POLICY

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RAC_Restrictive Practice Policy

Purpose

To provide policy, position and/or procedural information on Restrictive Practice 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 a restrictive practice.
- Restrictive practice only considered after exhausting all reasonable alternative strategies. In these circumstances, a restrictive practice in relation to a resident is used only:
    - as a last resort and for the shortest time, necessary to prevent harm to the resident or other persons; and
    - after consideration of the likely impact of the use of the practice on the resident.

Applicability / Scope

This policy applies to Residential care employees of CHL.

Only Registered Nurses can complete the Assessment and Restrictive Practice Authorisation and Evaluation procedures for this policy.

All nursing staff can apply, document, and release Restrictive Practices in accordance with the procedure and a Resident's Care Plan.

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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Definitions

Approved Health Practitioner	An approved health practitioner is defined as a **Medical Practitioner**, **Nurse Practitioner or Registered nurse.**
Authorised Representative	The person recognised by the Home Management as the Legal 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. An **'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)
DBMAS	Dementia Behaviour Management Advising Service
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.ndis.gov.au/)
SRBT	Severe Behaviour Response Teams
Perimeter Alarms	Alarm is activated when a Resident moves away from the designated perimeter.
Restrictive Practice	Any practice or intervention that has the effect of restricting the rights or freedom of movement of a resident.

National Quality Indicator Definitions (From 01 July 2021)

Physical Restraint	The Quality of Care Principles 2014 (Quality of Care Principles), define restrictive practices as any practice or intervention that has the effect of restricting the rights or freedom of movement of a care recipient. The QI Program physical restraint quality indicator measures and reports data relating to all restrictive practice, excluding chemical restraint. This includes physical restraint, mechanical restraint, environmental restraint, and seclusion, as defined in the Quality of Care Principles. Approved providers of residential aged care must collect and report on physical restraint data quarterly, according to the requirements set out in the National Aged Care Mandatory Quality Indicator Program (QI Program) Manual 2.0.

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1. Restrictive Practice Management

Catholic Healthcare Limited strive to preserve the dignity, autonomy, safety, and human rights of Residents. Management and staff are committed to a person-centred care approach, and appropriate behavioural management to avoid the use of restrictive practice. Restrictive practice is only considered after exhausting all reasonable alternative strategies. In these circumstances the least restrictive form of restrictive practice is used.

2. Practices or Interventions that are Restrictive Practices

1. 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. *Refer to RAC_Psychotropic Medication & Chemical Restraint Policy.*

2. Environmental Restraint is the practice or intervention that restricts, or that involves restricting, a resident's free access to all parts of the resident's environment, including items and activities, for the primary purpose of influencing a resident's behaviour.

3. Mechanical Restraint is the practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a resident's movement for the primary purpose of influencing the resident's behaviour. It does not include the use of a device for therapeutic or non-behavioural purposes in relation to the resident.

4. Physical Restraint is the practice or intervention that:

    - is, or that involves, the use of physical force to prevent, restrict or subdue movement of a resident's body, or part of a resident's body, for the primary purpose of influencing the resident's behaviour; but
    - does not include the use of a hands-on technique in a reflexive way to guide or redirect the resident away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the resident.

5. Seclusion is a practice or intervention that is, or that involves, the solitary confinement of a resident in a room or a physical space at any hour of the day or night where:

    - voluntary exit is prevented or not facilitated; or
    - it is implied that voluntary exit is not permitted.

    for the primary purpose of influencing a resident's behaviour.

3. Examples of Restrictive Practice

Restrictive practice can be applied through **devices, equipment, furniture, secured spaces or actions** to limit the movement of a resident, excluding examples of chemical restraint, as bellows:

Environmental Restraint	• **Bed against a wall** - A bed pushed against a wall restricting the free movement of the Resident using that bed, this would be considered a form of restrictive practice. • Restricting access to an outside courtyard, sitting room, or excluding a Resident from an area to which they want to go. • Secure dementia units. • **Perimeter alarms** used by staff to prevent a Resident from leaving. Refer to *Aged Care Quality and Safety Commission - Perimeter restraint self-assessment tool*. • The use of a coded keypad on doors to exit the Home. • Preventing a Resident who has capacity and physical ability to make a decision to leave the Home or restricting free movement.
Environmental Restraint Not Permitted in the Homes include:	• Psychological measures that create a belief that acts to limit a Resident's mobility such as placing a tape across a doorway to stop them from exiting the room or blocking /locking the door.
Mechanical Restraint	• Bedrails **which restricts resident's free movement** • Protective chairs with table. • Lap belts or seat belts on chairs/princess chair. • Chairs that are difficult to get out of such as princess chairs, beanbags, water chairs, deep chairs, rockers, recliners, removing cushion. • Concave mattresses or bumpers. • Leaving meal tray in place for extended period. • Wedging a chair next to a table so the resident is 'stuck'. • **Low bed** or **Lo Lo Bed-** the use of this bed that restricts the movement of the resident to get in and out of bed themselves and in the absence of documentation to determine the use of the bed, this would be considered a form of restrictive practice.
Mechanical Restraint Not Permitted in the Homes include:	• Pelvic belts  • Posey criss-cross vest  • Soft wrist or hand mitts restraints.  

