

Restrictive practices

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KEY STATEMENT

The Australian College of Nursing (ACN) is committed to ensuring older people are provided safe, person-centred and high-quality care, where restrictive practices are used only as a last resort. A restrictive practice should be used in the least restrictive form, only to the extent it is necessary and in proportion to the risk of harm to the care recipient or other persons. As far as possible, best practice alternative strategies should be used before a restrictive practice is introduced.

ACN believes restrictive practices are an imposition on an individual's rights and dignity and, in some cases, may subject the person to an increased risk of physical and/or psychological harm. While taking a person-centred approach to care, aged care providers must have a clinical governance framework in place to minimise the use of restrictive practices.

BACKGROUND

Restrictive practices are defined as interventions or actions that lead to limits or barriers on a care recipient's decision-making ability or freedom of movement (Royal Commission into Aged Care Quality and Safety 2019). This includes chemical, environmental, mechanical, or physical restraints and seclusion (Aged Care Legislation Amendment Principles 2021). For at least 20 years, a culture of restrictive practice overuse has been reported, which led to the Royal Commission into Aged Care Quality and Safety in 2018 (Royal Commission into Aged Care Quality and Safety 2021a, p 8, 99). In March 2021, the Royal Commission released its Final Report, which found restrictive practices were being used in residential aged care facilities (RACFs) on residents without attempting any alternative strategies first (Royal Commission into Aged Care Quality and Safety 2021b).

ACN believes restrictive practices are an imposition on a care recipient's rights and dignity according to the Charter of Aged Care Rights (Aged Care Quality and Safety Commission 2019), and current use of restrictive practices does not allow provision of quality care according to the Aged Care Quality Standards (Department of Health 2020), as it may subject them to an increased risk of physical and psychological harm (Melbourne Social Equity Institute n.d.). Evidence shows that restrictive practices have been used without any medical requirement or clear justifications; with restrictive practices sometimes misused to manage challenging resident behaviours the staff did not have the time or training to deal with, due to understaffing and lack of resources (Royal Commission into Aged Care Quality and Safety 2021b; Human Rights Watch 2019; Peisah, Jessop & Breen 2019). ACN believes all care recipients, particularly older persons, have the right to receive quality evidence-based care consistent with their needs.

The use of restrictive practices is more common for care recipients with dementia, generally to 'manage' behavioural or psychological symptoms of dementia (BPSD). Dementia causes deterioration in memory and thinking capability, gradual loss in communication and ability to undertake day-to-day activities, as well as behavioural and psychological changes (Royal Commission into Aged Care Quality and Safety 2021a). BPSD in people with dementia vary in severity and type and evolves differently over the course of dementia. It may include becoming aggressive (verbally and/or physically), restless and agitated, wandering, experiencing depression, apathy and anxiety, as well as delusions and disinhibition (sexual and/or social) (Royal Commission into Aged Care Quality and Safety 2021a, p 11, 100). More than half of the care recipients living in RACFs have a diagnosis of dementia (Royal Commission into Aged Care Quality and Safety 2021a; Australian Institute of Health and Welfare 2021). Therefore, in order to minimise use of restrictive practices, it is important for staff to have an in-depth understanding of dementia and best practice strategies to care for residents who have dementia. Care recipients must be supported to live in the setting of their choice and receive services that promote independence, meet their preferences, and facilitate social connection.

KEY ISSUES

Unmet needs and alternative approaches to care

Research on the *Unmet Needs Model* (or *Needs-Driven Behaviour Model*) shows that BPSD can be caused by, and may be an expression of, the unmet needs of a care recipient with dementia (Peisah & Skladzien 2014; Cohen-Mansfield, Dakheel-Ali, Marx, Thein & Regier 2014). BPSD stems from the care recipient's reduced ability to communicate their unmet needs and provide for themselves. Unmet needs include physical, emotional and psychological needs, discomfort and untreated pain, as well as care recipients' perception of and interaction with their physical environment (Peisah, Jessop & Breen 2019). The most common unmet needs among care recipients with dementia are for stimulation, as well as meaningful and social activities. The imbalance between care recipients' lifelong habits and personality; current physical and mental states; and the suboptimal environmental conditions they reside in create challenging behaviours (Cohen-Mansfield, Dakheel-Ali, Marx, Thein & Regier 2014).

Any restrictive practice should be used in the least restrictive form, only to the extent that it is necessary, and in proportion to the potential risk of harm to the care recipient or other persons. There is deterioration of BPSD if the care recipient living with dementia does not receive quality and safe care (Human Rights Watch 2019). Thus, using restrictive practices to manage BPSD may lead to worsening symptoms, as unmet needs may place the care recipient in further discomfort, pain or emotional and psychological strain (Peisah & Skladzien 2014). Inappropriate application of restrictive practices has a negative impact on a care recipient's quality of life by removing independence and leaving needs unmet. Based on the *Unmet Needs Model*, this dependence usually leads to a negative cycle of deteriorating health, worsening BPSD, with more restrictive practices used to manage behaviours (Human Rights Watch 2019; Peisah & Skladzien 2014).

