ACCPA
Aged & Community Care Providers Association

Exposure Draft - Quality of Care Amendment (Restrictive Practices) Principles 2022

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About ACCPA

Aged and Community Care Providers Association (ACCPA) is the national Industry Association for aged care providers offering retirement living, seniors housing, residential care, home care, community care and related services.

ACCPA exists to unite aged care providers under a shared vision to enhance the wellbeing of older Australians through a high performing, trusted and sustainable aged care sector. We support our members to provide high quality care and services while amplifying their views and opinions through an authoritative and comprehensive voice to the government, community and media.

Our sector serves to make better lives for older Australians, and so do we.

Main issues

- Aged care providers need to be provided with guidance as to the procedures they are expected to undertake to satisfy themselves that informed consent was obtained for the restrictive practice and how to evidence that they have met this requirement.
- Can the substitute decision maker give consent for only one kind of restrictive practice or can they give consent for multiple restrictive practices (e.g. environmental and chemical restraint)?
- Does the nomination of a restrictive practices nominee need to identify the kind or kinds of restrictive practices the nominee can give substitute consent to?
- Will there be a time limit to substitute decision makers' consent powers (if chosen from the hierarchy), e.g. do providers need to re-seek consent for this role at particular intervals?
- In considering decision makers from tier three to tier six in the hierarchy: if for example, an eligible person on a higher tier is unwilling to become substitute decision maker for a restrictive practice and disagrees that the person on the next tier (e.g. tier four) becomes the restrictive practices substitute decision-maker, rather they want the person on tier five to take on the role, how do providers move down the hierarchy of decision makers in such a case?
- Potentially, the restrictive practices substitute decision-maker may be a different person to the substitute decision maker for medical treatments. This is confusing for providers and there is the potential for conflict between the two decision makers. How is this to be managed?
- If existing guardianship arrangements do not include any provision for substitute consent for a restrictive practice, can providers seek substitute consent from a person listed in the hierarchy? Can existing guardians be included in the hierarchy?
- The Quality of Care Amendments (Restrictive Practices) enable providers to seek informed consent where an application has been made for authorisation of a decision-maker with the relevant State or Territory guardianship body or tribunal and while waiting for this person to be appointed. Can this arrangement can be used in both, States and Territories with and without legislation authorising substitute consent for a restrictive practice in aged care? Any guidance material for providers needs to clearly identify how and in which States and Territories this arrangement applies.
- Will the Commonwealth be working with the States and Territories to make provisions for substitute consent for restrictive practices while families and/or providers are awaiting authorisation of a decision-maker with the relevant State or Territory guardianship body or Tribunal?

- Do the immunity provisions in the Amendment apply not just to the provider (and their staff and volunteers) but also the person who gives substitute consent if all requirements for a restrictive practice under the Quality of Care Principles and the Amendment have been met?

Submission

ACCPA is pleased to have the opportunity to provide feedback to the exposure draft and the explanatory statement to the *Quality of Care Amendment (Restrictive Practices) Principles 2022.*

We welcome that arrangements are being put in place for authorising certain individuals or bodies to provide substitute informed consent for restrictive practices in residential aged care where State or Territory legislation does not authorise such consent and where the resident lacks capacity to provide informed consent.

ACCPA has identified some concerns that may arise for providers when applying the legislation, these and other issues are discussed below.

Interim arrangement

The Amendment Principles introduce interim two-year arrangements for the provision of substitute, informed consent decisions if no one is authorised to give such consent for a restrictive practice in aged care under the relevant State and Territory laws.

We welcome that these arrangements will provide an adequate degree of clarity for aged care providers located in States and Territory without such laws on how to obtain this consent. ACCPA hopes that the States and Territories without relevant legislation will utilise the two-year window to introduce regulatory requirements for substitute consent for a restrictive practice in aged care that provide certainty to providers, care recipients and their next of kin alike.

ACCPA understands that the interim measures can be used by providers to seek informed consent where an application has been made for authorisation of a decision-maker with the relevant State or Territory guardianship body or Tribunal. However, what remains unclear to ACCPA is whether this arrangement can be used in both, States and Territories with and without legislation authorising substitute consent for a restrictive practice in aged care. Any guidance material for providers needs to clearly identify how and in which States and Territories this arrangement applies.

Further, what arrangements will be available to providers to seek substitute informed consent for a restrictive practice once the 2-year interim period for the Quality of Care Amendment (Restrictive Practices) expires? For example, will the Commonwealth be working with the States and Territories to make provisions for substitute consent for restrictive practices while awaiting authorisation of a decision-maker with the relevant State or Territory guardianship body or tribunal?

Immunity provisions

We note the immunity provisions for aged care providers included in the Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022 (Royal Commission Response Act) and the limited circumstances in which these apply. Does the immunity also apply to the giver of substitute consent, if the requirements for a restrictive practice under the Quality of Care Principles and the Amendment were met?

