Restraint Minimisation Policy

1. Background

A restraint free environment is a basic human right for all persons accessing health care services and restraint should not be implemented unless alternatives have been explored. Any decision to restrain a person carries significant ethical and legal responsibilities. *Aged Care Act 1997* (Cth) Section 96-1 Quality of Care Principles 2014 Part 4a.

The National Safety and Quality Health Service Standards (NSQHS), Comprehensive Care Standard, action 5.35) require that:
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

- minimise and where possible, eliminate the use of restraint
- govern the use of restraint in accordance with legislation
- report use of restraint to the governing body

The Aged Care Quality Standards (ACQS) (Standard 8) require that:

- where restraint is clinically necessary to prevent harm, the organisation should have systems in place to manage how restraints are use. This is in accordance with legislation and the organisation's policy on reporting the use of restraints.

2. Policy Statement

This policy outlines the requirements for all WACHS health services to act on eliminating, or minimising where possible, the use of restrictive practices, and meeting the requirements to practice safely and lawfully if restraint is applied during a period of health care.

WA Health supports working towards eliminating restrictive practice. Restraint would be a last resort and any episodes of restraint would be reviewed to try to prevent this reoccurring. WA has successfully and significantly reduced restrictive practice in mental health settings over the last decade. All staff have a responsibility to seek to eliminate restrictive practice.

This policy document is to be used in conjunction with:

- WACHS Cognitive Impairment Clinical Practice Standard which includes management of agitation guidelines, management of cognitive impairment and prevention of delirium.
- Disturbed Behaviour Management Clinical Practice Standard
- Alcohol Tobacco and Other Drugs Clinical Practice Standard

3. Scope

This policy applies to all WACHS staff (hereafter referred to as 'Staff') who provide acute and community health services or residential aged care services and who may be required to provide care for a person who is experiencing distress or exhibiting responsive behaviours. These may:

- result in actions or behaviours that may, or have the potential to, physically or psychologically harm another person or self, or property;
- limit the ability to safely provide treatment to the person;
- lead to consideration of the use of restrictive practices.

All health professionals are to work within their scope of practice appropriate to their level of training and responsibility.

3.1 Out of Scope: This policy **does not** apply to:

- mental health patients who are being treated in an authorised mental health service (Refer to WACHS Mental Health Restraint and Seclusion Minimisation Policy)
- persons who are not patients of the health service (e.g. visitors, relatives and friends)
- persons under arrest or a prisoner of WA Police or Department of Correctional Services where statutory requirements exist and obligation to public safety and maintaining custody, override medical need
- discharge against medical advice patients (refer to WACHS Discharge Against Medical Advice Policy)
- the use of any medical protective devices that protect a person's medical injury/condition. This includes:
    - Traction;
    - The use of medical or surgical appliances used for the treatment of physical disease or injury;
    - Use of seatbelts on chairs or other devices used to support posture; or
    - Low beds and crash mats for care recipients who are high falls risks.

4. Definitions

4.1. Mechanical Restraint: The application of equipment or devices (including belts, harnesses, manacles, sheets and straps) to a person's body to restrict their movement. Mechanical restraint can include tables, bed rails and chairs that are difficult to get out of if these are being used to restrict a person's movement.

Note: Injuries and death have occurred as a direct complication of mechanical restraint use. Improvised restraint arrangements such as bandages, sheets, meal trolleys must never be used as a restraint.

4.2 Physical Restraint: The intentional physical restriction of a person's voluntary movement by use of physical force to immobilise a person.
If staff are required to manually restrain a person, it must occur under the direction and supervision of a senior medical practitioner or registered nurse.

- A person is not being physically restrained if they are being provided with physical support or assistance; to enable the person to carry out daily living activities; or to redirect a person because they are disorientated.

4.3 Chemical Restraint: A restraint that is, or that involves, the use of medication for the purpose of influencing a person's behaviour, other than medication prescribed for treatment of, or to enable treatment of, a diagnosed mental disorder, physical illness or a physical condition. (*Quality Care Amendment {Minimising the Use of Restraints} Principles 2019)*

4.4 Environmental Restraint: Limiting a person to a particular environment (e.g. their bedroom) or excluding a person from an area they want to go to (e.g. restricting access to an outside courtyard or sitting room, or preventing a person from leaving the building). Note: some dementia specific units may have swipe only or keypad access and alarms fitted on exit doors. A safe area in which to move about within the unit should be provided in this instance; for example a protected garden with free access to the inside of the building.

