Answers to questions on notice - Loula Koutrodimos - Acting CEO - Leading Aged Care Australia - received 30 March 2016 Trim: D16/09496

Australian Government

Department of Health and Ageing

DECISION-MAKING TOOL: SUPPORTING A RESTRAINT FREE ENVIRONMENT IN

Residential aged care

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About the development of Decision-making tool: supporting a restraint free environment in residential aged care

The development of this tool has been informed by:

- systematically searching relevant published literature to identify the best available evidence
- Web-based materials available nationally and internationally
- a review and update of existing documents produced by the Department of Health and Ageing
- telephone interviews with a random selection of organisations providing residential and community aged care services across Australia.

Ethics approval for the project was obtained from the University of South Australia Human Research Ethics Committee. Informed consent of participants was obtained prior to interviews.

This tool replaces the *Decision-making tool: responding to issues of restraint in aged care* published by the Department of Health and Ageing in 2004.

The tool includes posters and information sheets which can be photocopied to provide in-house staff development and an information sheet that has been designed to be photocopied and handed to relatives. The purpose of the information sheet is to stimulate discussion between clients, relatives and friends with staff about:

- a restraint free environment
- why restraint is not appropriate
- restraint free options to be considered
- details of community organisations and government support.

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SUPPORTING A RESTRAINT FREE ENVIRONMENT

Introduction

This *Decision-making tool: supporting a restraint free environment in residential aged care* has been developed to assist staff to provide a restraint free environment. A restraint free environment is seen as a basic human right for all residents living in a residential care setting.

In keeping with Health Ministers' endorsement of the Australian Safety and Quality Framework for Health Care in 2010, each section of the *Decision-making tool: supporting a restraint free environment in residential aged care* aligns with one of the three endorsed core principles, namely:

1. person-centred
2. driven by information
3. organised for safety.

Person-centred: a restraint free approach

A person-centred approach is a restraint free approach – a way of thinking that preserves the human rights of any person. All residents are entitled to respect and protection of their basic rights and freedoms, regardless of where they live. This entitlement includes all persons bearing a corresponding obligation to respect and protect the rights and freedoms of others.

The delivery of the best possible residential aged care services can be assured where staff receive the support of each other, and in turn receive support from their employing organisations. Organisational policies and procedures need to be underpinned by a restraint free way of thinking and developed in conjunction with:

- the requirements of the *Aged Care Act 1997*
- the Charter of Residents' Rights and Responsibilities
- the requirements of the Aged Care Standards and Accreditation Agency
- professional and ethical requirements.

With a restraint free approach, the use of any restraint must always be the last resort after exhausting all reasonable alternative management options.

Stopping a resident without their consent from doing what they appear to want to do, or are doing, is restraint. Any device that may stop a resident getting out of a bed or a chair and/or stops their free movement is restraint. Restraint is any aversive practice, device or action that interferes with any person's ability to make a decision or which restricts their free movement.

The application of restraint, for ANY reason, is 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. The inappropriate use of restraint may constitute assault, battery, false imprisonment or negligence. Staff need to identify, in a proactive approach with management, how to prevent situations that may lead to a perceived need for restraint.

A way to ensure the safety of residents is not compromised is to know what restraint free options are available.

Restraint free options

Residents can be provided with different options to ensure their safety. The strategies that follow identify restraint free options to be considered and implemented. The diagram opposite is also available as a poster to display to all staff.

Restraint free options

ENVIRONMENTAL

- 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
- Lowered bed height to suit individual needs
- Remove wheels from beds
- Appropriate mobility aids close at hand (railings on the wall, trapeze to enhance mobility in bed)
- Appropriate signage and visual reminders to aid orientation (e.g. use pictures)
- Seating to meet the needs of individual residents
- A quiet area
- Reduce environmental noise
- Safe areas for residents to wander such as circular corridors with activity stations
- Protected outdoor areas
- Transfer rails
- Provide familiar objects from the resident's home (e.g. photo albums, furniture etc)
- 'Snoozelen' room
- Appropriate alarm systems to alert staff to risky situations (e.g. a resident who has wandered into a dangerous area)

ACTIVITIES AND PROGRAMS

- Rehabilitation and/or exercise
- Regular ambulation
- Continence program
- Physical, occupational and recreational therapies
- Exercise program
- Night-time activities
- Individual and group social activities
- Appropriate outlets for industrious people (e.g. gardening, folding linen)
- Facilitate safe wandering behaviour
- Falls prevention program
- 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

ALTERATIONS TO NURSING CARE

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

PHYSICAL STRATEGIES

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

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

Adapted from Joanna Briggs Institute (2002) Physical Restraint – Pt 2; Minimisation in Acute and Residential Care Facilities. *Best Practice, Vol 6 Issue 4*, Blackwell Publishing Asia,, Australia

Falls prevention

The use of restraint is known to increase the risk of a person falling and incurring harm from that fall. Preventing falls and any subsequent harm is a necessary component of a restraint free approach.

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) has developed falls prevention resources – *Preventing Falls and Harm from Falls in Older People – Best Practice Guidelines for Australian Residential Aged Care.* An implementation guide, a guidebook and fact sheets are available at: http://www.safetyandquality.gov.au

Managing health problems, ensuring safe walking areas and the quality use of medicines are integral to a falls prevention approach.

Quality use of medicines

Australia's *National Medicines Policy* (1999) seeks to bring about better health outcomes for all Australians, focusing especially on people's access to, and wise use of, medicines. The term 'medicine' includes prescription and non-prescription medicines, as well as complementary healthcare products and those medicines bought over the counter, including in supermarkets.

One of the key objectives of the policy is the quality use of medicines. A National Strategy for Quality Use of Medicines (2002) is available at: http://www.health.gov.au

While many people maintain their health without using medicines, for others medicines play an important role in maintaining health, preventing illness and curing disease. The quality use of medicines can have a positive impact on health and can improve quality of life.

A resident is likely to have a complex medicine regimen. A restraint free approach includes the monitoring and ongoing review of medicines for all residents. All permanent residents of Australian Government-subsidised aged care homes are entitled to a Residential Medication Management Review (RMMR). When requested by a resident's general practitioner, an accredited pharmacist conducts an RMMR in collaboration with the GP and appropriate members of the eligible resident's health care team. Information about the resident's medicine is collated and a comprehensive assessment is undertaken to identify, resolve and prevent medicine related problems. A report of this assessment is provided to the resident's GP.

A RMMR is generally provided every 12 months, unless there is a major change to the resident's condition or medicine.

Information about RMMR can be found at: http://www.health.gov.au

Being older and with age-related changes may mean an older person could suffer from more than one concurrent illness. Normal ageing increases an older person's sensitivity to particular medicines. Older people are at risk of increased side effects and therefore require careful monitoring for expected effect and possible side effects. Some conditions can affect the pharmacokinetic and pharmacodynamic properties (the way in which the body and

medications interact) of some medicines, necessitating an adjustment to the dosage, or in some cases avoidance of some medicines.

While medicines can make a significant contribution to the treatment and prevention of disease, increasing life expectancy and improving the quality of life, they also have the potential to cause harm. It has been shown that inappropriate or incorrect use of medicines can have an adverse effect on health, including increased risk of falls and confusion. Adverse medicine events also include any unexpected reactions that do not appear in the product information.

