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POSITION STATEMENT

Use of restrictive practices in Residential Aged Care Facilities

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This document outlines the AMA position on use of restrictive practices in the care of people in residential aged care facilities (RACFs).

1. Guiding framework

1.1. AMA is committed to achieving better health outcomes for all Australians by working with all stakeholders to minimise the use of restrictive practices in aged care.

1.2. The patient's needs and rights should always be the first consideration when considering the application of restrictive practices. Patients have died or been seriously injured or harmed by inappropriate use of restrictive practices.

1.3. Under Australian aged care legislation, the responsibility for decisions surrounding environmental restraints, mechanical restraints, physical restraints and seclusion lies solely with aged care providers. The role of the doctor is limited to advocacy on behalf of the patient in ensuring their clinical appropriateness. For this reason, this position statement focuses primarily on the role of doctors in prescribing chemical restraint, for which doctors have clinical responsibility.

1.4. The application of restrictive practice should always be based on individual assessment of the patient and their needs. The assessment must take into consideration ethical, legal and medical domains. Key to this decision is finding the balance between

- a patient's right to self-determination and the right to live their best lives
- protection from harm
- the possibility of harm to others.

1.5. The medical practitioner providing patient care is ultimately responsible for clinical decisions to prescribe chemical restraint. Before making the clinical decision, the medical practitioner must understand the patient's needs, the acute health issue being addressed, understand the options available to address that issue, and weigh the positive and negative aspects of each option, including the option of not prescribing.

1.6. The decision for chemical restraint should not occur in isolation. It involves a process of patient assessment, care team involvement and consent by either the patient or substitute decision-maker within an ethical and legal framework.

1.7. Any decision to prescribe and apply chemical restraint, as defined below, must be documented and signed by the doctor in the patient's record.

2. Definitions

2.1. Restrictive practice is any practice or intervention that limits the rights or freedom of movement of an aged care recipient. Restrictive practices under the legislation include chemical restraints, environmental restraints, mechanical restraints, physical restraints and seclusion.[1]

2.2. Chemical restraint is used in this position statement to describe the practice or intervention involving use of medication that is administered for the purpose of influencing the behaviour of a person.[2] It does not include the use of medication prescribed for the treatment of the consumer for a diagnosed mental disorder, a physical illness or a physical condition, or end of life care.

2.3. Psychotropic medications are any drug capable of affecting the mind, emotions, and behaviour.

2.4. Behavioural and Psychological Symptoms of Dementia (BPSD) refers to the non-cognitive presentations of dementia, such as agitation, aggression, psychosis, depression and apathy.[3]

2.5. Terms 'patient', 'aged care recipient' and 'resident' are used interchangeably in this document.

3. Principles

3.1. Environmental restraints, mechanical restraints, physical restraints and seclusion should play almost no part in the care of patients in residential aged care facilities due to their impact on the rights and safety of the individual. Under Australian aged care legislation, the responsibility for decisions surrounding these forms of restraint lies solely with aged care providers and the role of the doctor is limited to advocacy on behalf of the patient in ensuring their clinical appropriateness. For this reason, this position statement focuses primarily on the role of doctors in prescribing chemical restraint.

3.2. The AMA believes that the prime consideration of application of chemical restraint should be the safety, wellbeing and dignity of the patient.

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[1] Aged Care Quality and Safety Commission, Minimising the use of restrictive practices.

[2] Aged Care Quality and Safety Commission, Minimising the use of restrictive practices.

[3] Roya Australian & New Zealand College of Psychiatrist (Dec 2022), Clinical Guideline: Assessment and Management of Behaviours and Psychological Symptoms associated with Dementia (BPSD).

3.3. Chemical restraints should only be considered where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained.

3.4. The AMA believes that any use of chemical restraint must always be the last resort after exhausting all reasonable alternative management options, and only after appropriate informed consent has been obtained

3.5. The AMA supports using the least restrictive form of restraint and only as a temporary solution. It must be time limited and subject to regular review and with a clearly defined goal of treatment. If chemical restraint is used it must be in the lowest effective dose for the minimum necessary period. If impacts such as sedation, falls, reduced function and quality of life occur, then early review should occur and deprescribing should be considered.

3.6. Prescribing chemical restraint should take into consideration any previously expressed or known values and wishes of the patient including those expressed in a patient's Advance Care Directive or known by substitute decision makers. In the short term the welfare and protection of others (patients, carers, residents and staff) and the statutory occupational health and safety obligations on employers should also be considered.