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<table>
<tr><td rowspan="2">Mechanical Restraint Not Permitted in the Homes include:</td><td colspan="2">• Restrictive clothing, e.g., ‘all-in-one’ leotard-type underwear, overalls, and outer clothes which zip at the back.</td></tr>
<tr><td>• Leg or ankle restraints
  </td><td>• Manacles/shackles (hard)
  </td></tr>
<tr><td>Seclusion Not Permitted in the Homes include:</td><td colspan="2">• Placing/locking a Resident alone in a space or in of their bedroom from which they cannot exit, including in a space by themselves where their access to a call bell or walker is limited, or imposing a ‘time out’.</td></tr>
<tr><td>Physical Restraint Not Permitted in the Homes include:</td><td colspan="2">• Physical Restraint is the control of a Resident’s behaviour through the use of:
o Physical force or ‘hands on’ that limits a Resident’s mobility.
o Physically holding a resident in a specific position to enable personal care issues such as showering to be attended to, pinning a resident down, or physically moving a resident to stop them moving into a specified area where they may wish to go.</td></tr>
</table>

3.1 Not Considered as a Restrictive Practice/ Not Requiring a Restrictive Practice Authorisation

Bed against a wall	If the Resident can **freely get out of the other side of the bed**, then the wall is not a restrictive practice.
Low bed or Lo Lo bed	It is not considered a restrictive practice if a Resident **cannot mobilise.**
Mental Health Care Contracts/Care Plan	Mutually agreed upon Care Contracts, between the Resident and care staff to facilitate the provision of assistance with activities of daily living, are not considered to be aversive treatment when they form part of the Resident's mental health care planning and have been developed through a process of consultation and collaboration with allied health professionals, e.g., DBMAS interventions – 'Actions with Consequences'.
Environmental Restraint	<u>It is not Environmental Restraint:</u> • If a Resident **overall health condition**, and not their environment, restricts their free movement. • Perimeter alarms are not considered a restrictive practice if the Home is using the alarm system to notify staff if a resident enters or exits the Home. • If this alarm system does not prevent the resident from leaving the Home and the alarm system does not restrict the resident's free movement. • If the PIN-code to exit the Home is provided to the Resident and they can used it.
Tray Table (Fixed or Mobile)	It **does not consider** the used of tray table (Fixed or Mobile) device ***during meals or an activity*** to be a restrictive practice.  
Tub/Water Chairs	It **does not consider** the use of Tub/Water Chairs for the comfort and pressure area care of Residents **who are not able to mobilise** to be a restrictive practice. 

4. Consideration

- A Resident's family member or Authorised Representative DOES NOT have the legal power to require that a resident be restrained.
- A Resident may make a specific request to use a restrictive item, such as bedrails, to provide them with an enhanced feeling of comfort and security. Where this has been an informed decision this individual's choice should be acknowledged; an informed decision would require that other options have already been discussed with this Resident. Any device or action that interferes with a Resident's ability to make a decision or which restricts their free movement is a restrictive practice.
- Because bedrail is considered High-Risk Restrictive Practice, bedrail use should only be based on clinical judgement and risk assessment in consultation with the Resident, Medical Practitioner, Registered Nurse and/or other relevant Health Professionals.

5. Alternative Strategies

Catholic Healthcare aims to create a Restraint Free Environment by implementing:

5.1 Environmental Initiatives

- Improved lighting.
- Lights that are easy to use.
- Non-slip flooring.
- Carpeting in high-use areas.
- Ensure a clear pathway.
- Easy access to safe outdoor areas.
- Activity areas at the end of each corridor.
- A quiet area.
- Orientation (e.g., use pictures).
- Reduce environmental noise.
- Safe areas for Residents to wander.
- Corridors with activity stations.
- Protected outdoor areas.
- Seating to meet the needs of individual Residents.
- Lowered bed height to suit individual needs.
- Provide familiar objects from the Resident's home (e.g., photo albums, furniture etc).
- Appropriate mobility aids close at hand (railings on the wall, appropriate signage, and visual reminders to aid).
- Appropriate alarm systems to alert staff to risky situations (e.g., a Resident who has wandered into a dangerous area).