Adverse medicine events should be reported to the treating prescriber or directly to the Therapeutic Goods Administration (TGA). The TGA asks that suspected adverse reaction to any medicines available in Australia are reported. These include:

- prescription medicines
- vaccines
- over the counter medicines that are purchased without a prescription
- complementary medicines, including
  - herbal medicines
  - naturopathic or homeopathic preparations
  - nutritional supplements such as vitamins and minerals.

To report an adverse drug event, please refer to the TGA website: http://www.tga.gov.au

Useful links to find additional and more specific medicines information for older people are available from the National Prescribing Service (NPS) *Better Choices Better Health*: http://www.nps.org.au

NPS was established in 1998 and enables people to make better decisions about medicines and medical tests, leading to better health and economic outcomes. At NPS *Better Choices Better Health* the latest evidence is provided for health professionals to keep them up to date and provide individuals with the tools and knowledge to make better decisions.

Consumer Medicine Information (CMI) is designed to inform consumers about prescriptions and pharmacist-only medicines. CMI provides important facts to know before, during and after taking a medicine. Please refer to: http://www.nps.org.au

In recognising that eyesight problems are common in older age and reading medicines labels may be difficult, NPS *Better Choices Better Health* provides some hints that might help older people avoid mistakes managing medicines. Please refer to: http://www.nps.org.au

To understand the role of antipsychotics in managing behavioural and psychological symptoms of dementia, please see NPS Prescribing Practice Review 37: http://www.nps.org.au

Safe walking areas to accommodate wandering

Wandering is known to be a common occurrence among people with a diagnosis of dementia. From a person-centred focus, the intent is not to stop wandering but to reduce the associated risks. To encourage a restraint free approach, residents who need to move around should be provided with a safe walking area.

Alzheimer's Australia has developed many help sheets which provide advice, common sense approaches and practical strategies on the issues most commonly raised about dementia and the common problems related to dementia. Please refer to: http://www.alzheimers.org.au

A *Changed behaviours and dementia* help sheet includes a section on wandering behaviours. Reasons for wandering are discussed as well as some management strategies. The help sheet is available at: http://www.alzheimers.org.au

While wandering may be very worrying for carers who are concerned for the person's safety or fear they may get lost, wandering can help a resident in many ways, including:

- physiological benefits of exercise
- stimulating appetite
- relieving boredom
- improving mood/coping with stress
- feeling of empowerment and better self-esteem
- may improve sleep.

In order to reduce the risks associated with wandering, the need exists to identify:

- the reason for wandering and ways to address the reason if appropriate
- if any pattern is associated with wandering
- safe walking/wandering areas.

Therefore:

1. Ensure family/friends can understand why their family member/friend feels the need to wander.
2. Discuss with them the benefits of walking.
3. Point them to safe walking areas around the residential care setting.

IDENTIFYING TRIGGERS TO CHANGES IN BEHAVIOUR

Introduction

In this section the focus is on learning how to anticipate changes in behaviours that may create a feeling of immediate concern to the resident, family, friends, other residents, visitors and staff. Learning what triggers or causes changes in a resident's behaviour should be based on the best information possible obtained from a comprehensive assessment.

It is important to:

1. Learn when to introduce an appropriate distraction or an activity if a trigger to a challenging behaviour cannot be avoided – e.g. where the trigger is a relative leaving after a visit.
2. Know that there may be a combination of triggers. Critical to success is identifying all triggers through a comprehensive assessment, and keeping alert to changes.

NOTE:
The behaviour of any resident, not only those who are cognitively impaired, can change and create a feeling of immediate concern to the resident, family, friends, other residents, visitors and staff.

The assessment process should be a systematic and collaborative process that involves the resident and their family/friends. An assessment needs to be coordinated by a person with the required knowledge and skills, such as a registered nurse (RN). Appropriate assessment tools should be used.

Assessment tools

Decisions made by staff must be based on information obtained through the use of appropriate assessment tools.

A variety of assessment tools are available. The task of the registered nurse is to identify the most appropriate tool to use. A tool should:

- be evidence-based – confirm that the tool has been based on the results of research and has been tested for validity, reliability and user friendliness. This will ensure that the questions will be able to elicit the best information possible.
- be designed to include appropriate cues and prompts to guide clinical decision-making and, where appropriate, questions to be answered by the resident concerned.
- comply with professional standards and guidelines
- be usable by the different levels of staff.

The RN needs to ensure that there are educational resources to support the use of the tool.

The best person to provide information in an assessment is the resident. Another resident or family/friends should only be asked for their assistance when an individual has not been able to answer the questions for themselves.

Residential care staff need to be aware that, under the *Aged Care Act 1997*, Commonwealth-approved providers (and therefore their staff) have a responsibility to protect personal information of persons receiving residential aged care services. Approved providers must also comply with the *Privacy Act 1988* and with relevant state and territory legislation in the way they collect, use and disclose personal information about residents.

A comprehensive assessment

Being alert to or recognising triggers that can cause changes in a resident's behaviour is an essential first step to minimise the risk that any behaviour causing concern will recur or escalate.

A comprehensive assessment should be commenced:

- when a person first receives residential care services and has a diagnosis of impaired cognition e.g. dementia
- whenever there is any change in the functioning, situation or behaviour of a resident
- on an ongoing basis as part of a regular review process.

Organisational policies and practices can be informed by information gained from a comprehensive assessment.

This needs to:

- take place in context
- consider the needs of the resident **and** their family/friends
- take place over a continuous period sufficient to identify their individual needs
- be fully documented and the information used to build up a picture of the behaviour and the context in which it occurs.

Examine the resident and relationships in context

Understanding a resident and their relationships will help to identify:

- triggers such as actions, events, sounds and smells that bring about changes in the way a resident behaves
- how staff or family/friends/visitors respond to a particular behaviour.

How residential care staff or family/friends/visitors respond to a behaviour displayed by a resident may need to be addressed rather than changing the behaviour. For example, the behaviour may be causing no harm to anyone but may be embarrassing for family/friends/visitors.

All residents will react to the environment in which they live and interactions they encounter.

The physical surroundings of a residential care setting, as well as the relationships between staff, between staff and residents and between residents and their family/friends, can influence how someone behaves.

Almost anything can trigger or influence behaviour. To identify possible triggers for a change in behaviours, or how a resident responds to behaviours, it is important to consider:

- **physical factors:** physical health and functional ability of residents and their family/friends
- **cognitive functioning:** mental state of residents and their family/friend's mood, speech and thoughts, including those of residential care staff
- **relationships:** dimensions of interactions between residents, their family/friends and residential care staff
- **communication:** residents and their family/friends' attempts at being understood
- **tasks:** what a resident and their family/friends are doing, including meaningful activities they engage in
- **physical environment:** refers specifically to the impact that building design, materials, colours, climate, lighting and odour have on residents and their family/friends.

Physical and functional assessment

A change in behaviour may be the result of an acute physical condition such as an infection, constipation or uncontrolled pain. Side-effects to a medicine may also trigger a change in behaviour, or a resident may be hungry, thirsty or be in pain or discomfort. It is important that physical causes are recognised and treated and a full medical examination and/or a medicine review is undertaken.

The following box contains a list of factors to consider. It is important to note that the list is not exhaustive or behaviour-specific, but represents a composite of factors that may provide information to inform an assessment of physical causes of behaviours which can cause concern.