4.5 Aversive treatment practices: One that uses unpleasant physical, sensory or verbal stimuli e.g. any voice tone, command or threats that are used to limit a person's mobility or actions in an attempt to reduce undesired behaviour. Aversive treatment also refers to any withholding of basic human rights or needs (e.g. food, warmth, clothing, or positive social interaction); or a person's goods/belongings; or a favoured activity for the purpose of behaviour management or control.

Advocate	A person, who speaks, writes or acts on behalf of the person they care for and has the requisite experience to speak as an informed carer to defend their right to accessible, safe, quality healthcare.
Carer	A carer is someone who provides unpaid care and support to family members and friends who have disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue, or who are frail aged. Extract*:* Carers Australia*.*
Cognitive Impairment	Refers to diminishing ability in judgement, memory, learning, comprehension, reasoning and/or problem solving and can result from a number of conditions, including dementia, delirium and/or depression. This can also include substance abuse/misuse, including medication mismanagement/electrolyte imbalance. Cognitive Impairment can be temporary, fluctuating or permanent.
Delirium	A disturbance of consciousness and a change in cognition that develops over a short period of time as a consequence of a general medical condition or toxin exposure. It may complicate dementia and it often presents with an acute change in behaviour.

Health Practitioner	A person who is a health practitioner registered under the *Health Practitioner Regulation National Law* (WA) *2010.*
Family member	Any parent, legal guardian or identified carer of the person. For a person of Aboriginal or Torres Strait Islander decent, this includes a person within their kinship group who is recognised as their carer under customary laws and traditions.
Medical Practitioner	Any doctor including a psychiatrist who is registered under the Health Practitioner Regulation Law (WA) as being in the medical profession.
Representative	Defined in section 5, Quality of Care principles: • A person nominated by the consumer to be told about matters affecting the consumer. • A person who nominates themselves as a person to be told about matters affecting a consumer, and who the provider is satisfied has a connection with the consumer and is concerned for the safety, health and well-being of the consumer. A 'representative' includes a person who: • is a consumer's partner, close relation or other relative • holds an enduring power of attorney • has been appointed by a State or Territory guardianship board • represents the consumer in dealings with the provider.
Responsive Behaviour	Formerly known as Behavioural and Psychological Symptoms of Dementia (BPSD). This can include: agitation, wandering, anxiety, depression, physical aggression, vocally disruptive behaviour.
Restraint	Any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement (*Quality Care Principles 2014*)
Staff	***staff member***, of a health service provider, means — (a) an employee in the health service provider (b) a person engaged under a contract for services by the health service provider. (section 6, *Health Services Act 2016* (WA))
Substitute Decision-Maker	A substitute decision maker is a person permitted under the law to make decisions on behalf of someone who does not have capacity. A person can have more than one substitute decision maker who can make decisions about personal or financial matters. OD0657/16 WA Health Consent to Treatment Policy

5. Roles and Responsibilities

Regional Directors (RD) are to:

- ensure that restrictive practice is eliminated or minimised, health professionals and managers are aware of legal considerations and potential consequences, and any use is in accordance with this policy, legislative and other relevant policy requirements.
- provide advice to the Chief Executive (CE) on any issues of public concern arising from the use of restraint in the region.

Regional Medical and Nursing/Midwifery Directors are to:

- ensure all nursing and medical staff comply with the policy and guidelines.
- establish maintain and review systems and associated processes for best practice minimisation of restraint at a regional level, including reporting systems.
- ensure appropriate training and support is provided to WACHS staff.

Operations Managers are to:

- ensure that obligations under this policy, legislation and relevant Clinical Practice Standards, including incident reporting and review, complaints management, open disclosure, informed consent, recovery strategies and education and training are met.
- ensure there is a system for clinical governance with responsibility for monitoring and improving performance, and for conducting relevant quality improvement activities and support for teams to practice practical responses to incidents.
- provide advice to the RD on any issues of public concern arising from the use of restraint in the region.

Safety and Quality and Risk Coordinators are to:

- promote the policy, guidelines and any relevant tools and resources.
- assist staff to meet their obligations under this policy, legislation and other relevant policy documents, including incident reporting and review, complaints management, open disclosure, informed consent, education and training.
- ensure that an evaluation strategy is in place to monitor practice and outcomes and assist in appropriate quality improvement activities.

Health Service Managers are to:

- ensure all new staff are provided with access to this policy and related legislation during orientation.
- ensure implementation, accountability and compliance with this policy.
- develop, implement and monitor local systems and procedures, including data collection, analysis and improvement planning; staff training; mechanisms for clinicians and consumers to raise concerns regarding the abuse of restraint and engagement with consumers and the community.
- review all incidents of restraint use in their area. Ensure that appropriate follow up takes place including discussion with the consumer/carer/family in accordance with OD0592/15 WA Open Disclosure Policy.
- provide ongoing support to nursing and medical staff.
- ensure compulsory reporting requirement are carried out.