5.2 Activities and Programs

- Falls prevention program.
- Regular ambulation.
- Continence program.
- Night-time activities.
- Facilitate safe wandering behaviour.
- Individual and group social activities.
- Rehabilitation and/or exercise program.
- Physical, occupational, and recreational therapies.
- Appropriate outlets for industrious people (e.g., gardening, folding linen).
- Activities box containing, for example, laundry to fold, stuffed animals, purses, and wallets.
- Offer a change of seating arrangements at regular intervals with their consent, for Residents who are not independently mobile.

5.3 Alterations to Nursing Care

- Know the Residents as individuals.
- Increased supervision and observation.
- Appropriate footwear.
- Increased staffing level as required.
- Check 'at-risk' Residents regularly.
- Body padding (e.g., hip/head protectors).
- Better communication strategies.
- Individualised & structured routines e.g., toileting, naps.
- Regular evaluation and monitoring of conditions that may alter behaviour, e.g., noise level.

5.4 Psychosocial Programs and Therapies

- Companionship.
- Active listening.
- Visitors.
- Staff/Resident interaction.
- Familiar staff.
- Therapeutic touch.
- Massage.
- Relaxation programs.
- Reality orientation.
- Sensory aids.
- Sensory stimulation.
- Decreased sensory stimulation.

5.5 Physical Strategies

- Specialist referral- DBMAS, SRBT, Psychogeriatrician.
- Comprehensive physical check-up.
- Comprehensive medication management review.
- Treat infections.
- Pain management.
- Physical alternatives to sedation (e.g., warm milk, soothing music).

Please note that these alternative strategies all need to be considered before a Restrictive Practice is used as a last resort. In these circumstances the least restrictive form is used.

6. Use of a Restrictive Practice

The Home Must not use a restrictive practice on a resident unless certain conditions are met in relation to the use of that restrictive practice.

7. Before a Restrictive Practice is Used

The four conditions which **Must** be satisfied before using a restrictive practice are:

7.1 Assessment by an Approved Health Practitioner

An approved Health Practitioner (as per definition), who has day to day knowledge of the resident, **must** conduct an assessment. The approved Health Practitioner **Must** assess whether:

- the resident poses a risk of harm to themselves, or another person; and
- it is necessary to use a restrictive practice due to the risk of harm.

Unless the Restrictive Practice is necessary in an emergency, the assessment Must be documented before the restrictive practice is used.

7.2 Alternatives to the Use of the Restrictive Practice

The Home **must** consider whether the risk of harm can be managed by using any alternatives to physical restrictive practice and use those alternatives to the extent possible. The use of physical restrictive practice should always be the **last resort** and viewed as a temporary solution to any behaviour causing concern or circumstantial factor.

Unless the physical restrictive practice is necessary in an emergency, the Home **must** document its consideration, and use of, these alternatives before the physical restrictive practice is used. The Home must document the alternative strategies to restrictive practice which have been considered and used and the reasons why they were not successful.

7.3 Risk Assessment & Least Restrictive Form of the Restrictive Practice

The Home **Must** ensure it uses the least restrictive form of the restrictive practice to address the risk of harm. *eCase Risk Assessment* needs to be completed before consideration of the restrictive practice.

To use the least restrictive form of the restrictive practice, the Home **Must** have regard to the total period for which restrictive practice will be used, including periods of release. This should be determined before the restrictive practice is commenced.

7.4 Informed Consent

The Home **Must** ensure the following is completed:

- **Case conference conducted annually** and as required with the Resident (if applicable) and/or their Authorised Representative.
- *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form* signed by the Resident (if applicable), or their Authorised Representative.
- Upload the signed consent form to ***eCase Galley***.
- Ongoing consent from the Resident and/or their Authorised Representative Must be obtained according to review **timeframe** on *RAC_Restrictive Practice (other than Chemical) Assessment and Consent Form*.
- Maintain and update *SOM – Clinical Directive Register*.