FACTORS TO CONSIDER:

- temperature, pulse and respiration rate
- blood pressure
- urinalysis
- evidence of unexplained weight loss
- hunger and thirst
- dehydration
- constipation
- infection (chest, urinary tract, ear, systemic)
- changes in mobility and gait e.g. can the person walk to the toilet or change position when necessary?
- pain – residents may not always verbalise
- deterioration in hearing and/or vision
- change in eating, sleeping or toilet habits
- unattended ailments such as dental problems, pressure sores or tinea
- the need for a medicine review to consider adverse effects of medicines (prescribed, over-the-counter, complementary and alternative medicines)

Mental state and cognitive functioning

Sudden changes to mental state and cognitive functioning can be caused by conditions that respond to treatment. A resident who has a diagnosis of dementia may also have depression or episodes of acute confusion/ delirium.

CONSIDER THE FOLLOWING:

- Could the resident be depressed?
- Has the resident's level of confusion or disorientation suddenly increased?
- Is the resident overly suspicious?
- Does the resident appear to be responding to hallucinations? (Auditory, visual or tactile?)
- Does the resident appear to be delusional?
- Could this be a side-effect of medicines?

Knowing that delirium, depression and dementia are different is important. Having appropriate people make an accurate diagnosis is imperative. Staff can assist in identifying whether something is different for residents and collect necessary information to assist in the assessment and diagnosis.

Differentiating delirium, depression and dementia

Delirium develops over hours, depression over days or weeks, and dementia over months and years.

If any of these conditions are suspected then an assessment should be undertaken by the most appropriate person.

Delirium in older people

Delirium is a term that describes changes to thinking and behaviour that occur over a very short time, usually hours. Delirium should always be considered as an acute illness.

The most important features of delirium to remember are:

- the speed with which symptoms develop
- the way symptoms tend to fluctuate
- problems people have paying attention.

A booklet, *Delirium in older people,* is available at: http://www.health.gov.au

The booklet provides excellent information about how to assess and manage delirium. Also included are necessary cognitive and confusion screening tools. Routine screening of cognitive function and the appropriate investigation of changes in cognition and function helps to identify those at risk of delirium and to improve their management.

It is important to assess the cognitive function of older, particularly frail people, as the outcome of an assessment will affect diagnosis, choice of interventions and a resident's ability to engage with treatment.

There are a number of risk factors to consider for delirium. These include:

- large number of medicines
- immobility
- drug and alcohol use/misuse or withdrawal
- dehydration and malnutrition
- hepatic or renal dysfunction
- electrolyte disturbance
- sleep deprivation
- existing cognitive impairment / brain damage

- pain
- respiratory/cardiovascular disease
- infection
- urinary retention and/or severe constipation.

You may find useful information about managing delirium in older people at *Australian Prescriber*: http://www.australianprescriber.com

The *Clinical Practice Guidelines for the Management of Delirium in Older People* may also be found at: http://www.health.vic.gov.au

Depression in older people

Depression is not a normal part of ageing. Depression is more than just a low mood – it is a serious illness.

Visit: www.beyondblue.org.au or *beyondblue* info line 1300 22 4636

At the *beyondblue* website, it is made clear that the following problems or events can place an older person at risk of depression:

- an increase in physical health problems/conditions e.g. heart disease, CVA (stroke) and dementia (e.g. Alzheimer's disease)
- unrelieved pain
- side-effects from medicines (prescribed and non-prescribed);
- losses: relationships, independence, work and income, self-worth, mobility and flexibility
- social isolation – minimal social interactions
- particular anniversaries and the memories they evoke.

Be alert to the impact that moving from independent living into a residential care setting may have on a new resident. It is necessary to identify depression in an older person to be able to treat it.

Fact sheets and resources on a range of topics relevant to depression are downloadable at *beyondblue*. For example, *beyondblue* fact sheet 17 – Depression in Older People. Please visit: http://www.beyondblue.org.au

It is important to stress that early detection and treatment of depression in an older person may help to keep depression from becoming severe. Depression is treatable and effective treatments are available.

Know the signs of dementia

Dementia is not a normal part of ageing, although it is more common in older people and affects about one in four people over the age of 85. Younger people can also develop dementia.

Recognising the early signs of dementia is an important part of assessing the mental capacity and cognitive functioning of a resident. Some of the early signs of dementia include:

- memory decline that affects daily life
- decline in judgement and reasoning
- increasing difficulty with words or language
- difficulty completing familiar and everyday tasks
- unexplained changes in personality and mood.

A number of common behaviour changes are associated with dementia, including:

- aggression
- repetitive behaviour
- wandering
- sundowning – where the person may become more confused, restless or insecure late in the afternoon or early evening.

Information about recognising the signs of dementia and what to do when you see them is available at: http://www.health.gov.au

It is important to have an accurate diagnosis. Referral to a specialist centre or a geriatrician may be necessary.

Psycho-social assessment

To help understand how residents and their family/friends are coping with their emotions, a psychosocial assessment may be helpful:

An assessment can identify:

- potential areas or issues needing immediate attention
- potential sources of conflict and tensions for the individual and their functioning within their community
- resident distress
- possible supports.

In order to perform a thorough psychosocial assessment it is important that relevant aspects of a resident's life history be reviewed. Staff should have an understanding of the cultural traditions and practices of a resident and their family/friends.

Staff can contribute to the delivery of culturally appropriate care. Ensuring culturally appropriate supports are in place for residents from culturally and linguistically diverse backgrounds is important. Care and attention needs to be given to how to establish and maintain an appropriate connection and relationship with all residents. It is important that staff are aware of the appropriate way to ask questions politely.

A resident might never have been able to communicate in English or might have lost the ability to do so. In these circumstances, it can be helpful for the resident if their family/friends are involved in the process.

As social contact and social interactions are an important part of life for everyone, identifying what contacts or interactions a resident had with their family/friends is a necessary part of understanding how to plan appropriate care.

The following table lists the psycho-social factors to consider

- resident's previous ways of handling stress
- patterns of sleep, exercise and relaxation
- lifetime habits; for example, were they shift workers, regular church attendees etc
- any change in circumstances – e.g. arrival at the aged care home, death or loss of relative/friend or pet?
- level of communication by staff: communication that is either too child-like or, conversely, too difficult to understand, may cause confusion or frustration
- need for privacy and/or social contact
- attitudes, knowledge and behaviour of staff
- comfort e.g. too hot/too cold
- restriction of freedom of movement
- spiritual needs
- need to communicate in a language other than English.

It is important that all relevant staff (personal care assistants, nurses, medical practitioners, allied health), as well as the resident and their family or representative, are aware of and involved in planning and implementing the program of care.

It may be helpful to consult with external experts such as a psycho-geriatrician or behaviour management advisory service.

Resources for screening and diagnostic assessment of residents from non-English speaking backgrounds

Resources have been developed for screening and diagnostic assessment of residents from non-English speaking backgrounds. For more information please see: http://www.alzheimers.org.au

It is important to emphasise that the assessment process should be person-centred and driven by obtaining the best information possible. Any assessment should take account of the impact on the resident's quality of life as well as the potential effect on the resident's family and friends.

Assessment of the physical environment

The physical environment can have a profound effect on residents, including their behaviour. This includes being a contributing factor to the development of behaviours that cause concern to staff and other residents.