Registered Nurses are to:

- adhere to the principles, recommended practice and intent of this policy.
- participate in training to ensure competency in assessing the specific needs and risks of the individual and other.
- participate in quality improvement activities to minimise or eliminate restraint, to improve multi-disciplinary teamwork and consumer-centred care.
- report all incidents where restraint is used to their Line Manager.
- complete all relevant documentation for interventions, monitoring and evaluations regarding the use of restraint.

All staff are to:

- comply with this policy and legislation to ensure all professional and legal obligations are met in the provision of evidence based quality care.
- undertake relevant training to ensure that they have the skills and knowledge to provide care in accordance with best practice.
- ensure that all appropriate interventions have been trialled prior to restraint being investigated and implemented.
- ensure that people in their care have the right and ability to move as desired as much as possible without causing harm to others.

6. Consent

6.1. Consent for the restraint must be provided by either the person, or if unable to do so, by a representative who has authority such as a substitute decision-maker or guardian or enduring guardian. The person or their representative may withdraw their consent at any time during the period of restraint. The organisation should therefore take steps to regularly communicate with the person or their representative and obtain consent.

- If a person provides their consent to share their information, staff should contact the person's representative and advise them of the restraint as soon as practicable.
- When a person, or their representative, are concerned or unhappy about their care, or the use of restraint, they should be encouraged and supported by staff to raise these issues with the treating team as they occur.
- If the application of mechanical and/or chemical restraint is urgently required (i.e.in a critical need situation) it may be applied without consent initially. However, consent must be obtained as soon as possible from the person's representative.
- Where a person has no substitute decision-maker and if restraint is considered necessary as part of an ongoing Behavioural Management Plan, an urgent application to the State Administration Tribunal (SAT) must be made. The SAT can appoint a guardian or enduring guardian with the function of providing consent for the use of restraint.

Consent is not required:

6.2. Where there is legal authority to restrain a person to provide treatment, maintain safety or carry an order into effect. (*Guardian and Administration Act 1990* (WA) or *Mental Health Act 2014* (WA))

6.3. **When there is an immediate need to protect people and property from harm:** When a person is exhibiting aggressive behaviour and is posing an immediate and serious risk of harm to themselves or another person, it will be lawful to restrain the individual to prevent the harm, or further harm eventuating. However, any use of restraint should be reasonable in the circumstances and use the minimum amount of force or sedation for the shortest duration required in response to the threat or risk of harm.

6.4 Potentially unlawful use of restrictive practices.
Use of restraints without lawful consent (by the person and/or legal representative) may infringe on the person's legal rights and constitute a civil or criminal offence, such as assault or false imprisonment.

If emergency treatment is required and the person cannot consent, Section 4.1 OD0657/19 WA Health Consent to Treatment Policy sets out circumstances in which a health practitioner can lawfully administer medical treatment.

Impaired decision-making capacity and ability to consent can arise in situations where, for example, the person's consciousness is impaired or they are in the later stages of dementia. Refer to WACHS Adults with Impaired Decision Making Capacity Procedure

7. Prevention, Elimination and Minimisation of Restrictive Practices

A safe approach to managing the care of persons who exhibit agitation, responsive or aggressive behaviour is one that focusses on prevention strategies and positive changes and implements evidence-based strategies for the prevention, early recognition and response to behaviours of concern. The approach should be relevant to their health setting, staff roles and responsibilities and the person accessing the service e.g. strategies for adolescents will differ from those for older people living with dementia or experiencing delirium.

Older people with an altered cognitive state e.g. dementia, have the highest incidence of all persons for being restrained when hospitalised. Best practice supports individualised care without physical or chemical restraint including:

- screening of cognition to detect delirium (4AT) which should be performed on admission and as determined by clinical condition.
- screening for any reversible disease.

Refer to: WACHS Cognitive Impairment Clinical Practice Standard.