Furthermore, restrictive practices may do more harm than good (Human Rights Watch 2019; Peisah & Skladzien 2014, 14). For instance, while the use of physical restraints has generally been justified as enhancing safety for care recipients and staff, research shows that physical restraints can increase risk of injury (Walker 2019). Additionally, restraints can prevent residents from forming positive social relationships and increase residents' isolation from their peers and staff, which leads to anxiety, depressive symptoms and cognitive decline. Positive social relationships protect against cognitive decline (Human Rights Watch 2019; Peisah & Skladzien 2014; Breen 2019a). Based on the Charter of Aged Care Rights and the Aged Care Quality Standards, when considering the use of restraints, the aim should be to support dignity and choice, and to maintain the person's previous level of independence (Aged Care Quality and Safety Commission 2019, Department of Health 2020). Choice of intervention must promote the highest level of

functioning, particularly mobility and eating (Walker 2019). Generally restrictive practices do not allow this level of care; instead, they lead to significant decline in health for care recipients, including malnutrition, weight loss, decline in mood, increased fatigue, lethargy and longer periods of sleep (Human Rights Watch 2019).

For BPSD, chemical restraints such as antipsychotic medication is commonly used, even though this class of medication is not particularly effective at treating BPSD (Human Rights Watch 2019; Peisah & Skladzien 2014). Antipsychotic medication can have mild to serious side effects including anxiety, stroke, pneumonia and death (Australian Institute of Health and Welfare 2021; Cerejeira, Lagarto & Mukaetova-Ladinska 2012; Royal Australian and New Zealand College of Psychiatrists 2016). Treating BPSD with antipsychotic medication is also considered less effective than other non-pharmacological approaches to treatment of BPSD (Department of Health 2020). Chemical restraint is not a necessary or last-resort option (Peisah & Skladzien 2014; Schneider, Dagerman & Insel 2016). Clinical studies demonstrate that non-medical interventions focused on care recipients' unique qualities as a person, and building nurturing relationships are effective tools for addressing symptoms of dementia, including agitation and aggression (Human Rights Watch 2019). Alternative approaches – when tailored to the individual – are more effective and provide better outcomes for care recipients (Royal Commission into Aged Care Quality and Safety 2021a p19, 68).

Implementing person-centred care

A person-centred, psychosocial and multidisciplinary approach is recommended for treating BPSD (Peisah, Jessop & Breen 2019; Royal Australian and New Zealand College of Psychiatrists 2016). Person-centred care involves the care recipient being placed at the centre of their own care, where they are supported to contribute to decision-making about their care (Mitchell & Agnelli 2015). Treatment plans are developed by first conducting comprehensive needs assessment, allowing staff to identify needs of individual care recipients (Cohen-Mansfield, Dakheel-Ali, Marx, Thein & Regier 2014; Eichler, Thyrian, Hertel, Richter, Wucherer, Michalowsky, Teipel, Kilimann, Dreier & Hoffmann 2016). This assessment includes making observations and monitoring BPSD in order to assess the resident and possible causes of BPSD incidents (Peisah, Jessop & Breen 2019). Daily routine and care plans of care recipients are tailored to their unmet needs, facilitating their interests, pleasure and use of their capacities, rather than following a generic plan for a person living with dementia (Vernooij-Dassen & Moniz-Cook 2016). This will challenge the way care and delivery of support are organised, as professional care is generally oriented towards delivery of services specific to the practitioner or provider and their expertise, rather than focusing on the specific needs of the care recipient with dementia (Vernooij-Dassen & Moniz-Cook 2016).

The most positive and effective way of approaching care recipients for person-centred care is by forming interpersonal relationships (Vernooij-Dassen & Moniz-Cook 2016). Tom Kitwood first introduced this person-centred approach, which has since been trialed and proven successful in reducing use of antipsychotic medication for care recipients at RACFs. There is also strong evidence for person-centred care in clinical practice for care recipients with dementia leading to reduced agitation, neuropsychiatric symptoms, and depression, and to improvement in quality of life (Vernooij-Dassen & Moniz-Cook 2016; Brooker, Latham, Evans, Jacobson, Perry, Bray, Ballard, Fossey & Pickett 2016; Fossey, Ballard, Juszczak, James, Alder, Jacoby, Howard & Howard 2006). Interacting with care recipients allows staff to develop a rapport, as knowing their life stories and experiences is important in forming an understanding of their needs and preferences, as well as their personality and habits (Fazio, Pace, Flinner & Kallmyer 2018). Nurses are in a strong position to undertake assessments and care planning as frontline health professionals who have educational preparation and critical thinking skills to evaluate complex dementia care recipients. This planning would form the basis of a person-centred, tailored intervention that may address care recipient needs.