The tool: *Improving the environment for older people in health services: an audit tool* (2006) produced by the National Ageing Research Institute and published by Victorian Government Department of Human Services, Melbourne, Victoria, Australia is available at: http://www.health.vic.gov.au

While this tool was not designed specifically for residential aged care, it does address specific and relevant physical environmental aspects for older people and a night-time audit that can be adapted for use in residential and community aged care. There is also a section in the tool that considers whether there are policies and protocols in place to ensure the environment is adjusted to meet individual needs. Service providers should use such tools in conjunction with specific regulations for residential care settings.

RESPONDING TO AN EPISODE OF AT-RISK BEHAVIOUR

Where a resident's behaviour changes and becomes challenging, it may result in one or more of the following:

- a resident harming themselves or others
- a loss of dignity experienced by a resident
- damage to property
- disruption or severe embarrassment to relatives/friends or other residents.

Help sheets

Alzheimer's Australia has developed many help sheets which provide advice, common sense approaches and practical strategies about the issues most commonly raised about dementia. Please visit: http://www.alzheimers.org.au

At the bottom of Alzheimer's Australia's home page please click onto the link Help Sheets or go to: http://www.alzheimers.org.au

Help sheets available include:

Changed behaviours

This help sheet looks at some of the common behaviour changes that may occur when a person has dementia. Reasons for the changes and some general guidelines for coping with them are discussed.

Problem solving

This help sheet discusses some ways to think about any changes in behaviours that are occurring as a result of dementia. It describes a problem solving approach that may help with management of any behaviours if and when they arise.

Depression and dementia

This help sheet looks at depression in people with dementia, how to recognise it and, importantly, ways in which it may be treated.

Sundowning

This help sheet explains why some people with dementia are particularly restless in the afternoon and evening, a condition sometimes known as sundowning. It gives some practical advice to families and carers for managing sundowning.

Anxious behaviours

For some people anxiety may be a distressing symptom of dementia. This help sheet discusses the causes of anxious behaviours and suggests some ways for management as well as some sources of additional help.

Aggressive behaviours

Aggressive behaviour may sometimes occur as a result of dementia. This help sheet discusses the causes of aggressive behaviours and suggests some ways for management, as well as some sources of help.

Agitated behaviours

Agitated behaviours can be a very concerning symptom of dementia. This help sheet discusses some of the causes of agitated behaviours and suggests ways to prevent and manage them if they occur.

Hallucinations and false ideas

Hallucinations and false ideas such as paranoia and delusions can be very distressing symptoms of dementia. This help sheet discusses some of the causes, and suggests ways that families and carers can deal with them.

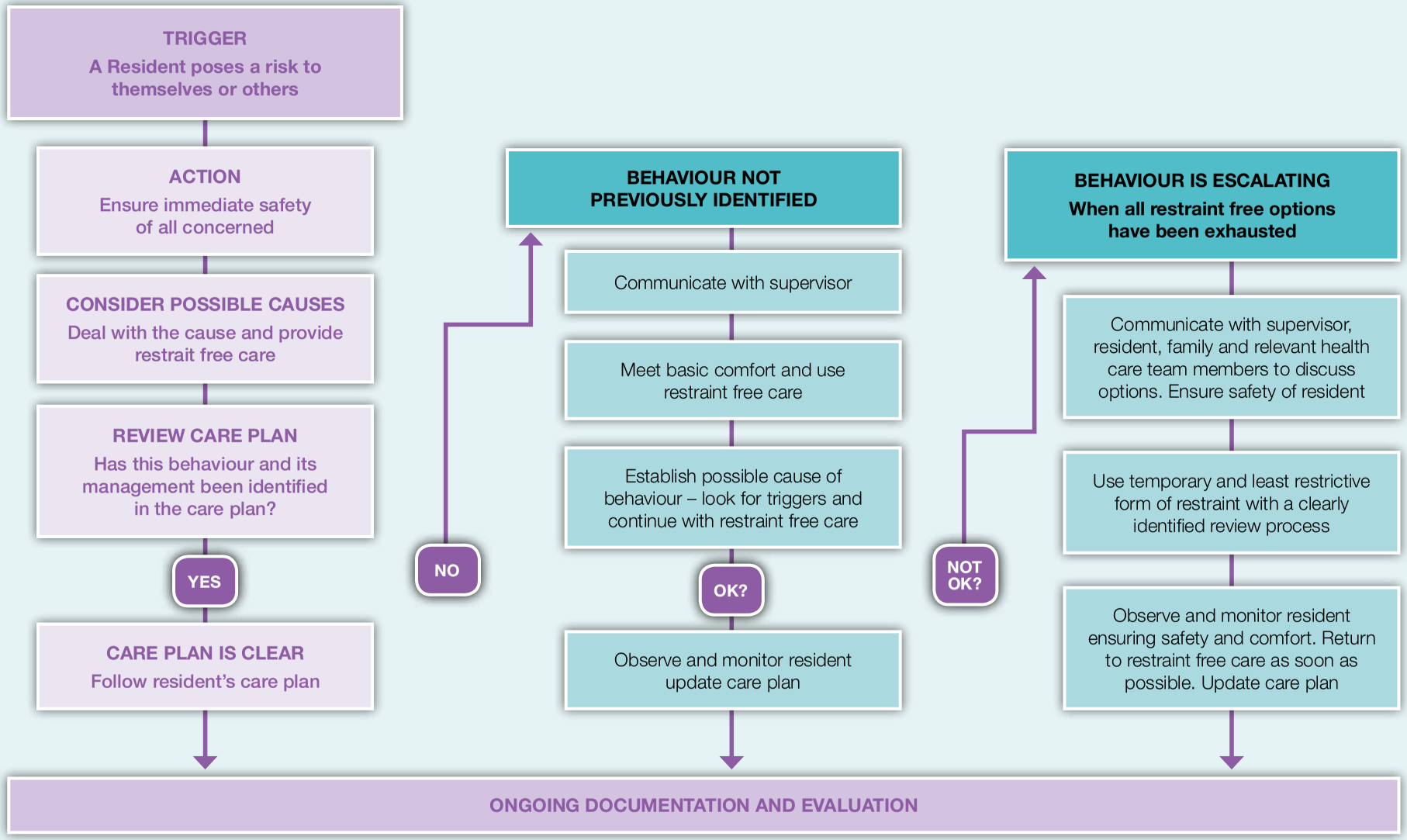
Disinhibited behaviours

Changes in the behaviour of people are very common. Sometimes this can include behaviours that are tactless, inappropriate or offensive. These are usually called disinhibited behaviours. This help sheet describes the signs and causes of disinhibited behaviours, as well as some sources of help.

Decision-making flow chart

A flow chart is provided at page 18 to assist staff to make a decision about how to respond to behaviour(s) that are challenging to manage in residential care setting.

Making a decision about how to respond to a behaviour of concern in a residential aged care facility



When a resident poses a risk to themselves or others

Ensure the immediate safety of all concerned

- Follow the emergency procedures, policies and protocols of your organisation.
- If possible, remove the resident and other people at risk from the situation.
- It is important that you make an informed decision as to how to deal with the situation.
- Clinical decision-making should be driven by information and wherever possible should be conducted or supervised by a registered nurse.
- Decisions made should promote a restraint free environment.