7.1 Clinical strategies to eliminate or minimise the use of restrictive practices:

- Involve families, carers and consumers in planning, reviewing and evaluating all aspects of care and support.
- If the restraint is used without consent, the consumer's representative must be informed as soon as practicable after the restraint starts to be used.
- Engage early with consumers and carers so that wherever possible individualised support plans, incorporating behaviour support plans, are implemented for all people who use services who are known to be at risk of presenting with challenging behaviours.
- Use appropriate screening and assessment tools to assess the consumer's behaviours, triggers or contributing factors, levels of distress, anxiety and risk.
- Develop a comprehensive multidisciplinary, person-centred care plan.
- Involve Allied Health Services to assess care recipient and implement suitable care plans.
- Initiate a pharmacy review of all medications.
- Provide care in a way that respects age, culture, diversity, language and spiritual differences and allows for differences in health literacy.
- Provide a physical, social and emotional environment, and formal and informal activities that avoid triggers and support prevention, care and recovery.
- Consider alternative strategies.
- Act early to de-escalate – this includes a range of verbal and non-verbal techniques, based around good communication.
- Make modifications to the physical environment to maximise a person's capability and reduce frustration.
- Consider possible health or medical factors which could contribute to or cause the behaviour.
- Assess for diminished eyesight, poor hearing and mental health concerns, balance issues and unstable blood pressure.
- Provide education to staff and family/carers about restraint minimisation.
- Ensure staff support is provided to enable safe movement around the aged care facility or other health care setting.

Persons assessed as a falls risk should not be restrained as a falls prevention

(Refer to **Appendix 1** for further examples) and the WACHS Management of Agitation in Older Adults with Dementia or Delirium Flowchart.

7.2 Assessment, Monitoring and Care of the Person during Period of Restraint

Restrictive practices should **NOT** be used; or should be minimised whenever possible. If required, any form of restraint must not be used unless:

- where practicable, the person is assessed by the treating medical practitioner and decision-making capacity is documented.
- the medical practitioner has assessed the person as posing a risk of harm.
- the plan is initiated and documented by the medical practitioner and a registered nurse (unless the use of restraint is necessary in an emergency.)
- the restraint used is the least restrictive and is used for the shortest time possible.

- the health service provider has the informed consent of the person or their substitute decision maker/legal representative to use the restraint, unless required in an emergency.
- immediately following restraint in an emergency, a clinical assessment is undertaken and documented by a medical practitioner to identify and treat the underlying conditions that may have caused the behaviour.
- restraint continues to be necessary, then appropriate assessments must be conducted and the restraint must be authorised and documented by a medical practitioner. If authorisation is by a junior medical officer, he/she should consult with a senior medical officer prior to authorisation.

The assessment and care plan should identify:

- the person's usual behaviour and their personal preferences and routines. If the person has a known history of cognitive impairment or dementia, consult with carer/family to ascertain current strategies that may be in place to support their management
- the person's behaviours that are relevant to the need for the restraint
- the alternatives to restraint that have been used (if any)
- any treatable causes of agitation. Reversible causes may include delirium, pain, sensory overload, sensory deprivation, hallucinations and delusions
- documented consultation regarding the restraint with the person (if they have capacity) -unless it is an emergency
- consent by a substitute decision maker or Guardian/Enduring Guardian if required, in the absence of capacity. A decision made on behalf of a person who lacks capacity must be made in the person's best interests
- persons who require an interpreter. Access to a registered interpreter must be provided if such a need is established
- an individualised management plan documented in the person's health record as soon as is practicable and **MUST** include at a minimum:
  - The care to be provided in relation to the person's behaviour; and
  - A risk assessment.
  - A behaviour chart which identifies triggers/underlying; causes and time of day of behaviour that could put the person or others at risk.
  - Medical practitioner/GP to document in the management plan specific parameters for consideration of removal of restraint.
  - Frequency of observations; any additional site requirements.

Key to a decision to use any form of restraint is finding the balance between:

- A person's right to self-determination.
- Protection from self-harm.
- The possibility of harm to others.

7.3 Monitoring

For safety reasons, the person who is under any form of restraint must have physical and behavioural supervision and observation by staff as per medical practitioner's recommendations. The aim of the observation is to:

- ensure the person's safety
- assess their behaviours and mood with a view to ceasing the intervention as soon as possible.

Environmental restraint (i.e. locking a resident in his room) should not be the first response to behaviours of concern, or as a substitute for adequate supervision. If, after careful consideration, environmental restraint is used, following a serious incident, to reduce the risk of harm to a person or others it must be the least restrictive option, for the shortest time possible and only as a last resort. The monitoring must follow the same procedure as for chemical/physical restraint as set out below.

Documentation in this instance must explain and support the decision for the restraint and provide an accurate record of the person's care, monitoring and ongoing regular review of the need for the restraint.

Following the decision to use chemical and/or physical restraint, staff must check and document on the person's observation chart the following at 15 minutes from commencement of the restraint, and then as a minimum hourly thereafter as directed by the medical practitioner:

- Blood Pressure (BP).
- Heart Rate (HR).
- Respiratory Rate (RR).
- Temperature.
- Level of consciousness.
- Oxygen saturation.
- Pain assessment.