Explanatory statement: Providers attending to their duty of care may risk their immunity

The explanatory statement includes examples of how providers are expected to consistently implement a restrictive practice as per the Behaviour Support Plan (BSP) or the immunity protections are voided. We are concerned that the guidance provided by the examples given may result in unintended, negative consequences for residents' quality of life and health. This is because these examples guide providers to write BSPs that focus on concrete and measurable implementation parameters. We argue that the examples should be worded in such a way as to demonstrate that the restrictive practice consented to, is also responsive to residents' preferences and health status (which may change even within a 24 hour period).

Page 18 explanatory statement

> These amendments are intended to ensure that approved providers are only using restrictive practices in accordance with the consent given by the care recipient or the restrictive practices substitute decision-maker. **For example, where the care recipient has consented to the use of bed rails between 10:00pm and 7:00am on weekdays, the approved provider does not have the authority to use bed rails in respect of that care recipient in any other circumstances, without first seeking additional authority from the care recipient or restrictive practices substitute decision-maker (if applicable).** The amendments made by items 5 and 6 also assist in clarifying the scope of the immunity arrangements under section 54-11 of the Aged Care Act (inserted by the Royal Commission Response No. 2 Act), and ensure these arrangements will not apply in circumstances where the use of a restrictive practice does not align with the consent that was provided**. For example, if the care recipient has given informed consent to the use of a lap belt (mechanical restraint) in the evenings before going to bed, and the approved provider continues to use the lap belt the next morning, then the use of restrictive practices is not consistent with the consent that was provided and therefore the approved provider and other individuals who used, or assisted in the use of the restrictive practice, would not be protected by the immunity provision under section 54-11.**

In the first example provided above a resident may have requested to have their bed rails up between 10pm and 7am because it makes them feel safe while sleeping. For this reason staff may decide on a given day to leave the bed rails in place when the resident is sleeping late, say until 8.30am. In such a circumstance it would be impractical for the staff to seek consent for this extension of time for this circumstance. It would be better to word this restrictive practice it in terms of the resident sleeping, i.e. **For example, where the care recipient has consented to the use of bed rails while asleep overnight.**

This statement would provide the same level of protection for residents from an unauthorised restrictive practice while respecting residents' changing preferences and supporting staff and providers in their compliance with the Quality of Care Principles.

The lap belt in the second example is most likely being used to give the resident stability in their chair in the evening when they tend to be tired. There may be other times than in the evening when the resident would benefit from the added support from a lap belt. For example on a morning, low blood pressure may make it difficult to stop the resident from sliding out of the chair without support from the belt. It would be better to reword this example to say: **For example, if the care recipient has given informed consent to the use of a lap belt (mechanical restraint) when the care recipient finds it difficult to maintain stability while sitting in their chair, such as in the evenings before going to bed…**

Wording the examples this way demonstrates that the BSP, devised according to the restrictive practice consent, must also be responsive to residents' temporarily changing health status.

Informed consent

Page 6 of the explanatory statement says that: *'The Amendment Principles require an approved provider to be satisfied that the requisite informed consent has been obtained.'* Aged care providers need to be provided with guidance as to the procedures they need to undertake to satisfy themselves that informed consent was obtained for the restrictive practice and how to evidence that they have met this requirement.

Items 5 and 6 include amendments obliging providers to ensure that the informed consent is given for the specific details of the proposed restrictive practice. "*and how, it is to be used (including its duration, frequency and intended outcome)," after "use of the restrictive practice*" in paragraph 15FA(1)(f) of the Quality of Care Principles.

Providers should be provided with procedures to follow on how to document that informed consent was given and how to identify the details required to satisfy the regulator that appropriate informed consent was given.

New terms included under definition of restrictive practices substitute decision-maker

"Medical treatment authority" – definition of this term is clear

"Restrictive practices authority" – definition of this term is clear

"Restrictive practices nominee" – definition of this term is clear

While the definitions for the new terms included under the definition of a restrictive practices substitute decision maker are clear, ACCPA notes that this introduces further complexity into substitute consent arrangements.

The exposure draft (e.g. page 6) and explanatory statement (e.g. page 24) say that the substitute decision maker can *give informed consent to the use of **a** restrictive practice or **the** restrictive practice (or decide not to give consent) if the care recipient lacks the capacity to give consent.*

Can the substitute decision maker give consent for only one kind of restrictive practices or can they consent to a number of different restrictive practices (e.g. environmental and chemical restraint)?

Does the nomination of a restrictive practices nominee need identify the kind or kinds of restrictive practices the nominee can give substitute consent to?

Hierarchy of decision makers

The hierarchy of decision makers should enable a provider to identify a person or persons able to become a restrictive practices substitute decision-maker. However, ACCPA is also envisaging that a number of issues may arise for providers seeking to utilise this hierarchy.