Consider possible causes

At the same time as you are ensuring the safety of all concerned it is important to observe and record in detail important information for making an initial assessment:

- Describe the incident of concern.
- Note when the incident of concern occurred and who was present.
- Understand what was happening prior to the incident using objective language.
- Describe what happened during the incident.
- Describe what happened immediately after the incident.
- Explore what might have led to the incident.
- Consider whether it was your behaviour or that of a relative/friend that was a trigger.
- Understand if the person's behaviour was an attempt to communicate or an expression of unmet need.

NB. There may be more than one behaviour and/or trigger.

Deal with the cause and provide interim solution

On the basis of your observations you need to plan what your actions will be so that you act in a well-informed way.

The best plan of action is to prevent or manage the behaviour that is currently causing concern. Implement a restraint free approach. The use of restraint (be it physical, chemical or environmental) is a strategy of last resort.

Follow the care plan

- If the behaviour is addressed by the resident's care plan, follow the plan of action outlined.
- Document the action taken.
- Review and record the outcome of that action.
- Discuss the action and outcome with other members of the health care team, the resident where possible and the resident's family representative.
- Commence a review of the care plan if indicated.

If the care plan does not include details of the behaviour that is of concern, notify the appropriate health professional, e.g. a registered nurse or medical practitioner, so that a comprehensive assessment can be undertaken.

In the meantime, you need to make a decision about what to do while ensuring a restraint free approach.

Ensure the basic comforts of a resident are attended to

Sometimes behaviours of concern are caused because a resident cannot tell you what they need and so the situation can be solved by attending to, for example:

- toileting needs
- thirst
- hunger
- pain
- boredom
- loneliness
- lack of activity
- constipation

If attending to the basic comfort of the resident does not solve the situation use strategies that provide alternatives to the use of restraint.

Strategies that provide alternatives to the use of restraint

Alternative strategies that could be implemented include:

- Prompt response/action to resident's call bell.
- Modification of the physical environment: e.g. improved lighting, removal of unwanted stimuli, highlighting important stimuli including toilet doors and aids to recognition on bedroom doors.
- Use alarm systems to warn of resident's whereabouts.
- Use alternative mechanisms to ensure safety in bed without the use of bed-rails.

- Use seating and position support that does not restrict free movement.
- Provide specific activities and programs to meet the needs of individual residents.
- Assist in toileting and continence to reduce discomfort and/or risk of falling for people who have difficulty mobilising.
- Alterations to nursing care programs to meet individual needs.
- Employ specific psychosocial strategies to meet individual needs.
- Address physical triggers or behaviours of concern such as infection or constipation.

Strategies to respond to specific needs

You also need to think about strategies that are appropriate for responding to the needs of a resident who:

- is cognitively impaired
- has a mental illness
- has sensory impairments
- is at risk of falling
- is prone to wandering
- is intrusive
- is likely to tamper with medical devices
- is agitated or violent
- has culturally specific needs.

A resident may have a combination of the above. Interaction between staff and residents should be tailored to each resident's individual needs.

Observe and monitor

Once you have ensured the safety, dignity and comfort of the resident and others through using alternatives to restraint, then you need to:

- monitor the resident closely
- document the care given as per the organisational policy
- evaluate the success of the strategies you have used
- communicate with senior staff, family, general practitioners, and relatives
- revise care plan as required.

CONSENT ISSUES

Any decision to restrain a resident carries significant ethical and legal responsibilities. The use of restraint should always be the last resort and viewed as a temporary solution to any behaviour causing concern or circumstantial factor. Its use should only be considered after exhausting all reasonable alternative options and be informed by a comprehensive assessment of a resident and her/his interactions.

Consultation should take place with the resident or their legal representatives (e.g. guardian, holder of an enduring power of attorney with unlimited authority, or with restraint as a specified authority), the resident's family or other close associates, the medical officer and other relevant health professionals prior to a decision to apply restraint.

Note that a guardianship order or an enduring power of attorney may cover a limited range of matters not including decisions about restraint. 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 restraint.

Legal requirements for consent to the use of restraint where the resident is not mentally competent may vary in different states and territories. A family member who does not have a relevant guardianship order or enduring power of attorney may not have the legal capacity to consent on behalf of the resident to the use of restraint, or may only be able to consent to its short term use in response to a crisis. In some circumstances consent might need to be obtained from the Guardianship Board or its equivalent in the particular state or territory.

Service providers should be aware of the legal requirements of their state or territory. In addition, service providers should obtain legal advice in cases where there is any doubt. Restraining a person without consent could result in civil action or criminal prosecution.

NOTE:
A family member or legal representative does not have the legal power to require that a resident be restrained. This is a clinical decision that must be made by appropriately qualified people. The reasons for the decision to restrain and the process by which the decision was reached should be documented, as those making the decision are legally accountable for the decision and its consequences.

The decision to use restraint in a residential aged care home is a clinical decision which, with the consent of the resident or their legal representatives e.g. guardian or holder of an enduring power of attorney, may be made by a competent person in order to protect the resident, or other residents and staff, and where there is no reasonable alternative. In an emergency, where there is a necessity to act urgently to safeguard someone, some restrictive practices, prior to obtaining consent, may be defensible as action taken under the service provider's duty of care. 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 restraint against the risks of not using restraint.

It is the responsibility of all individual care staff e.g. nurses, personal care assistants, medical practitioners and allied health professionals, to ensure a restraint free environment. Any decision about restraint use, and actions taken, is a strategy of last resort and decided upon in the context of relevant legislation, codes of practice and other professional standards, policies and guidelines relevant to the practice setting. In preparing care policies, aged care services should seek appropriate advice on legal and care issues.

WHAT CONSTITUTES RESTRAINT?

Restraint is any aversive practice, device or action that interferes with a resident's ability to make a decision or which restricts their free movement.

THE USE OF RESTRAINT

The use of restraint should always be viewed as a temporary solution to any behaviour causing concern or circumstantial factor. Restraint use should only be considered after a comprehensive assessment and the use of preventive strategies and alternative options have been exhausted.

A resident may make a specific request to use a restrictive item, such as bed rails, to provide them with an enhanced feeling of safety or 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. When someone cannot give informed consent then any device or action that interferes with a resident's ability to make a decision or which restricts their free movement is restraint.

Physical restraint

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 is physical restraint.

Physical restraint devices include but are not limited to:

- lap belts
- tabletops
- posey restraints or similar products
- bed rails
- chairs that are difficult to get out of such as beanbags, water chairs and deep chairs

General restraint devices include:

- bed boundary markers, to mark the edges of the bed such as mattress bumpers, rolled blankets or swimming noodles under sheets which act as a restraint if the resident cannot move past them or if they give the resident the belief that they cannot get past them
- concave mattresses
- comfort/supportive chairs that support posture and slumping but in so doing inhibit freedom of support
- chairs with deep seats
- rockers or recliners
- large pillows or bean bags on floors

- any skeletal support that restricts mobility
- lap rugs with ties
- lap sashes (waist restraints, including belts)
- hand mitts
- geri/protective chairs with tables
- wheelchair safety bars
- seat belts on chairs

High-risk restraints

- removing aids to mobility such as walking frames
- bed rails

Extreme restraint

- aversive treatment
- seclusion
- posey criss-cross vest
- leg or ankle restraint
- manacles/shackles (hard)
- soft wrist/hand restraints

At no time should extreme restraint be used in residential aged care

Chemical restraint

Chemical restraint is the control of a resident's behaviour through the intentional use of:

- prescribed medicines
- over the counter medicines and/or
- complementary alternative medicines.