If observations are outside of established parameters, refer to:

- WA health system MP0086/18 Recognising and Responding to Acute Deterioration Policy
- WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy and local escalation plans

Staff are to:

- document response to medication used in relation to the restraint
- provide emotional support and reassurance to the person being restrained
- have care and respect for the person's dignity
- check their airway is not compromised
- check skin integrity
- provide position changes for prevention of pressure areas
- ensure adequate nutrition and hydration if permitted based on clinical condition;
- provide regular continence management
- provide continuing assessment to detect any changes to physical condition. If indicated escalate via local processes
- conduct an environmental assessment e.g. noise, light, room temperature
- monitor for decreased level of consciousness, extra pyramidal adverse effects such as: tremor, slurred speech, restless or agitation, involuntary muscle movements, anxiety, distress, paranoia or slowed thinking processes for 48 hours and **notify the medical practitioner immediately of any side effects observed.**

In all instances, if restraint has a direct negative effect on the person, the restraint must be ceased immediately and alternatives sought. If a medical practitioner is not available, the senior clinician will monitor and provide a verbal report to the medical practitioner.

7.4 Review

Regular review of restraint authorisation must:

- be undertaken by two members of the clinical team, the person and/or authorised representative
- be performed at least daily and within the first 12 hours of commencement
- include a plan to identifying the desired outcome and target behaviour of the restraint used. The plan **should** identify when a review **should** be undertaken to determine whether the desired outcome has been achieved and whether the restraint needs to be altered or ceased
- be viewed as an opportunity for removing or reducing the restraint.

7.5 Handover

It is important for prevention, harm minimisation and least restrictive care that all occasions of clinical handover include information regarding:

- any behaviours that have the potential to escalate and could lead to restrictive practices being considered
- any restrictive practices that are in place, the care and review required to minimise harm and the duration.

Handover includes transfer into a service, such as emergency department, handover between shifts, or handover back to the person's residential aged care facility.

8. Mandatory Reporting for Residential Aged Care Providers

From 1 July 2019 it became mandatory for residential aged care providers to provide data on the use of physical restraint to the Department of Health (Commonwealth) (the Department) as part of the Quality Indicators program. Data will be collected each quarter and submitted to the Department through the My Aged Care provider portal. There are two measures and three definitions:

Measure 1: Intent to restrain: This measure is defined as the intentional restriction of a resident's voluntary movement or behaviour by the use of a device or removal of mobility aids, or physical force for behavioural purposes. It requires observation and recording of any instance where any restraint equipment or action is in place to intentionally restrain a resident using devices or actions contained in the definitions A, B and C.

Measure 2: Physical restraint devices: this measure is about counting all devices in use at the time of the assessment for any reason in accordance with Definition B. These are to be counted whether they are being used to intentionally restrain a resident or not.

Definition A: Intent to restrain: Physical restraint is defined as the 'intentional restriction of a resident's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force for behavioural purposes'.

Definition B: Physical restraint devices that are commonly used with physical restraint.

Definition C: other restraints: The assessment process should consider whether placement of furniture, use of concave mattresses, lap rugs with ties or any other devices are used with the intention to restrict movement.

Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019

9. Mental Health

Refer to the:

- *Mental Health Act 2014* (WA) and Mental Health Regulations 2015.
- Policy for Reporting of Notifiable Incidents to the Chief Psychiatrist - Public Mental Health Services 2018 (The MHA 2014 s254, 1 (a-c) and s525 (a-e) outline the types of incidents that must be reported to the Chief Psychiatrist. Notifiable incidents must be reported to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event)
- WA Chief Psychiatrist's Standards for Clinical Care 2015
- Charter of Mental Health Care Principles
- WA Health Clinical Care of People with Mental Health Problems who may be at Risk of Becoming Violent or Aggressive Policy (and supporting information).
- Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services: Policy and Standards.
- WACHS Mental Health Care in Emergency Departments and General Wards Policy.
- WACHS Mental Health Seclusion Policy and WACHS Mental Health Restraint Policy

10. Education

Basic knowledge and education in restraint minimisation strategies and the application of restraints if used should be delivered as an integral part of individual site orientation for all staff and those actively involved in the care and treatment of older persons. This will ensure that staff have the required skills required according to their roles and responsibilities.