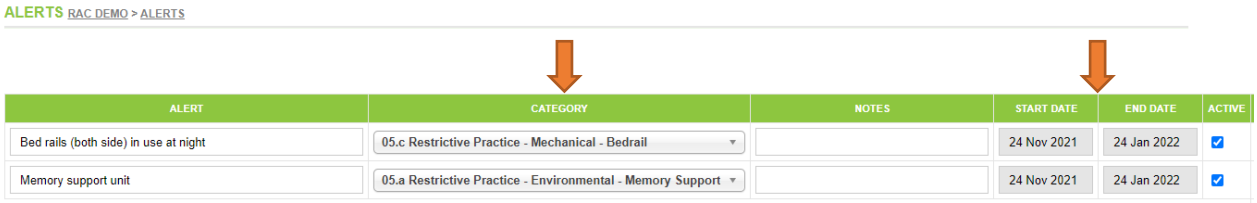
Note:

Legal requirements for consent to use the restrictive practice:

- A Resident's Authorised Representative (refer to above definition) have the legal capacity to consent to the use of the restrictive practice.
- A guardianship order or an enduring power of attorney may cover a limited range of matters not including decisions about the 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 the 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 the restrictive practice for the Resident requiring a restrictive practice.
- Service providers should obtain legal advice in cases where there is any doubt about the use of the 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.

7.5 eCase Alert

If the Home uses a restrictive practice 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 on *RAC_Restrictive Practice (other than Chemical) Assessment and Consent Form*.



8. Emergency Intervention

Emergency Intervention of the restrictive practice may be required for the short-term management of a situation where the Resident is about to engage in an activity, and they could hurt themselves or someone else. The restrictive practice Must be considered a necessity to avoid death or serious harm.

In such an instance, staff Must use the least restrictive form of the restrictive practice possible and:

- Contact the Medical Practitioner (or an after-hours service), as soon as possible for further instruction.
- Evaluate and follow up the incident according to Behaviour Management protocols.

Examples of the possible need for Emergency Intervention would be where:

- A visitor to the Home has accidently allowed a new Resident out of a secure environment. The Resident is attempting to walk onto the street and is at risk of being injured by a car, and verbal redirection is not achieving a safe environment for the Resident OR
- Aggressive behaviour is placing the Resident at risk of physical injury to themselves or another person.

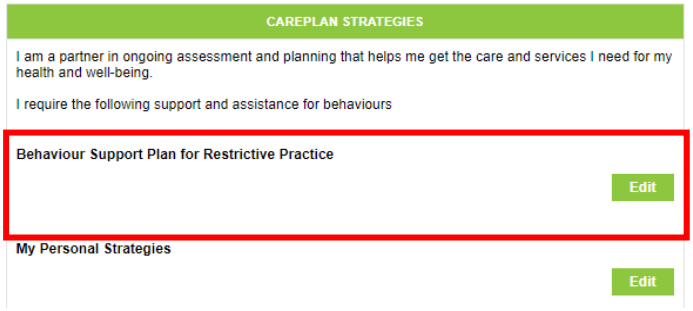
In all cases, the decision to restrict a person's voluntary movement or behaviour should only be made after weighing up the risks of using the restrictive practice against the risks of not using the restrictive practice.

9. While a Restrictive Practice is being Used

If the Home uses a restrictive practice on a Resident the following requirements **Must** be met:

9.1 Behaviour Support Plan within Behaviour Care Plan Should Include and Identify:

- The Resident's behaviours that are relevant to the need for the restrictive practice.
- The alternative strategies to the restrictive practice that have been used, exception of emergency situations.
- The reasons that the restrictive practice is necessary.
- The care to be provided to the Resident in relation to the Resident's behaviour.



9.2 Minimum Time Necessary

The restrictive practice **Must** only be used for the minimum time necessary.

9.3 Monitoring and Review

While the Resident is subject to the restrictive practice, the Home **Must**:

- regularly monitor the Resident for signs of distress or harm; and
- regularly monitor and review the necessity for the restrictive practice.

  Note: Please refer to **Documentation and Process Map for Restrictive Practice** in this policy for how to monitor, review, and release restrictive practice.

The use of the restrictive practice itself poses risk. For the protection of a Resident who is restrained the Home should ensure:

- the correct use of the restrictive practice.
- the frequency and type of observation required.
- comfort and safety of the Resident through maintaining activities of daily living such as regular toileting, hydration, nutrition, exercise and mobility, skin care, pain relief, and social interaction.

The Home **Must** also regularly monitor and review the use of the restrictive practice to determine whether it is still required and optimal. The review **Must** reassess the need for the use of the restrictive practice and consider alternative strategies to the restrictive practice.

10.Restrictive Practice: Mechanical Restraint - Bedrails

Bedrails being raised to an upright position **which restricts resident's free movement** **is a mechanical restraint** and increases the risk of injury and mortality to a resident.

Use of bedrails requires appropriate **consultation** and **clinical assessments** including a **risk assessment** to be undertaken. The use of bedrails should be the **last resort**.

Note: To minimise the use of restrictive practice, CHL new built Homes will be implemented king size bed without bedrails. When the Home to replace existing bed, king size bed without bedrails will be purchased.

