POLICY

RAC_Psychotropic Medication & Chemical Restraint Policy

Purpose

To provide policy, position and/or procedural information on Psychotropic Medication Management which includes:

- Catholic Healthcare Limited (CHL) Residential Aged Care (RAC) specific and in line with the Mission, Vision and Values of the organisation.
- Consistent with State & Commonwealth legislation & Aged Care Quality Standards.
- Representative of contemporary, evidenced- based best practice in Residential Aged Care.
- CHL strives to preserve the dignity, autonomy, safety, and human rights of the Resident (Consumer).
- Management and staff are committed to appropriate behavioural and care management to avoid the use of Chemical Restraint.

Applicability / Scope

This policy applies to residential care employees of CHL.
Only Registered Nurses can complete the Care Plan Evaluation for this policy.

Principles of Resident and/or Authorised Representative Consultation

- CHL recognises:
    - That consumer engagement is a two-way stream of required communication.
    - The RAC Home is considered the home for each resident.
    - Each resident and/or their authorised representative has the right to participate in decision making processes concerning their life and the formulation of their care planning.
- Residents and/or their authorised representatives will be a partner in consultation in matters concerning both their care and the overall management of the Home.
- Refer to RAC Consultation Policy and RAC Resident's Right to Make Informed Choices Policy for more information.

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Contents

Definitions

Authorised Representative (AR)	The person recognised by CHL Management as the Representative of the Resident. This appointment may be supported by official legal documents or in their absence, be determined from current legal precedents where a hierarchy of responsibility has been recognised by legislative authorities in NSW or QLD.
Resident's Authorised Representative/s able to Give Consent for Restrictive Practice Note: the Aged Care Quality and Safety Commission makes use of the term "restrictive practices substitute decision maker".	The meaning of **'Authorised Representative'** is: • a person nominated by the Resident to be told about matters affecting the Resident; or • a person who nominates themselves as a person to be told about matters affecting a Resident, and who the provider is satisfied has a connection with the Resident and is concerned for the safety, health and well-being of the Resident. A **'Authorised Representative'** includes a person who: • is a Resident's partner, close relation or other relative? • holds an enduring power of attorney. • has been appointed by a State or Territory guardianship board; or • represents the Resident in dealings with the provider.
Enduring Power of Attorney NSW Only	The person appointed to begin or continue to make decisions for a person (Resident) when they no longer have the capacity to make their own decisions about their **financial affairs.** (NSW Guardianship Act 1987 & NSW Guardianship Regulation 2010)
Enduring Power of Attorney QLD Only	An attorney for **financial matters** appointed by the Resident under an enduring power of attorney. An attorney for **personal matters** (such as cares and welfare decisions like where you live) appointed by the Resident under an enduring power of attorney or advance health directive. Your attorney's power to make personal decisions only commences when you lose capacity to make these decisions. (QLD Guardianship Administration Act 2000)

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Enduring Guardian NSW Only	The person appointed to make **personal and health decisions** on their behalf when they no longer have the capacity to make their own decisions about their health and person: • How and where the person lives? • Decisions about support services. • Who might the person want to see and when? • Medical and dental treatment decisions. An Enduring Guardian can be: • One or more persons, These persons can be appointed to each make different types of decisions or have to agree on all decisions. OR One can make decisions and the other only has the decision-making capacity if the other passes away. (NSW Guardianship Act 1987 & NSW Guardianship Regulation 2010)
Adult Guardian QLD Only	Is a person appointed if the adult has impaired capacity for the matter; and there is a need for a decision in relation to the matter or the adult is likely to do something in relation to the matter that involves, or is likely to involve, unreasonable risk to the adult's health, welfare, or property. (QLD Guardianship Administration Act 2000)
DSA	Dementia Support Australia.
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. (https:/www.health.nsw.gov.au/disability/Pages/ndis.aspx)
Behavioural and Psychological Symptoms of Dementia (BPSD)	Behavioural and Psychological Symptoms of Dementia (BPSD) are defined by the International Psychogeriatric Association as 'symptoms of disturbed perception, thought content, mood, and Behaviour frequently occurring in patients with dementia'. (Dementia Centre for Research Collaboration)
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.
Restrictive Practice	Any practice or intervention that has the effect of restricting the rights or freedom of movement of a resident.