Where restraint is an issue in the community setting, access to education for formal and informal carers is essential and should include:

- the ethical, medical, legal issues associated with the use of restraint;
- provision of written guidelines for the application of environmental, pharmacological and physical restraints;
- identification of individuals and groups that may be more vulnerable to harm from restrictive practices – older people, Aboriginals, or those who have a history of trauma;
- the potential harm arising from the use/non-use of restraints;
- optimal prevention, minimisation, assessment and management of aggressive and/or challenging behaviours;
- timely access to medical assessment and treatment of illnesses associated with, and potentially causing aggressive and/or challenging behaviour; and
- monitoring of aggressive, challenging and responsive behaviours and the subsequent use of restraints.

11. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework

issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

12. Records Management

Non-Clinical:
All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System.

Records Management Policy

Clinical:
The use of any form of restrictive practices is to be documented in the person's health record, both during and after any incident involving restrictive practices. This is to include:

- clear and comprehensive documentation of the person's behaviours, the level and type of threat, the circumstances and the unsuccessful alternative strategies
- the results of clinical assessment, assessment of decision-making capacity, clinical rationale
- an individualised care plan developed and approved by the treating team in consultation with the person and their family and with the consent of the relevant legal authority
- the name of the medical practitioner authorising the restraint
- the names, signatures and designations of the registered nurse initiating confirming the care plan and describing the use of restrictive practices; and
- the duration of the pan and proposed review timeframes.

Health Record Management Policy

13. Evaluation

- Regular audit and clinical review of the use of restraints, including individual case review, critical incidents (SAC1) and near misses
- Seek consumer experience and feedback and consumer engagement
- All incidents of restraint must be entered on CIMS Datix
- Oversight and reporting of training and education – LMS Capabiliti Use of Restraints ACO9 EL2

14. Standards

National Safety and Quality Health Care Standards:
Clinical Governance Standard: 1.1, 1.2, 1.6,
Partnering with Consumers Standard: 2.6, 2.7, 2.10,
Medication Safety Standard: 4.2, 4.3, 4.4, 4.10, 4.15
Comprehensive Care Standard: 5.35
Communicating for Safety Standard: 6.2, 6.3, 6.4, 6.7, 6.8, 6.9, 6.10, 6.11

Aged Care Quality Standards
Standard 1

Standard 8

WA Chief Psychiatrist's Standards for Clinical Care 2015

15. Legislation

*Aged Care Act 1997 (*Cwtlh)
Australian Charter of Health Care Rights
Australian Human Rights Commission Act 1986
Carer Recognition Act 2010 (Cwtlh)
Charter of Aged Care Rights 2019
Quality of Care Principles 2014 (Amended 1 July 2019)
Carers Recognition Act 2004) (WA)
Disability Services Act 1993 (WA)
Equal Opportunity Act 1984 (WA)
Guardian and Administration Act 1990 (WA)
Health Practitioner Regulation National Law Act 2010 (WA)
Health Services Act 2016 (WA)
Medicines and Poisons Act 2014) (WA)
Medicines and Poisons Regulations 2016 (WA)
Mental Health Act 2014 (WA)
Occupational Health and Safety Act and Regulations 1984 (WA)
The Western Australian Carers Charter - schedule 1, page 13 of the Act.

16. References

Australian Government: Department of Health. Ageing and Aged Care

Australian Government: Department of Health and Ageing (2012) Australian Safety and Quality Commission - Minimising Restrictive Practices Decision-making tool: Supporting a restraint-free environment in residential aged care

Australian Government: Department of Health, myagedcare National Aged Care Mandatory Quality Indicator Program Manual

Australian Medical Association (AMA) [Internet] Restraint in the Care of People in Residential Aged Care Facilities; 2001 (revised 2015); published 24 March 2015 [Accessed: 19 August 2019]

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New South Wales Agency for Clinical Innovation, 2013 Minimising Restraint Use in Adults toolkit

Peisah C, Skladzeing E. The use of Restraints and Psychotropic Medications in People with Dementia. Alzheimer's Australia; 2014; 36 p. Paper 38. Office of the Public Advocate WA [Internet] Government of Western Australia: Department of Justice [Accessed 19 August 2019]

Position Statement 2015 'Restraint in the Care of People in Residential Aged Care Facilities' 2001 revised 2015,

Ranasinghe C, Gray L, Beattie E. Management of Behavioural and Psychological Symptoms of Dementia (BPSD) Australian and New Zealand Society for Geriatric Medicine - Position Statement 26; 2016; 14 p.