10.1 Risk Assessment and Consent

Note: A family member or a Legal Authorised Representative **does not** have the **authority** to request for bedrails to be applied.

Bedrails used can be harmful. There are potential risks (some of which are serious) associated with the use of bedrails and hazards related to the use of this equipment include:

- Parts of a person's body can become trapped where there are gaps, for example between the rails of the bed rail, between the mattress and bed rail, between the mattress and bedhead/bed-end, between the end of the bed rail and the headboard/footboard.
- The risk of suffocation if the person's face is wedged against a soft surface (mattress or bed rail cover) restricting breathing.
- Injuries from falls if the person climbs over the rails.
- Injuries from falling or striking against the rails.

Before making decision to use bedrails ensure all other alternative options have been considered. Many people can be safe in their beds without the use of rails. Other options to consider include but not limited to:

- Consider the need for a medical review (medication affecting sleep/settling, skin integrity, nutrition, pain management, circulation, etc).
- Ensure needs are anticipated (e.g., drinks are accessible, regular toileting, call bell within reach).
- Ensure falls prevention strategies, behaviour management and continence management have been assessed and implemented.
- Lowering an electrically height adjustable bed close to minimum height for sleeping (use caution where person can independently transfer).
- Using lo lo beds that can be lowered to floor level or near.
- Placing a fall out mattress next to the bed if the person is at risk of falling out of bed.
- Using other bed mobility aids to assist bed mobility, such as overhead grab bars.
- Use of monitoring systems/sensor alarms/alarm devices.
- Increased supervision when in bed.
- Using a larger bed.
- Catholic Healthcare Limited recommends that bed rails are removed from a bed if they are not required to reduce the risk of accidental use.

In some situations, the above options may not work for an individual person. Decisions about the use of bed rails should be based on clinical judgement and risk assessment in consultation with the Resident, Medical Practitioner, Registered Nurse and/or Allied Health Professional.

This includes the completion of the *eCase Mobility and Transfers Assessment, eCase PAS – CIS Assessment (Generated Behaviour Care Plan), eCase Cornell Depression Scale Assessment (as required), eCase Risk Assessment, eCase Sleep Assessment* and other relevant assessments and charts such as the *eCase Falls Risk Assessment Tool (FRAT).*

The rationale for using bedrails MUST be documented in eCase Resident's *Progress Notes and Behaviour Support Plan within Behaviour Care Plan.* Regularly evaluate the use, effectiveness and ongoing need for bedrails and document this in the Resident's Behaviour Support Plan within Behaviour Care Plan every 3 months or as required. Where a Resident declines ongoing consent or the need for bedrails is no longer required, this is to be documented in the Resident's Progress Notes and Behaviour Care Plan and bedrails MUST be removed.

Note: The use of bedrails should only be considered after all other options have been eliminated.

Bedrails must NOT be used to keep a resident in bed against their wishes, for example a resident that has the potential physical ability to attempt to either climb over the rails or out from the bottom of the bed.

10.2 Safety Alert

When bedrails are being used in conjunction with pressure alternating air mattresses to reduce the risk of resident rolling towards the bed rail or out over the top of the bed rail, the following should be applied:

- When using overlay pressure alternating air mattress place on top of the existing bed mattress.
- When using full replacement pressure alternating air mattress place on top of the pressure. underlay and the existing bed mattress must be removed.

Overlay Pressure Relieving Air Mattress

Full Replacement Pressure Alternating Air Mattress

Bedrail protectors may be used when bedrail or bedrails are applied. Please ensure bedrail protectors are correctly applied to prevent the risk of entrapment.

10.3 Decision Matrix: Bedrails - Risk of Injuries Matrix

The following Decision Matrix is to be used as a guide to determine if bedrails should be used.

Bedrails - Risk of Injuries Matrix				
Use this matrix to aid in the identification of risk of injuries to residents caused by entrapment and falls. *Circle* the Cognitive/Mental State (columns) and Mobility (rows) that applies to achieve result.				
Decision-Making Capacity	**Cognitive/Mental State**	**Mobility**		
		Immobile Never leaves bed, hoist dependent.	**Mobilises with assistance**	**Mobilises without assistance**
Yes	**Oriented and alert**	Bedrails may be considered if resident consents and requests them.	Bedrails may be considered if resident consents and requests them.	Not required **unless** requested by the resident.
No	**Delirious, confused, disoriented, agitated, restless, unpredictable poor memory**	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.
Uncertain	**Drowsy/sedated/ impaired consciousness**	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.
No	**Unconscious**	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.	Not recommended. Use alternative strategies.

