSDM/ Guardian	• Chemical restraint **MUST** be ceased and documented in eCase Progress Notes (select ***Restrictive Practice – Ceased/No Longer required).*** • Update eCase Behaviour Support Plan within Behaviour Care Plan. • **Inactivate** relevant eCase Alert. • Manager or as delegated to **remove** resident from the *Psychotropic Medication Register* & SOM – Clinical Directive Register.	RN/Management

Annexure E: 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

Annexure F: Decision Matrix – Is It Chemical Restraint?

Drug Class	Indications for Use	Chemical Restraint YES/NO
Anticonvulsants	Treatment for primary function, e.g., Epilepsy, Mood Stabilise	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Antidepressants	Treatment for primary function, e.g., Depression/Anxiety	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Antipsychotics	Treatment for primary function, e.g., Schizophrenia or Bipolar/Mania	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Anxiolytics	Treatment for primary function, e.g., Anxiety	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Opioids	Treatment for primary function, e.g., Pain	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Other Central Nervous System Agent	Treatment for Mild to Moderate Dementia, e.g., Aricept, Exelon Patch	NO
Hypnotics/Sedative	Treatment for primary function, e.g., Insomnia	NO
	Treatment for the primary purpose of managing behaviour	**YES**
Hormonal	Treatment for primary function, e.g., Prostate Cancer	NO
	Treatment for the primary purpose of managing behaviour, e.g., Reduce Sexual Desire	**YES**

Version History:

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

Reference:

- Behaviour support plans – fact sheet, Aged Care Quality and Safety Commission.
- Consent to medical or dental treatment fact sheet, NCAT Guardianship Division.
- Frequently asked questions about consent, Aged Care Quality and Safety Commission.
- Guardianship orders, NSW Civil and Administrative Tribunal (NCAT).
- Overview of restrictive practices, Aged Care Quality and Safety Commission.
- Regulatory Bulletin: Regulation of restrictive practices and the role of the Senior Practitioner, Restrictive Practices, Aged Care Quality and Safety Commission.
- Reportable incidents: inappropriate use of restrictive practices, 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).

Related Policies, Procedures & Forms

- RAC Incident Management Flow Process
- RAC Incident Management System Manual
- RAC National Disability Insurance Scheme (NDIS) Policy Guideline
- RAC_Positive Behaviour Support & Restrictive Practice Policy
- RAC Psychotropic and Chemical Restrictive Practice Consent Form
- RAC Psychotropic Medication Register
- 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

Keywords:

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