Additionally, aged care providers should have a clinical governance framework in place to minimise use of restrictive practices, including regular evaluation and monitoring (Breen 2019b, Australian Commission on Safety and Quality in Health Care 2017, Victorian Department of Health 2015). ACN strongly advocates for a restraint-free environment as the recommended standard of care. Once staff have evaluated there are no alternative BPSD strategies for a care recipient, and their safety and the safety of others around them is compromised, they should ensure the benefits of using the restrictive practice outweigh any potential adverse effects. A restrictive practice should then be used in the least restrictive form, only to the extent that it is necessary, and in proportion to the risk of harm to the care recipient or other persons. A restrictive practice should be used for the shortest time possible. The clinical governance framework should have checks in place to ensure these restrictions are followed, as well as obtaining informed consent (PwC 2021; Australian Commission on Safety and Quality in Health Care 2017; Australian Commission on Safety and Quality in Health Care 2019; Victorian Department of Health 2015). Thus, the clinical governance framework must have mandatory periodic reviews.

Research shows there are other factors within RACFs that may perpetuate restrictive practices, including staffing, fear of staff injury, limited resources, and education (Lawrence 2019; Moore & Haralambous 2007; Hodgkin, Warburton, Savy & Moore 2016). Addressing this lack of education and information about alternatives to restrictive practices, as well as insufficient education and skills in dealing with complex cases in aged care, such as dementia, is vital in moving towards positive change (Royal Commission into Aged Care Quality and Safety 2021a; Breen 2019b; Lawrence 2019). When

designing person-centred care interventions, strategies for minimum mandatory education and skills as well as supporting continuing professional development for staff should be included (Australian College of Nursing 2019, Australian College of Nursing 2021b).

In a 2019 white paper, titled *Regulation of the unregulated health care workforce across the health care system* (Australian College of Nursing 2019), ACN argued that unregulated health care workers should not be used as substitutes for registered or enrolled nurses. 'The literature demonstrates that having an adequate 'skill-mix' of staff available is more important than having a specific number of nurses on duty' (Australian College of Nursing 2019, p11). It is important that RACFs have an educationally prepared aged care workforce. An appropriate skill-mix and nurse-resident ratio depending on the number and acuity of the care recipients in the RACF is required (Australian College of Nursing 2019; Lawrence 2019).

Clinical governance and education practices to reduce the use of restrictive practices were trialed in the 'Reducing Use of Sedatives program' (RedUSE) program (Australian Government Aged Care Quality and Safety Commission 2021; Westbury, Gee, Ling, Brown, Franks, Bindoff, Bindoff & Petersen 2018). Over the course of two years, RedUSE used multi-strategic and interdisciplinary interventions on antipsychotic prescription in 150 Australian residential aged care facilities. The program saw 40 per cent of residents in these facilities reducing their doses or in some cases completely stopping their medications (Australian Government Aged Care Quality and Safety Commission 2021; Westbury, Gee, Ling, Brown, Franks, Bindoff, Bindoff & Petersen 2018). This program provides evidence that targeted interventions to minimise restrictive practices – specifically chemical restraints such as antipsychotics – can be successful.

RECOMMENDATIONS

ACN strongly supports recent amendments to the *Aged Care Act 1997* (Department of Health 2021). In addition to these changes, ACN recommends that the Australian Government:

- Introduce additional quality indicators and measures, as well as regular mandatory reporting and in-person audits to ensure RACF providers minimise the use of restrictive practices only to the extent necessary.
- Develop a standardised national clinical governance framework, in collaboration with RACF providers, consumer groups and medical specialists. The framework should be based on contemporary research and best practice, and provide clear and practical guidance for RACF providers to minimise use of restrictive practices and implement alternative approaches.

- Mandate that all RACFs must employ an appropriately qualified and prepared workforce; an evidence-based and dynamic staffing that reflects required skills and 'skill-mix' (International Council of Nurses 2018); and at least one registered nurse on site and available at all times in every RACF (Australian College of Nursing 2021a). This includes regulation of the unregulated health care workforce and minimum education standards for all staff (Australian College of Nursing 2021b), including a minimum of a Certificate III and preferably a Certificate IV, with mandatory training in dementia care, human rights, end-of-life care and infection prevention and control (Australian College of Nursing 2021a).

ACN recommends that RACF providers:

- Consistently aim to achieve a restraint-free environment where appropriate.
- Provide a minimum of 20 hours per year for staff to undertake continuing professional development and in-service support. This should include special mandatory training for complex cases such as BPSD for all care staff.
- Actively implement strategies to ensure person-centred care, including exploring alternative approaches to care based on contemporary evidence-based programs and research.

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