Chemical restraint is:

- when no medically identified condition is being treated
- where the treatment is not necessary for a condition
- to over-treat a condition.

Chemical restraint includes the use of medicines when:

- the behaviour to be affected by the active ingredient does not appear to have a medical cause
- part of the intended pharmacological effect of the medicine is to sedate the person for convenience or for disciplinary purposes.

Examples of pharmacological agents used as chemical restraint are antipsychotic, antidepressant, antimanic, anxiolytic and hypnotic drugs.

Chemical restraint – medicines which sedate or tranquillise – must not be implemented until alternatives are explored extensively through assessment.

Aversive treatment practices/punishment

An aversive practice is one that uses unpleasant physical, sensory or verbal stimuli, e.g. any voice tone, command or threat that is used to limit a resident's mobility 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, positive social interaction, a resident's goods/belongings or a favoured activity for the purpose of behaviour management or control.

Person-to-person restraint

Person-to-person restraint is the control of a resident's behaviour through the use of:

- physical force or 'hands on': no matter how gentle 'hands on' is, this is a form of restraint if it limits a resident's mobility
- verbal: any commands or threats that are used to limit a resident's mobility
- psychological measures: any measure that creates a belief that acts to limit a resident's mobility e.g. placing a tape across a doorway.

Environmental restraint

Environmental restraint is the restriction of movement by the resident without the resident's explicit and informed consent. Examples of environmental restraint include:

- Limiting a resident to a particular environment: e.g. confining a resident to their bedroom, excluding a resident from an area to which they want to go.
- Restricting access to an outside courtyard or sitting room.
- Preventing a resident from leaving the building.

If it is decided, after careful consideration of all options, that restraint is to be used in the resident's best interests, then it is still restraint, and precautions must be rigorously observed in the care of the resident who is restrained. Usually these decisions are made in the interests of the resident's safety. However, the expected benefits need to be weighed against the potential harm of any form of restraint.

Perimeter restraints include:

- fenced areas with locked gates
- locked exit doors in the home or activity area
- exit doors that require opening via a code or keypad.

USING TEMPORARY AND LEAST RESTRICTIVE FORMS OF RESTRAINT

If restraint free options do not deal successfully with the behaviour causing concern, it may be necessary to use the least restrictive form of restraint to ensure the safety and dignity of all concerned.

Use the least restrictive form of restraint

The decision to use restraint should be preceded by a full, documented assessment.

Consultation should take place with the resident or their legal representative – e.g. a guardian or holder of an enduring power of attorney with unlimited authority, or with restraint as a specified authority, the resident's family or other close associates, the medical officer and other relevant health professionals prior to a decision to apply restraint. In an emergency situation this consultation may not be possible immediately, but should be done as soon as possible and in accordance with your home's policy.

Monitor and observe closely for signs of distress or harm

The use of restraint itself poses risk. For the protection of a resident who is restrained ensure:

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

Communicate and document

All assessments should be carried out in consultation with the resident and/or their family/representative where possible and all relevant health professionals.

- It is important to discuss all the options fully with the resident and/or their family/representative.

- This communication should be done in a way that they can understand and they should be given the opportunity to discuss their concerns and expectations.
- The communication is enhanced if families/representatives are given some written information that they can take home and read at their leisure. See information sheet for relatives at the end of this document. Time should then be made available for them to ask any questions once they have had time to think about the issues.

Documentation should address such issues as:

- the type of restraint – must be the least restrictive to achieve objectives / goals
- time limit for use of restraint
- monitoring and observation of resident while restraint is in use
- protection of the resident from personal injury, harm and adverse events
- review and evaluation of the restraint used
  - when
  - by whom.

Review

Once a decision has been made to use any form of restraint, the initial assessment and decision should be reviewed 'as soon as possible' and in accord with the home's policy. 'As soon as possible' relates to the specific restraint used.

Regular monitoring and review

- Regular monitoring and review to determine whether restraint is still appropriate and optimal is an essential component of restraint management. Whatever timeframe is determined this must be justified by the registered nurse (RN) making the clinical decisions and documented in the care plan.
- Review of the use of chemical restraint should be carried out in consultation with the resident's medical practitioner and an accredited pharmacist.
- The outcome of the review should be documented and explained to the resident, resident's family or other person with authority to make care decisions.

Reassess the need for the use of restraint and promote a restraint free approach

- Use the review process to trigger reassessment of the need for the use of restraint and, where possible, to try alternatives.

MANAGEMENT RESPONSIBILITIES

This section assists the management of a service to identify how best to create an organisational climate where all persons understand and implement-evidence based practice related to a restraint free approach.

Management has the responsibility to:

- develop policies and practices
- initiate prevention programs
- promote communication and consultation
- establish and maintain review processes
- ensure education and training support
- keep informed about best practice.

Management also has the responsibility to provide guidance and support to help staff members:

- create a restraint free environment
- prevent and respond to challenging behaviours and those that create concern
- provide a safe working environment
- as a last resort, know how to make decisions related to restraint use.

In considering these responsibilities, it is anticipated that there will be varied responses given the different contexts of care, the unpredictability and potential range of residents' behaviours, changing staff profiles and work conditions in different homes.

Legal requirements for consent to use restraint:

- A family member must have a relevant guardianship order or enduring power of attorney to have the legal capacity to consent to the use of restraint.
- Consent might need to be obtained from the Guardianship Board or its equivalent, particularly if the ongoing use of restraint is contemplated.
- Service providers should obtain legal advice in cases where there is any doubt about the use of restraint.

Develop policies and practices

Organisational policies which support a restraint free approach must reflect both the legislative and regulatory requirements and the local organisational context within which the policies and care practices will operate.

Proceed slowly: communicate and educate

As with any change management, it is necessary to proceed slowly, and include a focus on prevention of injury to both staff and residents. A restraint free approach is possible when care is taken to assess the 'state of play' within an organisation and if open lines of communication are created from the outset. Moreover, education of all persons is very important.

Establish the context

Determine the ethical, regulatory and legislative context

The aged care sector, in accordance with the *Aged Care Act 1997,* is committed to the provision of care to a standard appropriate to meet the needs of all recipients of residential aged care services. There is an obligation for all parties involved in the provision of residential aged care services to comply with all relevant legislation, regulatory requirements, professional standards and guidelines.

Determine the local context

Having determined the wider context, it is then necessary to understand the organisational setting in which restraint usage policies will operate.

With regard to providing a restraint free environment it is important to determine the:

- capabilities, goals, and objectives of the aged care home
- social, cultural, clinical and economic environment
- strengths and weaknesses of the current situation.

It is a responsibility of management to decide and document who has the responsibility to make a decision about the use of a least restrictive form of restraint when all alternative options have been unsuccessful.

There is no legal requirement for the use of restraint to be authorised by a medical officer.

Where a decision is made to allow a specific member of staff to make a decision about restraint usage, this must be in consultation with the resident, family/friends, medical officer and other staff as appropriate. It is imperative that this decision is resident-focused and not staffing related.

Make an organisational policy

Having undertaken a review of the organisation, the next step is to develop a restraint free policy that is tailored to the needs of the organisation and situated within the wider legislative and regulatory environment in which you operate.