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1. Policy Statement

CHL acknowledges the use of psychotropic medication for the treatment of specific medical conditions. Psychotropic medication administered in accordance with the instruction of the Authorised Prescriber / Medical Practitioner is deemed as ongoing pharmacologic treatment for a diagnosed medical condition.

2. Psychotropic Medication

The most common type of medications that can have the effect of restricting a person's movements or ability to make decisions are psychotropic medications, capable of affecting the mind, emotions, and behaviours of a person.

Psychotropic medications may be prescribed for the purposes of treating a Resident with a diagnosed illness or condition. Use of such medications may not be recognised as restrictive practices, unless the apparent purpose of using the medication is to restrict the Resident's movement or ability to make decisions, as opposed to treatment of an illness.

2.1 Psychotropic Medications Include but Not Limited To:

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. Temazepam (Temtabs, Temaze, Normison)	
	8. Zolpidem (Stildem, Stilnox)	9. Zopiclone (Imrest, Imovane)

Drug Class	Example: Generic (Brand) Names
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. Fentanyl (Abstral, Fentora, Actiq, Durogesic) 4. Hydromorphone (Dilaudid, Jurnista) 5. Methadone (Physeptone, Biodone Forte) 6. Morphine (Ordine, MS Contin, Kapanol, Contin) 7. Oxycodone (Endone, OxyContin, OxyNorm) 8. Oxycodone/Naloxone (Targin) 9. Tapentadol (Palexia) 10. Tramadol (Tramal, Zydol)

2.2 Consultation to Gain Consent

The following should be explained to the Resident or their Authorised Representative (in a Resident without capacity to make such health decisions) to gain informed consent for psychotropic medication use:

- Common side effects and risks of the medication.
- Alternatives to the use of the medication.
- The plan in regard to dosage changes (increases or decreases) and cessation of the medication.
- The likely outcome of not taking the medication.
- The degree of uncertainty of the diagnosis and any therapeutic outcome in relation to the treatment.
- Any significant long-term physical, emotional, mental, social, sexual, or other outcome which may be associated with use of the medication.
- Whether the treatment is conventional or nonconventional, and its approximate cost.
- How the medication will be administered and in the case of 'when required' administration, how the need for administration will be assessed and authorised.

Note: If a medical practitioner or nurse practitioner prescribes medication, including psychotropics, for the purpose of chemical restraint, they are responsible for seeking and obtaining informed consent before prescribing medications.

2.3 Psychotropic Medication Consent

Written Consent (RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form) must be obtained for all prescribed psychotropic medications **on admission** to the Home, with commencement of a **new** psychotropic, and at **dosage change** or **cessation**.

- The Resident's Authorised Representative (AR) or the Tribunal (Refer to definition on page 2) are the only persons who can provide consent for a Resident who lacks capacity.
- Except in emergencies requests for consent must be in writing, **must be obtained before** the treatment is administered and must specify:
  a. That the Resident lacks capacity,
  b. The condition of the Resident that requires treatment,
  c. The alternative courses of treatment that are available in relation to that condition,
  d. The general nature and effect of each of those courses of treatment,
  e. The nature and degree of the significant risks (if any) associated with each of those courses of treatment, and
  f. The reasons for which it is proposed that any course of treatment should be carried out.
- If an emergency exists and it is not possible to obtain written consent, verbal consent should be obtained and documented as soon as possible after the administration of the treatment.

2.4 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 Used to Modify or Influence Behaviour	**YES**
Antidepressants	Treatment for primary function, e.g., Depression/Anxiety	NO
	Treatment Used to Modify or Influence Behaviour	**YES**
Antipsychotics	Treatment for primary function, e.g., Schizophrenia or Bipolar/Mania	NO
	Treatment Used to Modify or Influence Behaviour	**YES**
Anxiolytics	Treatment for primary function, e.g., Anxiety	NO
	Treatment Used to Modify or Influence Behaviour	**YES**
Opioids	Treatment for primary function, e.g., Pain	NO
	Treatment Used to Modify or Influence 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 Used to Modify or Influence Behaviour	**YES**
Hormonal	Treatment for primary function, e.g., Prostate Cancer	NO
	Treatment Used to Modify or Influence Behaviour, e.g., Reduce Sexual Desire	**YES**

3. 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.