KEY		
	Bedrails not recommended. Risk of using is generally higher than risk of not using. Use alternative strategies.	Discuss with Resident and/or their Representative, and with clinical team. If resident with decision-making capacity consents, Bedrails (Two Sides) or Bedrail (One Side) being raised to an upright position is a **restrictive practice**. The use of Bedrails or Bedrail is a **high risk** and should be **the last resort**.

Adapted from Safe use of bed rails, Government of South Australia, 2015.
https://www.sahealth.sa.gov.au/wps/wcm/connect/ab85d2004b7bd87db8d2f97c1f47d846/15093.6+-+Tool+3+%28v3%29WebS.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ab85d2004b7bd87db8d2f97c1f47d846-m2tkcNl

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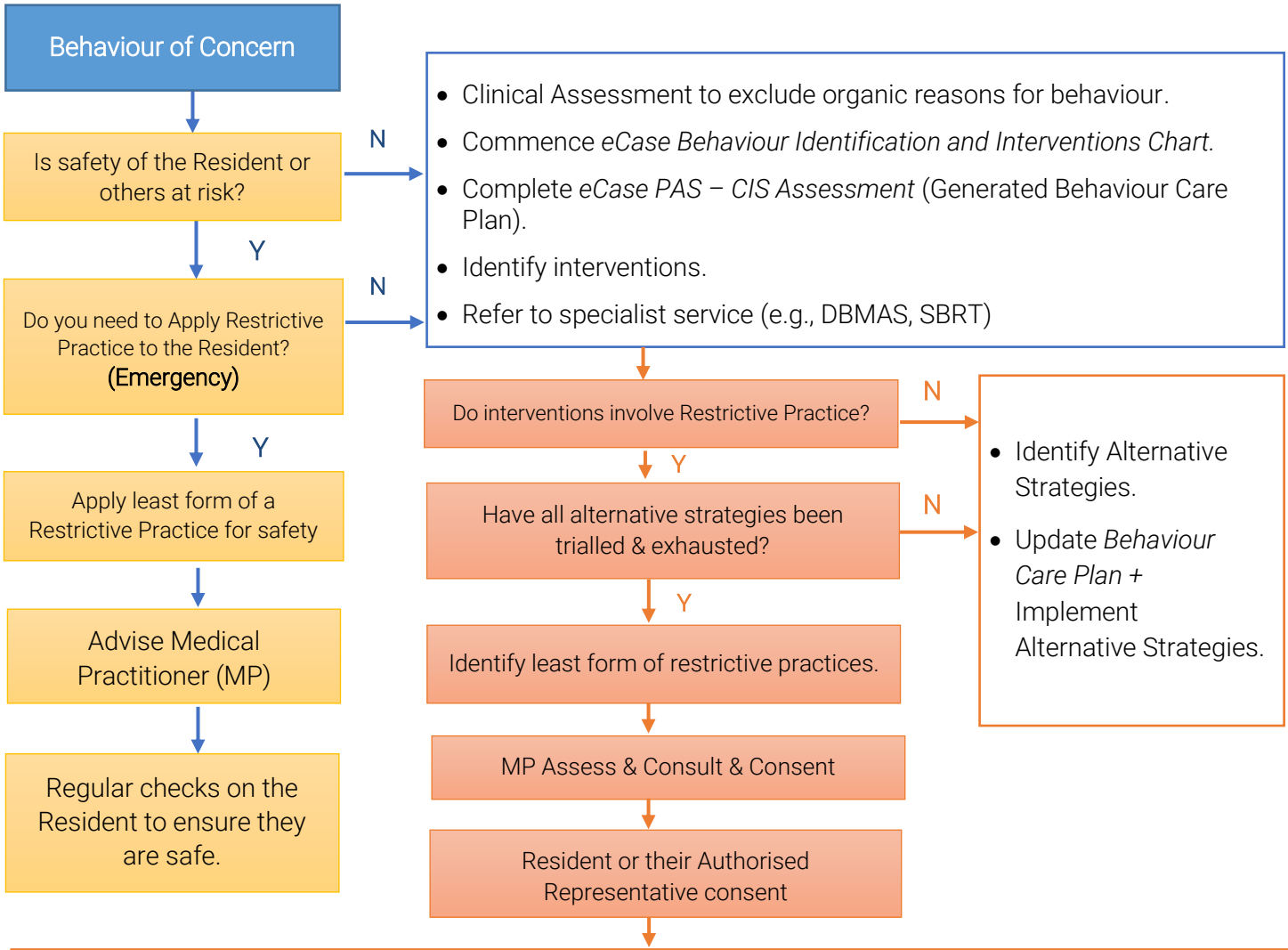
11.Decision Matrix - Making the Decision to Apply Restrictive Practice

The decision to use a restrictive practice is a clinical decision that should be preceded by a full, comprehensive clinical assessment. Consultation should take place with the Resident, their Authorised Representative, Nursing, Medical Practitioner and/or other relevant Health Professionals prior to a decision to apply the restrictive practice.