3.7. However, restraint of a patient for staff convenience or to manage patient/resident workloads in RACFs is unacceptable. RACFs should be appropriately funded and monitored to ensure presence of Registered Nurses on staff 24/7 and adequate staff to resident ratios. Any RACF funding model and its accreditation must ensure that staff are adequately trained to recognise and manage BPSD in residents.

3.8. Many challenging and changed behaviours can be prevented or minimised through appropriate social and staffing structures, including staff to resident ratios in RACFs, and the implementation of evidence-based and person-centred strategies along with creative, friendly physical environments.

3.9. Before considering prescribing chemical restraints the attending medical practitioner should thoroughly assess the underlying causes of aggressive and/or challenging behaviour, particularly taking into consideration any recent change in behaviour. The assessment should be done in partnership with the patient's substitute decision makers, family and RACF staff and seek to understand why an individual patient may be responding in this way to their condition and their environment.

3.10. The medical assessment should ensure that any organic causes of changed behaviour are excluded before chemical restraint is considered and that all other non-pharmacological interventions have been tried and exhausted.

3.11. Those causes which are medical, such as delirium or pain, or which may respond to medical interventions, such as depression, psychosis, anxiety and should be considered and treated. The application of psychotropic medication may remain appropriate if only to directly treat a specific medical or psychiatric condition.

3.12. A key consideration when making decisions to prescribe chemical restraint is the capacity of the patient to consent. Consent should be sought in line with legislated requirements, whenever restraint is used.

3.13. The AMA supports continuity of care by the patients' usual medical practitioner. Continuity of care after the patient has developed dementia and/or has moved into

residential aged care can result in better patient-centred care, reduced need for restrictive practices and prevent inappropriate initiation of psychotropic medicines.[4] [5]

3.14. All health and residential care facilities must ensure mechanisms are in place for timely review and regular monitoring of restrictive practices, their effectiveness and any negative consequences to the care recipient. The review must take into consideration both the welfare of a patient and the welfare of others and should ideally include objective measures of response to treatment which can be compared against initial goals. In the AMA view, practice of prescribing chemical restraint 'just in case' is unacceptable.

3.15. The AMA supports improved partnerships between RACFs and the prescribers. Such partnerships are beneficial as they can lead to improved awareness of BPSD in patients, better management of BPSD by RACF staff and improvement of overall health and wellbeing of residents.

3.16. Patients, families of patients and/or their substitute decision makers, health care professionals and staff must be informed about and have access to mechanisms to complain, anonymously if desired, about the use of restraints.

4. Education and training

4.1. Education about the issues related to restrictive practices should be a fundamental element of training for health professionals.

4.2. The AMA upholds that basic education courses and continuing education in the application of restrictive practices should become an integral part of education for health care professionals and all those actively involved in the care and treatment of older persons within RACFs.

4.3. Where restraint becomes an issue in domiciliary settings, access to education for formal and informal carers is essential.

4.4. Education and training should be developed and delivered in collaboration with the RACF Medication Advisory Committee and should include:

a. The ethical, medical, and legal issues associated with the use of restraint.
b. Provision of written guidelines for the application of chemical restraints.
c. The potential for harm arising from the use or non-use of restraints.
d. Optimal prevention, minimisation, assessment and management of aggressive and/or challenging behaviour.
e. Timely access to medical assessment, specialist advice and treatment of illnesses associated with, and potentially causing aggressive and/or challenging behaviour.

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[4] Welberry, Jorm, Schaffer, et al. (2021), Psychotropic medicine prescribing and polypharmacy for people with dementia entering residential aged care: the influence of changing general practitioners. MJA.

[5] Delgado, Evans, Pereira Gray, et al. (2022), Continuity of GP care for patients with dementia: impact on prescribing and the health of patients. BJGP.

f. Regular audit and clinical review of the use of restraint in the facility including individual case review, critical incidents and near miss monitoring, aggressive and/or challenging behaviours and the subsequent use of restraint(s).
g. Flexible work practices.

4.5. Medical practitioners have an educative and mentoring role in minimising the use of restrictive practices and advocating for the rights and wellbeing of their patients.

See also:

AMA Position Statement: Resourcing Aged Care 2018

AMA Position Statement: Health and Care of Older People 2018

AMA Position Statement: Medical Care for Older People 2020