Consent for each restrictive practice

Page 12 of the explanatory statement says:

> *Item 3 of the table in new subsection 5B(1), which is the third tier, is only applicable if both items 1 and 2 of the table do not apply. If these circumstances exist, but the care recipient has a partner (including a spouse or de-facto partner) with whom they have a close continuing relationship, who has capacity to act as a restrictive practices substitute decision-maker, and has agreed in writing to be a restrictive practices substitute decision-maker for the care recipient (and has not withdrawn that agreement), then the restrictive practices substitute decision-maker for the care recipient is that partner.*

Noting that decision makers on tiers 3 to 6 are not restrictive practices nominees, do they have to agree in writing to be substitute decision maker each time consent to a restrictive practice is sought? If not, will there be a time limit to their consent powers, e.g. do providers need to re-seek consent for this role in particular intervals?

Negotiating the hierarchy

Providers will require guidance as to how to negotiate the hierarchy of substitute decision makers. For example, the partner (third tier) may refuse to step into the role of substitute decision maker while agreeing to the restrictive practice

proposed. This situation may occur because the person on this tier is very aged. In this case, is the provider able to approach the next tier of substitute decision maker? How should a provider proceed if the third tier of decision maker, who is unwilling to become substitute decision maker, expressly prohibits the provider to seek substitute consent from a person fitting the requirements of the fourth tier in the hierarchy? But if the person on the fifth tier is supported by the partner, can the person on the fourth tier be omitted in favour of the person on the fifth tier?

If existing guardianship arrangements do not include any provision for substitute consent for a restrictive practice, can providers seek substitute consent from a person listed in the hierarchy? State legislation may prevent the existing guardian from inclusion in the hierarchy. If this is the case, there will be two decision makers and potential for conflict.

Further, the restrictive practices substitute decision-maker may be a different person to the substitute decision maker for medical treatments. This is confusing for providers and there is again potential for conflict between the two decision makers.

Close continuing relationship

Substitute decision makers for a restrictive practice on tiers three to five must have maintained a close, continuing relationship with the care recipient. Providers will require some guidance as to how to evidence that such a relationship between the restrictive practices substitute decision-maker and the care recipient was maintained as the term 'close, continuing relationship' is open to varied interpretation.

Responsibilities relating to nominations under section 5A

Page 22 of the Explanatory statement

> *New subsection 15GC(3) provides that if a care recipient nominates an individual who can give informed consent to the use of a restrictive practice in relation to the care recipient, if the care recipient later lacks the capacity to give that consent, then the approved provider must assist the care recipient to:*
>
> - *notify that individual of the nomination; and*
> - *give the individual a copy of the nomination (as it must be made in writing under new section 5A); and*
> - *seek the individual's agreement, in writing, to act as a restrictive practices nominee for a restrictive practice in relation to the care recipient (in accordance with new paragraph 5A(1)(b)).*

We suggest that the sentence highlighted in yellow be revised as it appears to suggest that the provider should undertake the actions listed under the dot points **after** the resident has lost capacity to give consent.

Intervening in cases of coercion

Page 22 of the explanatory statement

> For example, if an approved provider becomes aware that an individual is coercing a care recipient to nominate them as a restrictive practices nominee, the approved provider should take reasonable steps to intervene, such as contacting the care recipients representative, or linking the care recipient with the necessary supports prior to any nomination.

Two difficulties may arise from the suggestion given in the explanatory statement (see yellow highlights above) as to how providers can approach situations where they observe that a resident may be coerced into nominating a restrictive practices nominee. Firstly, the care recipient's representative may be the coercer and secondly the care recipient may not consent to having an advocate involved. In this case, the provider's options for protecting the care recipient from coercion are significantly limited. How can a provider meet their legal responsibilities if this scenario ensues?

Schedule 2 – Amendments commencing 1 January 2023

> **2 Paragraph 15HC(g)**
>
> After "use of the restrictive practice", insert ", and how it is to be used (including its duration, frequency and intended outcome),".

Guidance to providers will need to include how PRN[1] medications should be documented so that regulatory requirements are met.

Medical and nurse practitioners must have guidance and education materials made available to them, from the Aged Care Quality and Safety Commission as to the legal requirements when chemical restraint is prescribed and the steps prescribers need to undertake to assist providers in meeting these requirements.

Page 21 of explanatory statement

> *The removal of the reference to paragraph 15FC(1)(c) is consequential to the amendments made by item 11 of Schedule 1 to the Amendment Principles, which repeals and replaces paragraph 15FC(1)(c), which is now a requirement, even in an emergency.*

[1] The PRN stands for 'pro re nata,' which means that the administration of medication is not scheduled. Instead, the prescription is taken as needed. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4129247/

ACCPA suggests that the sentence above be reviewed, as providers will experience difficulties in interpreting it as they seek explanation regarding the legislation they are expected to implement.

Page 21 of explanatory statement

> The details of which must also be recorded in the care recipient's behaviour support plan. While the requirements sit with the approved provider, when preparing, reviewing, or revising a behaviour support plan, **the approved provider must consult others including health practitioners with expertise relevant to the care recipient's behaviours of concern.**

Providers will require further guidance as to the obligation arising from the paragraph above which states that they must include health practitioners with relevant expertise when preparing, reviewing or revising behaviour support plans.