

## **EXPLANATORY STATEMENT**

**Issued by the authority of the Minister for Aged Care**

*Aged Care Act 1997*

*Quality of Care Amendment (Restrictive Practices) Principles 2022*

### **Purpose**

The purpose of the *Quality of Care Amendment (Restrictive Practices) Principles 2022* (Amendment Principles) is to amend the *Quality of Care Principles 2014* (Quality of Care Principles) to establish clear arrangements in the Commonwealth aged care legal framework that allow for certain individuals or bodies to be authorised to provide informed consent to the use of a restrictive practice in relation to a care recipient where the laws of the State or Territory in which the recipient receives aged care may not authorise an individual or body to provide consent on behalf of a care recipient. These arrangements will only apply where the care recipient lacks capacity to make an informed decision themselves.

These amendments aim to strengthen protections for care recipients from abuse associated with the unregulated use of restrictive practices, reduce the risk of unwarranted use of restrictive practices and reduce the risk of harm to care recipients.

The Amendment Principles also make consequential amendments needed to ensure the effective operation of the alternative consent arrangements, and to also ensure that immunity arrangements introduced by the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Royal Commission Response Act) apply in appropriate, limited circumstances. This instrument is a legislative instrument for the purposes of the *Legislation Act 2003*.

### **Background**

On 1 July 2021, the *Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021* (Royal Commission Response No. 1 Act) and the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021* (Royal Commission Response No. 1 Principles) established strengthened requirements for the use of restrictive practices in relation to care recipients in residential care and flexible care in the form of short-term restorative care provided in a residential setting.

The strengthened requirements for the use of restrictive practices responded to the recommendations of the Royal Commission into Aged Care Quality and Safety's *Final Report: Care, Dignity and Respect* (Royal Commission's Final Report), and the Australian Healthcare Associates' *Final Report: Independent Review of Legislative Provisions Governing the use of Restraint in Residential Aged Care* by ensuring more robust protections are in place for care recipients from abuse associated with the inappropriate use of restrictive practices.

From 1 July 2021, the Royal Commission Response No. 1 Principles amended the Quality of Care Principles to detail the responsibilities of approved providers of residential care, or flexible care in the form of short-term restorative care, relating to the use of a restrictive practice. Additional amendments commenced on 1 September 2021 detailing behaviour support plan requirements to be included in the care recipient's care and services plan by approved providers if a restrictive practice is to be used.

The Amendment Principles revise these strengthened restrictive practices arrangements to address unexpected outcomes in relation to informed consent and the interaction with State and Territory guardianship and consent laws by expanding the definition of a 'restrictive practices substitute decision-maker'.

In response to Recommendation 17(1)(b)(v) of the Royal Commission's Final Report, the amendments made by the Royal Commission Response No. 1 Principles require that if the care recipient lacks capacity, informed consent must be sought from and given by the "restrictive practices substitute decision-maker" before the restrictive practice can be used. A "restrictive practices substitute decision-maker" was previously defined to mean "a person or body that, under the law of the State or Territory in which the care recipient is provided with aged care, can give informed consent to:

- (a) the use of the restrictive practice in relation to the care recipient; and
- (b) if the restrictive practice is chemical restraint—the prescribing of medication for the purpose of using the chemical restraint;

if the care recipient lacks the capacity to give that consent."

The amendments made by the Royal Commission Response No. 1 Principles were not intended to affect the operation of any State or Territory laws in relation to restrictive practices. They were intended to complement and clarify existing State and Territory laws, which are designed to protect individuals from interference with their personal rights and liberties.

However, following the commencement of the amendments made by the Royal Commission Response No. 1 Principles, the Department of Health and Aged Care (Department) was informed that in many jurisdictions, it was unclear whether the relevant laws in that jurisdiction could authorise persons or bodies to give informed consent to the use of restrictive practices on another's behalf where the care recipient does not have capacity themselves. Without clear consent arrangements in place across all jurisdictions, restrictive practices cannot be used in certain circumstances where it may otherwise be appropriate or may be used without the consent of an appropriate person.