The use of an antipsychotic to treat **behaviours and psychological symptoms of dementia (BPSD)** is a **chemical restraint** as BPSD is not either a diagnosed mental disorder or a physical illness/condition. Use is still appropriate where non-pharmacological strategies have been unsuccessful. Similarly, other medications such as **benzodiazepines and anticonvulsants** are sometimes prescribed to **treat BPSD** and would therefore be **chemical restraint**.

Antipsychotics are medicines that can reduce symptoms of psychoses but have limited benefit for BPSD. The use of psychotropic medicines is also associated with increased risk of serious adverse events, and their use, particularly their overuse or misuse may have significant impacts on a Resident's health.

A chemical restraint may be prescribed regularly where there are frequent episodes of behaviours causing distress or risk of harm that cannot be adequately managed with non-pharmacological strategies or on a PRN basis where the frequency of such episodes is more intermittent.

Note:

It is NOT considered chemical restraint if a medication (included **regular and PRN** medications) is administered to treat ***a diagnosed mental disorder; a physical illness; a physical condition***. e.g., where a Resident requires an antipsychotic agent to treat a diagnosed mental disorder (such as schizophrenia or bipolar). However, the use of an anticholinesterase (e.g., donepezil) to treat dementia by slowing its progression is not a chemical restraint.

3.1 Before Chemical Restraint is Used

Chemical restraint is only considered after exhausting all reasonable alternative non-pharmacological management options. Chemical restraint should be viewed as a last resort and only used after the following strategies:

- Implementation of psychosocial supports such as redirection, engagement with others in the home, other therapies.
- Implementation of behaviour management charts and documentation.
- Consultation with Dementia Support Australia (DSA).
- Consultation with Geriatricians, Psychogeriatricians.
- Reviewing pain chart, assessment, and care plan.
- One to one nursing care.

These steps are cumulative (they all need to be undertaken before Restrictive Practice could be considered to be "a last resort".

The four conditions which must be satisfied before using Chemical Restraint are:

a. Assessment by a Medical Practitioner or Nurse Practitioner.
b. Record Decision to use Chemical Restraint.
c. Inform the Resident and their Authorised Representative (AR).
d. Complete eCase Risk assessment.

3.2 Use of Chemical Restraint

If a chemical restraint is used, the following requirements Must be met:

a. RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form and Behaviour Care Plan

- A Medical Practitioner or Nurse Practitioner must assess the Resident as requiring the chemical restraint. The Practitioner must also prescribe the medication that is, or is involved in, the restrictive practice.
- The Practitioner's decision to use the chemical restraint must be recorded in the Resident's eCase Progress Notes, Case Conference Chart and Behaviour Support Plan within Behaviour Care Plan.
- Record the following information in the *RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form* and Resident's behaviour care plan:
  - The Resident's behaviours that are relevant to the need for the chemical restraint.
  - The alternatives strategies that have been used (Refer to 3.1 strategies).
  - The reasons the chemical restraint is necessary; and
  - The information provided to the Practitioner by the CHL that informed the decision to prescribe the medication.

Where a Resident entered the Home, and has existing chemical restraint medication prescribed, the Home will not have had the opportunity to have explored alternatives to the use of restrictive practice prior to entry. In this circumstance, it is expected the Home will thoroughly investigate the reasons for the chemical restraint and communicate with the Medical Practitioner as soon as practicable with a view to implementing alternatives to chemical restraint.

b. Monitoring and review

- While the Resident is subject to the chemical restraint the Home should regularly monitor for the potential adverse effects particularly where these include:
  - Sedation, gait disturbances and increased risk of falls and fractures.
  - Infection.
  - Pain.
  - Increased cognitive impairment and confusion.
  - Weight loss.
  - Constipation and associated risk for faecal impaction and bowel obstruction.
  - Increased risk for extrapyramidal side effects (drug-induced movement disorders including restlessness and agitation).
  - Increased risk of respiratory complications (such as pneumonia), stroke and heart rhythm. abnormalities, cerebrovascular events (including stroke) and increased risk of death.