Developing a restraint free policy:

- Situate the policy within the wider context of your organisation's policies and framework including occupational health and safety policies.
- Decide how restraint use in the aged care home is to be managed and reviewed.
- Develop criteria that are to be included in any evaluation.
- Ensure consistency and safe practice by identifying areas that may require protocols, standard operating procedures and/or guidelines.

Initiate prevention programs

Prevention is the key to the successful management of the level of restraint use.

The proactive management of the level of restraint use should focus on the prevention of situations that may lead staff, residents and their family/ representative to perceive a need for restraint and on encouraging the acceptance by all concerned that restraint is only a strategy of last resort.

Issues for consideration in designing prevention programs include but are not restricted to:

- environment
- early identification and assessment of 'at-risk' residents
- assessment and modification of care programs
- care strategies
- occupational health and safety.

Address environmental issues

The general design and layout of your aged care home can influence the behaviour of residents. An environment audit of your home may be helpful to identify areas which contribute to difficult situations. An audit tool: *Improving the environment for older people in Health Services: An audit tool* (2006), is available at: http://www.health.vic.gov.au

In the box below is a list of some issues to consider when undertaking an assessment of your aged care home in order to identify and modify the environment to improve safety for residents and staff.

A changing resident profile creates the need to review how this profile matches the structural layout of an aged care home.

Environmental issues to consider:

- the installation of alarm systems for residents at risk of wandering or falling out of bed.
- lighting, including the level of lighting and how easy lights are for residents to access and use, and lights that are activated by residents' movement.
- structural design and layout of the aged care home.
- environmental hazards such as floor surfaces and furniture placement, the use/non-use of soft furnishings such as mats, safe access to outside areas.
- signage.
- design and access of toilet facilities.
- provision of equipment such as high-low beds, hip protectors, mobility aids etc.
- safe 'wandering areas' and 'quiet places'.

Develop strategies to assist the early identification and full assessment of new and 'at risk' residents

It is important that residents at risk are identified early and alternative strategies developed to manage any behaviours causing concern without the use of restraint.

Aids to assist assessment:

- The development and use of appropriate assessment tools should be considered. An assessment tool is an aid and should never replace sound clinical judgement based on best available evidence.
- Education programs in the area of assessment, particularly those drawing on the expertise of external experts.

Modify the way in which the program of care is organised

The way that personal, lifestyle and nursing care is organised and managed can influence the behaviour of residents. Measures need to be devised to minimise the occurrence of challenging behaviours and those that create concern in an aged care home. The review and audit process is a useful means to implement this strategy.

Examples of program modifications:

- Increase or decrease stimulation for individual residents.
- Provide a range of activity programs to which a resident can be directed.
- Implement falls prevention programs.
- Monitor and change staffing levels to meet changing requirements.
- Adapt organisation's routines to individual needs and preferences wherever possible.

Things to consider for audit and review:

- documented assessment covering physical, behavioural and functional aspects and considering context, environment and personal history
- care plan that includes strategies and objectives
- a review of care plan
- communicating with all staff, resident and family
- review of systems and processes including procedures around restraint.

Develop a database of care strategies:

Whilst care plans should be tailored to the needs of individual residents there is a range of care strategies that have been found to be effective in responding to 'at risk' behaviours.

A database of exemplar strategies, protocols and resources can be developed to act as 'prompts' when individual care plans are being developed by staff. These databases should be updated as information is collected during the evaluation process.

Developing a database of care strategies:

- A comprehensive list of strategies to help manage specific behaviours causing concern and to assist in the care of residents at risk of falling should be made available to act as prompts when developing individualised care plans.
- Care protocols based on best practice can be developed to guide the management of specific 'risky' situations. For example, care of residents in bed; seating and positioning residents; toileting and incontinence; showering and dressing residents.
- Promote the use of case conferencing and other enhanced primary care items.

Promote communication and consultation

The care given to residents should be evidence-based, involve the resident and/or their representative, and be consistent between different staff members, whilst allowing for individual requirements of residents.

It is the responsibility of management to ensure that open lines of communication are established and maintained between members of the multi-disciplinary team, residents and their representatives.

General discussion meetings

One way of opening up lines of communication and consultation is to have issues of restraint and behaviours of concern placed on the agenda of existing committees (such as quality assurance). These meetings can include:

- residents and families/representatives
- members of the multi-disciplinary care team
- education planning.

Liaison/coordination

Best available evidence suggests that it is useful to designate a liaison/ coordination person with expertise in restraint policy and practice issues to act as a case manager and conduit between staff, residents and families/ representatives, medical staff and allied health workers to develop and maintain active communication. This person can also facilitate the development of an education program.

Communication with families

Communication with families may be enhanced by the use of the information sheet. **(See resources section)**.

Areas to consider for inclusion in an education program:

- definition of restraint
- common misunderstandings about the use of restraint
- the safe, legal and ethical use of restraint
- alternative strategies e.g. falls prevention program
- staff assessment skills
- availability and use of available assessment tools
- how to support and educate residents and representatives
- occupational health and safety issues related to behaviours of concern and the decision to use restraint
- best practice developments in responding to behaviours of concern.

RESOURCES AND INFORMATION

Telephone numbers and web sites

Advocacy

The National Aged Care Advocacy Program (NACAP) is a national program funded by the Australian Government under the *Aged Care Act 1997*. The NACAP aims to promote the rights of people receiving Australian Government funded aged care services. More information can be found at: http://www.health.gov.au

Under the NACAP, the Department of Health and Ageing funds aged care advocacy services in each state and territory. These services are community-based organisations which give advice about your rights, and help you to exercise your rights. Aged care advocacy services also work with the aged care industry to encourage policies and practices which protect consumers.

These organisations are Commonwealth-funded and provide information and publications on the rights of persons receiving Australian Government funded aged care services including issues regarding elder abuse.

Australian Capital Territory
ACT Disability, Aged and Carer Advocacy Service (ADACAS)
02 6242 5060
(ACT free call number 1800 700 600)
http://www.adacas.org.au

New South Wales
The Aged-care Rights Service (TARS)
02 9281 3600
(NSW country free call number 1800 424 079)
http://www.tars.com.au

Northern Territory
Aged and Disability Rights Team
08 8982 1111
(NT country free call number 1800 812 953)
http://www.dcls.org.au

Queensland
Queensland Aged and Disability Advocacy (QADA)
07 3637 6000
(QLD country free call number 1800 818 338)
http://www.qada.org.au

South Australia
Aged Rights Advocacy Service (ARAS)
08 8232 5377
(SA country free call number 1800 700 600)
http://www.sa.agedrights.asn.au

Tasmania
Advocacy Tasmania
03 6224 2240 or
(TAS free call number 1800 005 131
http://www.advocacytasmania.org.au

Victoria
Elder Rights Advocacy (ERA)
03 9602 3066
(VIC free call number 1800 700 600)
http://www.era.asn.au

Western Australia
AdvoCare
08 9479 7566
(WA free call number 1800 655 566)
http://www.advocare.org.au

Specific service supports

As part of the Dementia Initiative, the Australian Government aims to strengthen the capacity of the health and aged care sectors to provide appropriate evidence-based prevention and early intervention, assessment, treatment and care for people with dementia, their families and carers. This occurs through a number of programs such as:

- The National Dementia Support Program
- Dementia Behaviour Management Advisory Service (DBMAS)

Through the National Dementia Support Program (NSDP) the Australian Government provides the following services through Alzheimer's Australia State and Territory offices:

- National Dementia Helpline and Referral Service
- support and counselling
- information, awareness, education and training
- support for people with special needs.