Charter of Mental Health Care Principles (the Charter)

17. Related Policy Documents

WACHS

Adults with Impaired Decision Making Capacity Procedure
Advance Health Directive and Enduring Power of Guardianship Guideline
Alcohol Tobacco and Other Drugs Clinical Practice Standard
Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy.
Clinical Observations and Assessment Clinical Practice Standard
Cognitive Impairment Clinical Practice Standard
Consumer and Carer Engagement Policy
Disturbed Behaviour Management Clinical Practice Standard
Employee Assistance Program Policy
Medication Administration Policy
Mental Health Restraint Policy
Mental Health Seclusion Policy

18. WA Health System Policies

Aboriginal Health and Wellbeing Framework 2015-2030
MP0095/18 Clinical Handover Policy
OD0657/16 WA Health Consent to Treatment Policy
OD0592/15 WA Open Disclosure Policy
MP0043/16 Reporting of Criminal Conduct and Professional Misconduct Policy
MP 0124/19 WA Health Code of Conduct
OD0589/15 WA Health Complaints Management Policy
MP0127/20 Discipline Policy
WA Chief Psychiatrist's Standards for Clinical Care 2015

19. Policy Framework

Clinical Governance Safety and Quality

20. Appendices

Appendix 1: Restraint Minimisation Decision Making Flowchart
Appendix 2: Alternatives to Restraint
Appendix 3: Culturally Specific Considerations.

This document can be made available in alternative formats on request for a person with a disability

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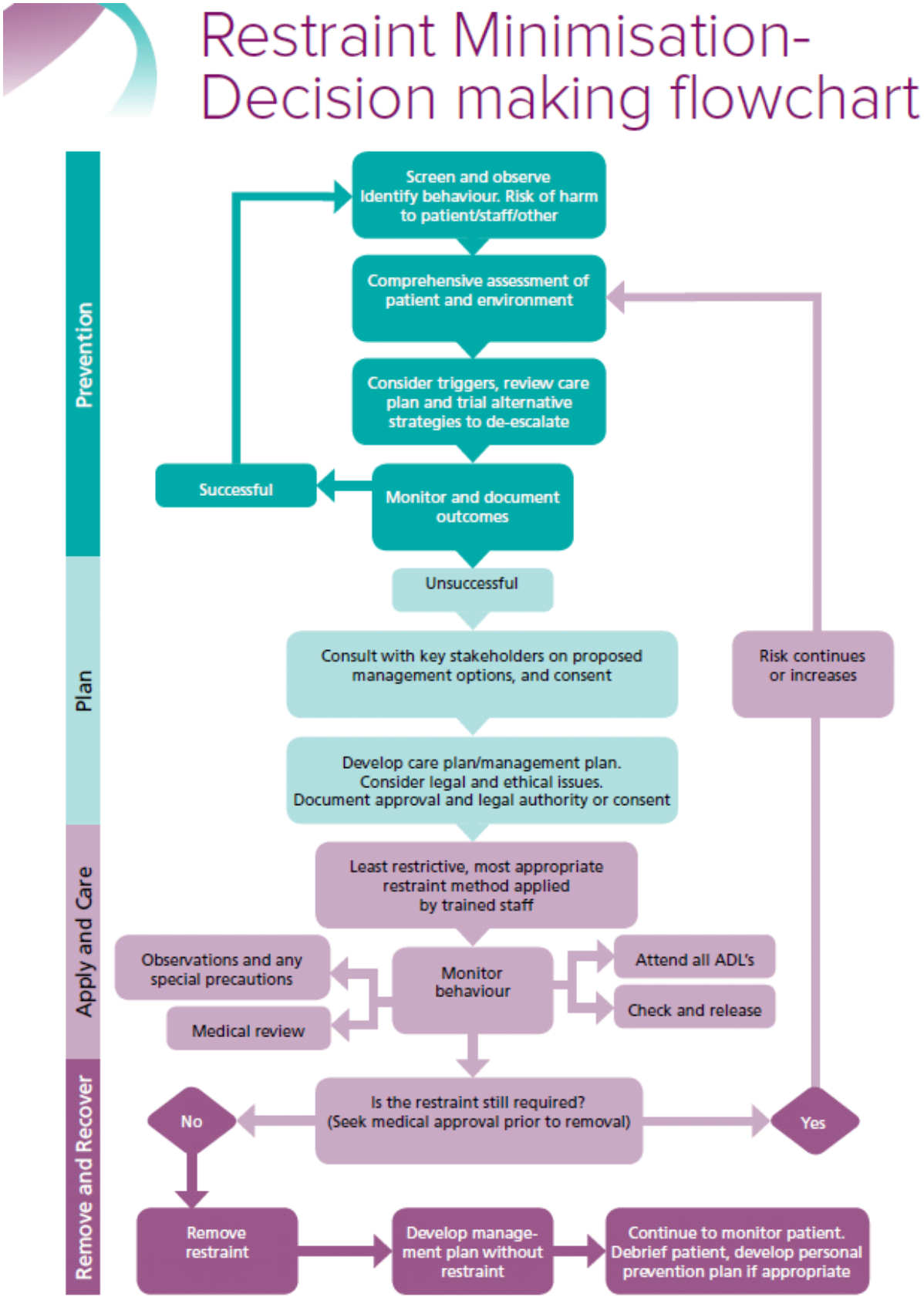
Appendix 1: Decision Making Flowchart.