The Home must also provide information to the Medical Practitioner regarding use of the chemical restraint. This review process aims to trigger reassessment of the need for the use of chemical restraint by the Medical Practitioner and, where possible, to implement alternative strategies to using restrictive practice.

c. Inform the Resident and their Authorised Representative (AR) or Tribunal

Medical Practitioner should obtain consent using *RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form* before the use of the chemical restraint unless in an emergency setting. This communication should be done in a way that the Resident or their Authorised Representative (AR) can understand, and they should be given the opportunity to discuss their concerns and expectations.

If the Resident or their Authorised Representative (AR) or Tribunal has not been informed or given consent for the use of chemical restraint due to an emergency the **eCase Progress Notes needs to be completed**, the Registered Nurse must inform the Resident or their Authorised Representative (AR) as soon as possible after the chemical restraint is used.

Note:

Legal requirements for consent to use Restrictive Practice:

- A Resident's Authorised Representative (refer to above definition) have the legal capacity to consent to the use of restrictive practice.
- A guardianship order or an enduring power of attorney may cover a limited range of matters not including decisions about restrictive practice. In such cases, it might not be appropriate to involve the guardian or the holder of an enduring power of attorney in making decisions about restrictive practice.
- In some circumstances consent might need to be obtained from the Guardianship Board or its equivalent in the particular state or territory. Residential Managers should contact the Guardianship Board to establish if they cover decisions about restrictive practice for the Resident requiring restrictive practice.
- Approval providers should obtain legal advice in cases where there is any doubt about the use of restrictive practice. Further rules may apply to persons under the NDIS which has specific rules in relation to restrictive practices and for those in mental health institutions.

4. Antipsychotic Medication

4.1 Management Plan

Identify the target responsive behaviour and liaise with the Medical Practitioner (MP)

1. Exclude delirium/depression, adverse drug effects or interactions, infection, or pain by liaising with the MP. Consider a medication review. Refer to appropriate guidelines to manage any identified causes.
2. If available, contact your local DSA team for advice regarding first-line non-pharmacological interventions.
3. Review and amend the current care plan, ensuring a focus on individualised, person centred care strategies.
4. Should these measures adequately manage the responsive behaviour, maintain care provision using the amended care plan, with regular monitoring and review.
5. If behaviour management strategies do not adequately manage the behaviour, liaise with the MP and pharmacological management may need to be considered at this time; however non-pharmacological approaches should be maintained throughout.

If an antipsychotic is to be trialled:

1. Commence antipsychotic medication as per prescribing guidelines.
2. Monitor for ongoing response and potential side-effects.
    a. If side-effects develop at any stage, immediately contact the MP.
    b. Maintain non-pharmacological approaches.
    c. Document behaviour in eCase Behaviour Identifications and Interventions Chart and Pain Chart.
    d. Liaise with MP regularly.

5. Special Case of Chemical Restraint - Hormonal agents

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.

The NCAT Fact Sheet - Special medical treatment guidelines is available at: https://www.ncat.nsw.gov.au/Documents/gd_factsheet_special_medical_treatment_guidelines.pdf and the Application for consent form is at: https://www.ncat.nsw.gov.au/Pages/guardianship/gd_forms.aspx

6. Roles and Responsibilities

6.1 Authorised Prescriber/Medical Practitioner (MP)

The Authorised Prescriber/MP has the following responsibilities:

- Obtain **consent** from a Resident or their Authorised Representative (AR) or Tribunal for medical intervention.
- Consent may be verbal in an emergency and written (*RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form*).
- Discuss the alternative non-pharmacological interventions for the medical conditions and risk.
- Ongoing monitoring and review is required every 3 months by completing a new *RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form* or as clinically indicated.

6.2 Residential Manager or as Delegated

The Residential Manager or as delegated has the following responsibilities:

- Ensure written consent (*RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form*) has been obtained.
- Ensure ongoing consent (*RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form*) has been reviewed in a new form every 3 months with Residents or their Authorised Representative (AR).
- Obtain Psychotropic Drug Usage Report Monthly from supply pharmacy and table at MAC meeting.
- Maintain the *Psychotropic Medication Register* in CONNECT. ***Refer to Quick Reference Guide – Updating RAC Psychotropic Register on CONNECT.***
- Monitor and review the effectiveness of medication and reduce as possible.
- Maintain and update the *SOM – Clinical Directive Register*.