Note: A Resident's Authorised Representative **does not** have the authority to request for a Resident be Restrained.

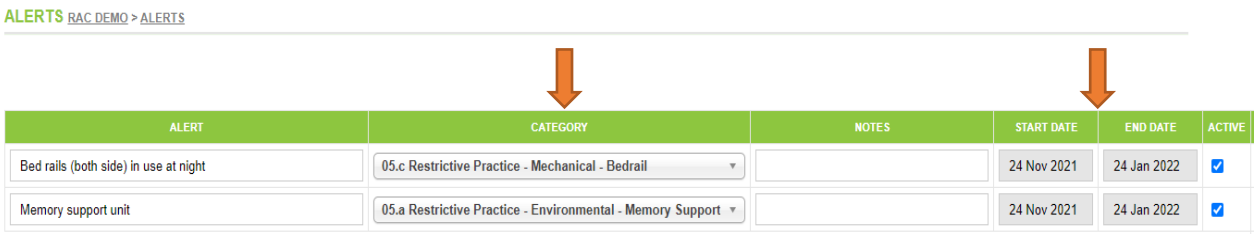
This is a clinical decision that **Must** be made by appropriately qualified health professionals in consultation with the Resident and/or their Authorised Representative.

If a decision is made to use a restrictive practice, the initial assessment and decision should be documented in the *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form*, *Progress Notes and Behaviour Support Plan within Behaviour Care Plan* and **Consent Form** should be reviewed according to review **timeframe** on *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form*.



- Update *Behaviour Support Plan within Behaviour Care Plan* + Implement least restrictive form of practice.
- Ongoing consent from the Resident and/or their Authorised Representative **Must** be obtained according to review **timeframe** on *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form*.

12. eCase Documentation and Process Map for Restrictive Practice

Step 1 Prior to Use of Restrictive Practice	Documentation, Upload to eCase Gallery (under Legal Documents)	Role Responsibility
1. Assessment by an Approved Health Practitioner & Alternatives to the Use of the Restrictive Practice	• eCase Progress Notes. • Review eCase Behaviour Identification and Interventions Chart and Pain chart. • Review eCase Mobility & Transfer, FRAT, Sleep and Medication Assessment. • Referral to specialist services as required.	RN/EN/RAO/PCA/ Management
2. Risk Assessment & Least Restrictive Form of Practice	• eCase Risk Assessment and care plan.	RN/Management
3. Communication, explanation of risks, alternative strategies explored	• eCase Conference Chart if required. • eCase Progress Notes (select Case Conference).	RN/Management
Step 2 Use of Restrictive Practice *(Last Resort)*	**Documentation, Upload to eCase Gallery (under Legal Documents)**	**Role Responsibility**
1. Informed Consent	• *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form* and behaviour care plan. **Note:** The consent form signed by MP, and Resident / Authorised Representative (AR) / Tribunal. • eCase Progress Notes (select ***Restrictive Practice -Decision to Use as Last Resort***) • Manager or as delegated to maintain and update *SOM – Clinical Directive Register*.	MP/RN/ Management/ Resident/AR/ Tribunal
2. Document eCase Alert	• Document in ***eCase Alerts tab***, select appropriate type of Restrictive Practice from 05.a – 05.e and record the ***START and END*** date according to review ***timeframe*** on *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form*. 	RN