National Dementia Helpline: Free call 1800 100 500

The Dementia Behaviour Management Advisory Services (DBMAS) is a nationwide network of services funded by the Australian Government as part of the dementia initiative. DBMAS is managed by different organisations in every state.

Dementia Behaviour Management Advisory Services (DBMAS): Free call 1800 699 799

Carers Australia
Free call 1800 242 636

Carers Australia is the national peak body representing carers in Australia.

Carers Australia works with the Carers Associations in each of the states and territories to deliver carer programs and services and advocate on behalf of all carers. Carers Australia's vision is that *caring be accepted as a shared community responsibility and our mission is leading change and action for carers.*

http://www.carersaustralia.com.au

The caring experience is a book that provides carers of people with dementia with information, advice and support. The carer information, stories and ideas in this book come directly from carers and service providers throughout Australia. Available at:

http://www.health.gov.au

Commonwealth Respite and Carelink Centres
Freecall 1800 052 222

These information centres are for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia.

http://www.health.gov.au

Charter of Resident Rights and Responsibilities

A resident has the same rights as those of any other Australian. Please visit:
http://www.health.gov.au

Alzheimer's Australia:
Free call 1800 639 331

Alzheimer's Australia is responsible for the content of many Help Sheets to provide advice, common sense approaches and practical strategies on the issues most commonly raised about dementia.
http://www.alzheimers.org.au

At the bottom of the Alzheimer's Australia's home page please click onto the link Help Sheets.

Australian Guardianship and Administration Council

AGAC is the Australian Guardianship and Administration Council.
AGAC member organisations have a role in protecting adults in Australia who have a disability that impairs their capacity to make decisions.

This website contains information about AGAC and has links to its member organisations' websites
http://www.agac.org.au

Department of Health and Ageing:

The Australian Government Department of Health and Ageing (DoHA) has a website that contains useful information.
http://www.health.gov.au

Occupational Health and Safety:

The Guide: Implementing Occupational Health and Safety in Residential Aged Care (The Guide) has been developed to provide information to assist residential aged care homes to develop their own occupational health and safety programs. The Guide is not, however, a legal document. The relevant Commonwealth and state occupational health and safety legislation should always be consulted in relation to any legal issues which may arise. Professional advice should be sought before applying the information contained in the Guide to particular circumstances.

The Guide: Implementing Occupational Health and Safety in Residential Aged Care is available at:

http://www.health.gov.au

FACT SHEET: HOW TO SUPPORT A RESTRAINT FREE ENVIRONMENT IN RESIDENTIAL AGED CARE

An introductory guide to help relatives, friends and carers

A restraint free environment means no words, devices or actions will interfere with a resident's ability to make a decision or restrict their free movement.

This information has been designed to stimulate discussion with staff about how to ensure restraint free care for your relative/friend.

The use of restraint confronts a resident's rights and dignity and, in some cases, may subject the resident to an increased risk of physical harm.

Supporting a restraint free environment

A restraint free approach means that staff and management approach their responsibilities always thinking of their need to preserve the human rights of residents, especially when responding to challenging behaviours your relative or friend may exhibit.

To ensure a resident has their individual needs identified and addressed is a priority of care. With management support, staff will work with you to identify and address your relative/friend's needs. Prevention is the key to a successful restraint free environment and critical to this success is a partnership approach with you.

Management and staff do not support any action or the use of any device that does not have the consent of a resident. They will not use:

- physical mechanisms such as bed rails or lap-belts
- medicines such as tranquillisers inappropriately
- aversive treatment practices / punishment / yelling
- locked doors where this is not necessary.

When a decision may need to be made about restraint use

The decision to use restraint in any of its forms is not taken lightly and is only used as a measure of last resort. Relatives need to feel comfortable to discuss with members of staff the potential for restraint use and this discussion needs to involve the resident if this is appropriate. Please feel comfortable to ask staff any questions including:

- Why has a decision been made to use restraint?
- What are the alternatives to using restraint?
- Is the restraint chosen the least restrictive form of restraint?
- How will the use of restraint be monitored?
- For how long will restraint be used?

A decision about using the least restrictive form of restraint possible may, as a last resort only, be necessary in situations where a resident is doing something that may result in them:

- harming themselves or others, or
- experiencing a loss of dignity, or
- causing damage to property, or
- disrupting or severely embarrassing other residents.

Prevention of these behaviours will always be a priority, and learning what may trigger any of these will have an ongoing focus of staff's attention.

The decision to use restraint is a clinical decision

Legal requirements for consent to use restraint:

- a family member must have a relevant guardianship order or enduring power of attorney to have the legal capacity to consent to the use of restraint
- consent might need to be obtained from the Guardianship Board or its equivalent, particularly if the ongoing use of restraint is contemplated
- service providers should obtain legal advice in cases where there is any doubt about the use of restraint.

Common misunderstandings about the use of restraint

Belief: *Restraints decrease falls and prevent injuries*

Evidence: Risk of injury or death through strangulation or asphyxia resulting from the use of restraints is a real concern.

Belief: *Restraints are for the good of the resident*

Evidence: Immobilisation through restraint can result in chronic constipation, incontinence, pressure sores, loss of bone and muscle mass, walking difficulties, increased feelings of panic and fear, boredom and loss of dignity.

Belief: *Restraints make care giving more efficient*

Evidence: Although they might be a short-term solution they actually create greater dependence, have a dehumanising effect, and restrict creativity and individualised treatment.

Further information

Commonwealth Respite and Carelink Centres

Freecall 1800 052 222
http://www.health.gov.au

These information centres are for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia.

Alzheimer's Australia:
Free call 1800 639 331
http://www.alzheimers.org.au

Carers Australia:
Free call 1800 242 636
http://www.carersaustralia.com.au

Dementia Behaviour Management Advisory Services (DBMAS):
Free call 1800 699 799
http://www.dbmas.org.au

Aged Care Advocacy Services

Australian Capital Territory

ACT Disability, Aged and Carer Advocacy Service (ADACAS)
02 6242 5060
(ACT free call number 1800 700 600)
http://www.adacas.org.au

New South Wales

The Aged-care Rights Service (TARS)
02 9281 3600 (NSW country free call number 1800 424 079)
http://www.tars.com.au

Northern Territory

Aged and Disability Rights Team
08 8982 1111
(NT country free call number 1800 812 953)
http://www.dcls.org.au

Queensland

Queensland Aged and Disability Advocacy (QADA)
07 3637 6000
(QLD country free call number 1800 818 338)
http://www.qada.org.au

South Australia

Aged Rights Advocacy Service (ARAS)
08 8232 5377
(SA country free call number 1800 700 600)
http://www.sa.agedrights.asn.au

Tasmania

Advocacy Tasmania
03 6224 2240 or
(TAS free call number 1800 005 131
http://www.advocacytasmania.org.au

Victoria

Elder Rights Advocacy (ERA)
03 9602 3066
(VIC free call number 1800 700 600)
http://www.era.asn.au

Western Australia

AdvoCare
08 9479 7566
(WA free call number 1800 655 566)
http://www.advocare.org.au

www.health.gov.au

All information in this publication is correct as at August 2012

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