6.3 Registered Nurse (RN)

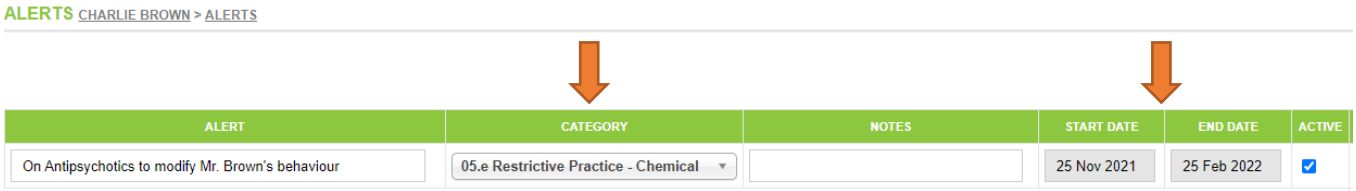
The RN has the following responsibilities:

- Ensure verbal in an emergency or written consent (*RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form*) has been obtained **before** the medication is administered.

  Note: If verbal, documentation in *eCase Resident's progress notes (select **Psychotropic Medication Commence**)* by the RN or MP should be made before the medication is administered and the Resident's Authorised Representative (AR) should sign the consent form as soon as possible.

- Upload consent form (*RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form*) to eCase Gallery after signed by a Resident or their Authorised Representative (AR) and MP.

- If the Home uses a restrictive practice such as a 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.



- Document in *eCase Progress Notes*, *select **Medication Management – Psychotropic Medication Commenced and/or Restrictive Practice - Chemical -Decision to Use as Last Resort***.
- Update Resident's eCase Diagnosis if required.
- Monitor for adverse side effect and report to MP.
- Review eCase Behaviour Care Plan every 3 months or as required.
- The Registered Nurse is responsible for making the decision to administer a PRN psychotropic medication at the time that the medication is being considered for administration. The Enrolled Nurse and Care Worker may administer a PRN psychotropic ONLY on the direction of the Registered Nurse.
- If PRN psychotropic medication use, document in eCase Progress Notes, *select **PRN Psychotropic Medication Use/ PRN Psychotropic Medication Evaluation***.

7. eCase Documentation Map for Psychotropic Medication & Chemical Restraint

Step 1 Prior to Psychotropic Medication Commenced	Documentation	Role Responsibility
1. Implementation of psychosocial supports such as redirection, engagement with others in the home, other therapies	• eCase Social Activity Chart. • Review about me, life history and leisure.	RN/RAO/PCA/ Management
2. Review and implementation of behaviour management charts & documentation	• eCase Behaviour Identification and Interventions Chart. • eCase Pain Chart. • Review medical history and diagnosis.	RN
Residents with BPSD, e.g., agitation, aggression, restlessness, depression, wandering, disinhibited, delirium, sundowning		
3. Consultation with Dementia Support Australia (DSA), Geriatrician, Psychogeriatrician	• eCase Gallery (under ***Clinician Correspondence***). • eCase Progress Notes (select ***Behaviour - Specialist Team Review***). • eCase Care Plan.	RN/Management
4. One to one nursing care	• eCase Progress Notes (select ***Behaviour - – 1:1 Specialised Nursing***).	Management/ Regional Manager
5. Case conference	• eCase Case Conference Chart. • 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.**		
1. Assessment by a Medical Practitioner or Nurse Practitioner	• eCase Gallery (under Clinician Correspondence). • eCase Progress Notes (select MP – Consult).	MP/NP
2. Discussion with Resident and their Authorised Representative (AR) or Tribunal and must be obtained for all prescribed psychotropic medications ***on admission*** to the Home, with commencement of a ***new*** psychotropic, and at ***dosage change*** or ***cessation***.	• eCase Case Conference Chart. • eCase Progress Notes (select ***Resident / Family Contact / Discussion - Authorised Representative Contact / Discussion***). • *RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form.* **Notes:** The consent form signed by MP, and Resident / Authorised Representative (AR) / Tribunal. • eCase Gallery (under ***Legal Documents - Consent***).	MP/NP/RN/ Management/ Resident/AR/ Tribunal