Step 3 Regular Monitoring and Reviewing	Frequency for Review & Consent	Role Responsibility
• Bedrails **which restricts resident's free movement** • Low Bed or Lo Lo Bed **which restricts resident's free movement** • Concave Mattress • Chairs with locked tables • Seatbelts • Bed against a Wall • Memory Support Units • Perimeter Alarms/Keypad on Entry/Exit	• eCase Behaviour Support Plan within Behaviour Care Plan review 3 monthly or as required. • The consent form signed by MP, and Resident / Authorised Representative (AR) / Tribunal according to review **timeframe** on *RAC Restrictive Practice (other than Chemical) Assessment and Consent Form*. • eCase Gallery (under Legal Documents - Consent). • eCase Progress Notes (select **Restrictive Practice - Authorisation Renewed**) • Update in ***eCase Alerts tab***, select appropriate type of Restrictive Practice from 05.a – 05.e and record the ***START and END*** date according to review **timeframe** on *RAC_Restrictive Practice (other than Chemical) Assessment and Consent Form*. • Case conference conducted **annually** and as required with AR or Resident (if applicable) or Tribunal.	MP/RN/ Management/ Resident/AR/ Tribunal
Step 4 Application and Release of Restrictive Practice	**Frequency for Review**	**Role Responsibility**
• Mechanical Restraint, e.g., Chairs with locked tables, Seatbelts - Must be released at least **every two (2) hours** for a period not less than **ten (10) minutes.**	• During the release period the Resident should be toileted, and/or their position changed. Such intervention does not preclude the need to provide person-centred care to the Resident at other times. • eCase Complex Health Procedures Chart: ***Restrictive Practice - Mechanical - Record each occasion when Restrictive Practice is used (start and end),*** must be recorded each time the restrictive practice device is applied and released, and this record must be attended to at the time.	RN/EN/PCA
• Bedrails **which restricts resident's free movement.** • Concave Mattress. • Low Bed or Lo Lo Bed ***which restricts resident's free movement.***	• Checked **every two (2) hours,** there is no need to release bedrails if the Resident is safe and comfortable. • eCase Work Log Activity: ***Restrictive Practice - Mechanical - Safety and comfort check or Safety and comfort check (Work Log ONLY).***	RN/EN/PCA
Step 5: Restrictive Practice Ceased	**Documentation**	**Role Responsibility**
• A Resident or their Authorised Representative decline ongoing consent **OR** • If the need for restrictive practice is no longer required.	• Restrictive practice **MUST** be removed or ceased. • eCase Progress Notes. • Update eCase behaviour care plan. • **Inactive** relevant eCase Alert. • Manager or as delegated to **remove** resident from the *SOM – Clinical Directive Register.*	RN/Management

End of Policy

catholic healthcare

RAC_Restrictive Practice Policy

Review History

Version Number	Date of update	Version Number	Date of update
		Version 12	11 Feb 2020
Version 15	29 Nov 2021	Version 11	30 Oct 2019
Version 14	01 July 2021	Version 10	27 Aug 2019
Version 13	08 Feb 2021	Version 9	22 Jun 2019

Reference & Related Documents

References	• Bedrails – Adult Inpatient Use, South Eastern Sydney Illawarra NSW Health, 2009.http://www.seslhd.health.nsw.gov.au/Policies_Procedures_Guidelines/Clinical/Aged_Care_and_Rehab/documents/PD-249-Bedrails-AdultInpatientUse.pdf • Bed Rails Clinical Considerations for Prescribers, Government of South Australia, 2015. • Code of Professional Conduct for Nurses in Australia, Nursing & Midwifery Board of Australia, AHPRA • Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care Commonwealth Department of Health & Ageing 2012 https://www.parliament.nsw.gov.au/lcdocs/other/9989/Answers%20to%20questions%20on%20notice%20-%20Loula%20Koutrodimos%20-%20Acting%20CEO%20-%20Leading%20Aged%20Care%20Australia.PDF • Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. https://www.legislation.gov.au/Details/F2019L00511 • Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019. https://www.legislation.gov.au/Details/F2019L01505 • Safe use of bed rails, Government of South Australia, 2015. https://www.sahealth.sa.gov.au/wps/wcm/connect/ab85d2004b7bd87db8d2f97c1f47d846/15093.6++Tool+3+%28v3%29WebS.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ab85d2004b7bd87db8d2f97c1f47d846-m2tkcNl • Safe use of bed rails, Medicines and Healthcare Products Regulatory Agency (UK), 2013. http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON2025348 • What Nurses Need to Know, Environmental Health Unit, QLD Health, 2008

Related Policies, Procedures & Guidelines	• RAC_Psychotropic Medication & Chemical Restraint Policy
	• eCase Quick Reference Guide (QRG):
	  ○ Completing eCase Documentation for Case Conferences
	  ○ Managing Case Conferences in eCase

Related Documents & Forms	Documents: (Delete not relating items) • 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 and Work Log ONLY Activities: • Behaviour Identification and Interventions Chart • Case Conference Chart • Complex Health Care Procedure Chart • Falls Risk Assessment Tool (FRAT) Form • RAC Restrictive Practice (other than Chemical) Assessment and Consent Form • SOM – Clinical Directive Register
Aged Care Quality Standards	This guideline may impact on the following Aged Care Quality Standards: • 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

Restraint, Physical, Environmental, Aversive, Authorised Representative, Bedrails, Concave Mattresses, Lap Belts, Seat Belts, Pelvic Belts, Risk, Fact Sheet; Low Bed; Special Care Unit, Bed against Wall, Restrictive Practice, Mechanical Restraint, Seclusion