To address this issue, these Amendment Principles introduce interim arrangements which authorise certain individuals or bodies to give informed consent to the use of a restrictive practice where a care recipient lacks the capacity to give consent themselves.

It is appropriate that these matters be dealt with in delegated legislation as they deal with operational matters and will be co-located with the existing restrictive practices framework under Part 4A of the Quality of Care Principles. Including these matters in delegated legislation will also ensure flexibility for prompt modifications should the arrangements have any unintended consequences that may impact the health, safety and well-being of care recipients.

As these arrangements relate to the interim measures to allow time for State and Territory governments to make amendments to their consent and guardianship laws, they are not intended to be ongoing. The Government will continue its engagement with State and Territory governments on this issue, including seeking their continued cooperation to investigate options to establish clear arrangements for the provision of substituted consent to the use of restrictive practices.

The Government will monitor these arrangements over the next two years and does not intend to continue the arrangements in the new Aged Care Act.

The Amendment Principles will not affect informed consent already given by an individual or body authorised to consent to the use of a restrictive practice under the relevant State or Territory where the use has already occurred. It also is not intended to displace the common law presumption of capacity. As State and Territory laws are amended, those new arrangements will be able to be recognised in determining who is the “restrictive practices substitute decision-maker” in accordance with new section 5B (explained below).

While the interim measures are primarily intended to address situations where there are no persons or bodies that can be appropriately authorised under State or Territory laws, approved providers will also be able to refer to the hierarchy of consent arrangements (see new subsection 5B(1)) to seek and ensure informed consent can be provided, including where there is an in-progress application for such authorisation with the relevant State or Territory guardianship body or Tribunal. This is intended to recognise the time it may take for State or Territory bodies to hear and decide applications, while providing safeguarded pathways for providers to obtain appropriate informed consent to the use of a restrictive practice and ensure that restrictive practices may be used where necessary to promote the health, safety and well-being of care recipients.

The Amendment Principles also make consequential amendments needed to ensure the effective operation of the revised consent arrangements, and to also ensure that the immunity arrangements, established by new section 54-11 of *Aged Care Act 1997* (Aged Care Act), apply in appropriate, limited circumstances.

The effect of the amendments to the Aged Care Act and the Amendment Principles is not to provide for a general immunity to approved providers and their staff in all circumstances where a restrictive practice is used. The immunity provision will only apply to the extent that an approved provider (or a staff member of the approved provider) relies on consent from a person in accordance with the table in new subsection 5B(1) for the use of a restrictive practice.

The purpose of the immunity is to ensure that where there may be no local State or Territory law available to authorise informed consent to be given to the use of a restrictive practice, an approved provider or individual who acts on consent given in accordance with the Commonwealth arrangements is not exposed to civil or criminal liability by relying on that consent to use a restrictive practice.

The immunity provision will only be available where all of the legal requirements around who may consent to the use of a restrictive practice are strictly followed. In circumstances where the restrictive practice has been used in accordance with all of the relevant requirements in Part 4A of the Quality of Care Principles and informed consent has been given by a person authorised under the interim measures, the immunity in new section 54-11 of the Aged Care Act will ensure that approved providers and other relevant individuals (e.g. staff members and volunteers) involved in the use of the restrictive practice are protected from civil and criminal liability.

The immunity from civil or criminal liability is limited and only applies where informed consent is provided by a person authorised to provide consent to the use of the restrictive practice through the Commonwealth arrangements and where the restrictive practice is used consistently with Part 4A of the Quality of Care Principles. The provisions in Part 4A of the Quality of Care Principles require, amongst other things, that restrictive practices must only be used:

- as a last resort to prevent harm to care recipient;
- to the extent that is necessary;
- for the shortest time necessary; and
- in the least restrictive form.

If the use of the restrictive practice is not used in accordance with the requirements under Part 4A of the Quality of Care Principles, the immunity will not apply. For example, if chemical restraint is used on a care recipient without the approved provider first considering alternatives, the immunity would not apply to the approved provider or other individuals involved in the use of the chemical restraint.