3. Complete documentation	• Medication chart. • eCase Risk assessment and care plan. • eCase 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 *SOM – Clinical Directive Register.*	MP/NP/RN/ Management/ Resident/AR
4. 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.***	RN
Step 3 Continued	**Documentation**	**Role Responsibility**
5. Regular monitoring and reviewing	• Review ***every 3 months*** and complete a new *RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form* or as clinically indicated. **Notes:** The consent form signed by MP, and Resident / Authorised Representative (AR) / Tribunal. • eCase Gallery (under ***Legal Documents - Consent***). • Pathology as per MP directive. • If **commenced on a Psychotropic Medication**, document in the *eCase Progress Notes (select **Medication Management - Psychotropic Medication Reviewed***). • If considered a **Chemical Restraint**, document in the *eCase Progress Notes* (select ***Restrictive Practice - Authorisation Renewed***).	MP/RN/ Management/ Resident/AR/ Tribunal
6. PRN Psychotropic Medication use	• eCase Progress Notes (select Medication Management – PRN Psychotropic Medication Use).	RN/Management
Step 4: Restrictive Practice: Chemical Restraint Ceased	**Documentation**	**Role Responsibility**
• If the need for chemical restraint is no longer required after consult with the Resident or their Authorised Representative	• Chemical restraint **MUST** ceased and document in eCase Progress Notes. • Update eCase behaviour care plan and **Inactive** relevant eCase Alert. • Manager or as delegated to **remove** resident from the SOM – Clinical Directive Register.	RN/Management

End of Policy

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Review History

Version Number	Date of Review & Update	Version Number	Date of Review & Update
Version 8	29 Nov 2021	Version 4	24 Oct 2019
Version 7	01 July 2021	Version 3	24 Sep 2019
Version 6	20 May 2020	Version 2	13 Aug 2019
Version 5	02 Dec 2019	Version 1	22 Jun 2019

Reference & Related Documents

References	• Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia, AHPRA • Guide to Poisons and Therapeutic Goods Legislation for Medical, Nurse and Midwife Practitioners and Dentists, NSW Health, 2014 • Guide to the Handling of Medication in Nursing Homes in NSW, Information Bulletin 2003/10, NSW Health 2003. • Guiding principles for medication management in residential aged Care facilities, Commonwealth Department of Health & Ageing 2012 • Health (Drugs and Poisons) Regulation 1996 (QLD) • Medication Management in residential Aged Care Facilities, A Guide for Health Care Workers, Australian General Practice Network, 2009 • Meditrax GP Newsletter - Chemical Restraint and Psychotropic Consent, April 2020Optimising antipsychotic medication management for responsive behaviour, Dementia Training Australia, https://www.dta.com.au/wp-content/uploads/2017/03/2476_AMM_cards_template1web.pdf • Poisons and Therapeutic Goods Regulations 2008 (NSW) • Quality of Care Principles 2014, Schedule 1 – Specified Care and Services for Residential Care Services (Part 3 Care & Services, Item 3.8 Nursing Services, The Aged Care Act 1997 • The Use of Restraints and Psychotropic Medication in People with Dementia, A Report for Alzheimer's Australia. Paper 38 March 2014

Related Policies, Procedures & Guidelines	• eCase Quick Reference Guide (QRG):
	  ○ Completing eCase Documentation for Case Conferences
	  ○ Managing Case Conferences in eCase
	• Quick Reference Guide (QRG):
	  ○ Updating RAC Psychotropic Register on CONNECT

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: • Behaviour Identification and Interventions Chart • Case Conference Chart • Falls Risk Assessment Tool (FRAT) Forms: • RAC Psychotropic Medication & Restrictive Practice (Chemical) Assessment and Consent Form • SOM – Clinical Directive Register
Aged Care Quality Standards & Outcomes	This guideline may impact on the following Aged Care Quality Standards expected outcomes & requirements: • 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
Legislation	This guideline is guided by the following legislation: • Aged Care Act 1997 • NSW Guardianship Act 1987 and NSW Guardianship Regulation 2010 • QLD Guardianship Administration Act 2000 • Quality of Care Principles 2014 • User Rights Amendment (Charter of Aged Care Rights) Principles 2019

Key words for search

Chemical Restraint, Authorised Representatives, Antipsychotic Medication, Psychotropic Medication, Consent Form; Restrictive Practice