Flowchart adapted from "Minimising restraint use in adults toolkit", NSW Agency for Clinical Innovation, 2013.

Appendix 2: Alternatives to Restraint

Environmental Changes	Care Approach	Alarms
▪ Improved lighting ▪ Easy access to turn on lights ▪ Lowered bed heights ▪ Non-slip strips on floors and non-slip floors • Non-slip footwear ▪ Clutter-free and reduced glare in corridors ▪ Appropriate seating ▪ Hip protectors ▪ Appropriate mobility aids ▪ Activity areas • Signage	▪ Person-centred care ▪ Spending one on one time ▪ Individualised and structured routines ▪ Communication strategies ▪ Increased supervision and staff interaction ▪ Identification of behaviour triggers ▪ Appropriate staffing levels and skill mix ▪ Regular evaluation and monitoring of conditions that may alter behaviour ▪ Address cultural needs – use of an interpreter	▪ Bed, chair or wrist alarms• Exit door alarms ▪ Electronic sensor systems

Activities and Programs	Physiological Alternatives	Psychosocial Alternatives
▪ Exercise programs that involve teaching safe transfers ▪ Walking programs ▪ Falls prevention programs ▪ Continence management programs ▪ Physical, occupational and recreational therapies ▪ Exercise incorporated into daily care plan ▪ Night time activities for those that wander at night ▪ Structured daily routines ▪ Activity boxes	▪ Comprehensive medical examinations and review ▪ Treat/remove any physiological causes of altered mental state ▪ Pain management ▪ Regular review of medications ▪ Regimens to help overcome insomnia. ▪ Nutrition and hydration management ▪ Glasses/hearing aids in place	▪ Provide companionship ▪ Increase social interaction ▪ Use familiar staff ▪ Therapeutic touch ▪ Relaxation techniques ▪ Aromatherapy ▪ Reduced lighting ▪ Reality orientation ▪ White noise for insomnia ▪ Sensory aids ▪ Sensory stimulation – increase or decrease as per individual needs ▪ Reduced environmental noise

(Adapted from Alzheimer's Australia 2014)

Appendix 3: Culturally Specific Considerations

Culturally and Linguistically Diverse People: There are increasing numbers of people from CALD communities who have come from war torn countries, have been the victims of abuse and torture in their country of origin, or have been subjected to lengthy periods of incarceration upon arrival in Australia. The risk of re-traumatisation is significant among this group and. their fear of authority figures may be substantial.

Cultural issues, such as access to a place and time for prayer, may be enough to reduce significant stress for people in this group. Providing appropriate options for food (such as halal food) and, where ever possible, utilising the same gender of staff to the individual are other considerations. People from a CALD background may have difficulty communicating their needs and accessing a translation service. Culturally inappropriate care may exacerbate behavioural symptoms

Where linguistic barriers exist, qualified interpreters should be used as early as possible to explain what is happening to both the consumer and their carers or family. The use of diagrams, telephone based interpreting, online translation for those who can read, assist to keep the person calmer when face to face interpreter services are difficult to access. Extra attention should be given to body language and non-verbal communication.

Aboriginal People: An awareness of the trauma experienced by Aboriginal people is important. Aboriginal people may have been subjected to varying degrees of trauma, violence and marginalisation within the community and the risk of re-traumatising this group is significant. Care and consideration should be given to the relationship Aboriginal people have to the land and that cultural issues can vary considerably between different Aboriginal communities.

Behaviours that may have some cultural basis include:

- Needing to ‘yarn’ and/or tell ‘stories’
- Shyness
- Limited eye contact
- A need to feel the earth
- A need to be outside
- Hiding the face when smiling
- Not interacting with the opposite sex
- Cultural constraints on interactions and activities due to having undertaken traditional lore
- Hearing ancestors talking
- ‘Sorry cuts’ for the acknowledgement of grief or sorrow

A prompt determination regarding the need for an interpreter and/or cultural advisor must be made and facilitated as soon as practicable. Involvement of an Aboriginal Liaison Officer can facilitate these processes.