The immunity does not prevent approved providers or their staff members from potentially being charged with a criminal offence, or a civil claim being brought in, for example, negligence where the use of the restrictive practice was not in accordance with the strict requirements set out in Part 4A of the Quality of Care Principles.

Introducing these arrangements will provide clarity and simplify the process around requirements on the use of restrictive practices in jurisdictions where limitations with consent and guardianship laws exist.

These arrangements will be repealed after two years following registration of the Amendment Principles in accordance with Schedule 3 to the Amendment Principles discussed below. This is because these arrangements are intended to be interim measures to allow time for State and Territory governments to make appropriate amendments to their consent and guardianship laws. The Government will continue to engage with States and Territories on this issue, including offering continued collaboration to investigate options to establish clear arrangements for the provision of substituted consent for the use of restrictive practices.

## **Authority**

Section 96-1 of the Aged Care Act provides that the Minister has the power to make instruments providing for matters that are required or permitted, or necessary or convenient, in order to give effect to the relevant Part or section of the Aged Care Act.

The Quality of Care Principles are made under section 96-1 of the Aged Care Act and set out matters for the purposes of Part 4.1 of the Aged Care Act. Subsection 54-1(1)(f) in Part 4.1 of the Aged Care Act requires that if an approved provider provides a kind of care specified in the Quality of Care Principles to care recipients, they have a responsibility to ensure a restrictive practice is only used in circumstances as set out in the Quality of Care Principles.

Subsection 54-10(1A) of the Aged Care Act also provides that the Quality of Care Principles made for the purposes of subsection 54-1(1)(f) may make provision for, or in relation to, the persons or bodies who may give informed consent to the use of a restrictive practice in relation to a care recipient if the care recipient lacks capacity to give that consent.

Further, subsection 54-11(2)(a) of the Aged Care Act provides that a protected entity is not subject to any civil or criminal liability for, or in relation to, the use of a restrictive practice in relation to a care recipient if informed consent was given by a person or body specified in the Quality of Care Principles made for the purposes of that paragraph of the Aged Care Act.

The Amendment Principles amend the Quality of Care Principles to specify these persons or bodies, and to amend the existing requirements to give effect to the new arrangements set out in subsection 54-10(1A) and section 54-11 of the Aged Care Act.

Under subsection 33(3) of the *Acts Interpretation Act 1901*, where an Act confers a power to make, grant or issue an instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend or vary any such instrument.

## **Commencement**

Sections 1 to 4 and Schedule 1 to the Amendment Principles, as well as anything else not otherwise covered by the commencement provisions, will commence the day after registration of the Amendment Principles.

Schedule 1 introduces interim measures to address the issues with the current State and Territory consent arrangements where a care recipient does not have capacity to consent to the use of a restrictive practice. These amendments commence the day after registration to ensure that the unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws are addressed as soon as possible.

Schedule 2 to the Amendment Principles commences on 1 April 2023. The amendments made by Schedule 2 introduce additional requirements for details of the informed consent given to be included in a care recipient's behaviour support plan.

This later commencement date will allow sufficient time for approved providers to prepare for these new requirements, which may involve changes to processes, systems, and templates.

Schedule 3 to the Amendment Principles commences two years after the registration of the Amendment Principles. The amendments made by Schedule 3 repeal the interim measures. This reflects that the arrangements are not intended to be ongoing, with more permanent arrangements intended to be put in place under the new Aged Care Act. This will allow time for State and Territory governments to establish their own arrangements and procedures for the authorisation of substituted consent for the use of restrictive practices (where they do not already exist).

### **Consultation**

The Department has consulted with key stakeholders in relation to these new arrangements regarding the giving of informed consent to the use of a restrictive practice.

In particular, since becoming aware of the unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws, the Department has worked closely with State and Territory government officials to understand the extent of the issue, the potential for legislative changes at a jurisdictional level, and to consider appropriate interim measures to be implemented through the Amendment Principles. The Department has also worked closely with consumer representative groups and advocacy organisations, industry peak bodies and the Aged Care Clinical Advisory Committee to understand consumer, provider and medical practitioner perspectives on the issue, and to also provide advice and seek input on the interim measures.

In late 2021, the Department undertook consultation on a draft of the Amendment Principles with key stakeholders including relevant State and Territory government officials, consumer representative groups, advocacy organisations, and industry peak bodies. The feedback identified a number of areas for further clarification which have been addressed in the Amendment Principles. This included revisions or clarification to ensure effective interaction with State and Territory laws and revisions to the order and operation of the hierarchy that replaces the definition of “restrictive practices substitute decision-maker”. Feedback has also been used to inform communications materials and policy guidance to provide clarification and examples to assist readers to understand how the interim measures are intended to operate.

The Department published an exposure draft and explanatory statement of the Amendment Principles on 1 September 2022 for a 14-day review period. Feedback received led to minor amendments of the exposure draft and the explanatory statement. This included strengthening the requirement that state and territory mechanisms be used where clear arrangements exist prior to considering using the Commonwealth legislation; allowing the care recipient to designate multiple individuals and/or a group of restrictive practices nominees; removing the requirement for the medical treatment authority to be appointed by someone other than the care recipient; clarifying that providers can only move down the hierarchy if the item above does not apply, and highlighting that if the eligible restrictive practice

substitute decision-maker does not consent to the use of the restrictive practice it cannot be used. The feedback also supported strengthening of information resources.

**Regulation Impact Statement (RIS)**

Consistent with the Office of Best Practice Regulation's (OBPR) RIS requirements, prior to establishment of the strengthened arrangements on the use of restrictive practices from 1 July 2021, the Department certified that a package of independent reviews undertook a process and analysis equivalent to a RIS. The certification and list of reviews can be found in the Explanatory Memorandum for the Royal Commission Response No. 1 Act.

A preliminary assessment for a further RIS was undertaken in relation to the interim measures to be introduced through the Amendment Principles. The assessment concluded that the interim measures are designed to clarify the operation of existing measures and to address unforeseen issues in relation to the same measures. The OBPR considers that the interim measures are unlikely to have more than minor regulatory impact, and therefore the preparation of a RIS is not required (Reference OBPR22-01498). The certification and list of reviews are available on the Office of Best Practice Regulation's website: <https://obpr.pmc.gov.au/published-impact-analyses-and-reports/aged-care-reforms>.

## **Details of the *Quality of Care Amendment (Restrictive Practices) Principles 2022***

**Section 1** provides that the name of the instrument is the *Quality of Care Amendment (Restrictive Practices) Principles 2022*.

**Section 2** sets out the commencement dates for sections 1 to 4 and each schedule to the Amendment Principles. Items 1 and 2 of the table in subsection 2(1) provides that sections 1 to 4, Schedule 1, and anything else not covered elsewhere in the table commence the day after the Amendment Principles are registered. Item 3 of the table in subsection 2(1) provides that Schedule 2 commences on 1 April 2023. Item 4 of the table in subsection 2(1) provides that Schedule 3 commences two years after the registration of the Amendment Principles.

**Section 3** provides that the Amendment Principles are made under the Aged Care Act.

**Section 4** provides that each instrument that is specified in a Schedule to the Amendment Principles is amended or repealed as set out in the applicable items in that Schedule, and any other item in that Schedule has effect according to its terms.

### ***Quality of Care Principles***

**Item 1** inserts new definitions in section 4 of the Quality of Care Principles for “individual nominee”, “medical treatment authority”, “nominee group” and “restrictive practices nominee”. These new terms are relevant to the new definition of “restrictive practices substitute decision-maker” inserted by items 2 and 3 of Schedule 1 to the Amendment Principles (explained below).

***individual nominee*** for a care recipient has the meaning given by new subsection 5A(2) (inserted by item 3 of Schedule 1 to the Amendment Principles, discussed below).

***medical treatment authority***, for a care recipient, means an individual or a body that, under the law of the State or Territory in which the care recipient is provided with aged care, has been appointed in writing as an individual or body that can give informed consent to the provision of medical treatment (however described) to the care recipient, if the care recipient lacks capacity to give that consent.

This definition does not have the effect of altering the State and Territory definitions of “medical treatment” or equivalent terms under the relevant State or Territory law, noting that in some jurisdictions this can be referred to as ‘health care’ or ‘medical and dental treatment’.

The definition relies on State or Territory laws only to the extent necessary to identify a particular restrictive practices substitute decision-maker in the table in section 5B (see item 6 in the table). It does not otherwise seek to incorporate the requirements set out in those laws or impact on their operation in contexts outside of the use of a restrictive practice in relation to a care recipient. For example, if the relevant State or Territory law provides that a person or body must comply with certain requirements as part of the process of making a medical treatment decision under the State or Territory law, where the restrictive practices substitute decision-maker is a medical



treatment authority, they are not required to comply with those requirements in order to make a decision about the use of restrictive practices for the purposes of the Quality of Care Principles.

A medical treatment authority can consent or refuse to provide consent for the use of a restrictive practice in relation to the care recipient regarding which they have that authority.

***nominee group*** has the meaning given by new subsection 5A(3) (inserted by item 3 of Schedule 1 to the Amendment Principles discussed below).

***restrictive practices nominee*** has the meaning given by new sub-section 5A(1) (inserted by item 3 of Schedule 1 to the Amendment Principles discussed below).

**Item 2** repeals the current definition of the term ‘restrictive practices substitute decision-maker’ from section 4 of the Quality of Care Principles and substitutes a new definition for the term. That is, that the term has the meaning given by new section 5B (inserted by item 3 of Schedule 1 to the Amendment Principles discussed below).

**Item 3** inserts new sections 5A and 5B at the end of Part 1 of the Quality of Care Principles.

#### New section 5A – Nominating restrictive practices nominee

New subsection 5A(1) provides that a “restrictive practices nominee”, for a restrictive practice in relation to a care recipient, means either an individual (a natural person), nominee group (more than one natural person), or if there is more than one individual nominee or nominee group nominated, the individual nominee or nominee group that takes precedence.

In order to be a “restrictive practices nominee”, the nomination and the individual(s) must meet the requirements set out in new subsection 5A(2) discussed below. If there is no restrictive practices nominee nominated in accordance with new section 5A, item 1 of the table in new subsection 5B(2) (as explained below) would not be applicable.

New paragraph 5A(1)(a) sets out that if there is only a single nominee then that person is the restrictive practices nominee. New subsection 5A(1)(b) provides that if there is only a nominee group (discussed below) then that nominee group is the restrictive practices nominee. New subsection 5A(1)(c) provides that if there is more than one individual nominee, or a nominee group and one or more individual nominees, then the individual nominee or nominee group (as applicable) that takes precedence under the nomination is the restrictive practices nominee.

This allows the care recipient to nominate more than one individual and/or a nominee group as a restrictive practices nominee and also to stipulate who takes precedence in the event that the care recipient nominates more than one restrictive practices nominee.

New subsection 5A(2) provides that an individual nominee for a restrictive practice in relation to a care recipient means an individual who:

- has been nominated by the care recipient in accordance with this section as an individual who can give informed consent to the use of the restrictive practice in relation to the care recipient if the care recipient lacks capacity to give that consent;
- agreed in writing to the nomination and not withdrawn the agreement; and
- has the requisite capacity to give the informed consent to the use of a restrictive practice.

New subsection 5A(3) provides that nominee group for restrictive practice in relation to a care recipient means a group of individuals:

- who have been nominated by the care recipient in accordance with this section as a group of individuals who can jointly give informed consent to the use of the restrictive practice in relation to the care recipient if the care recipient lacks capacity to give that consent;
- each of whom has agreed in writing to the nomination and not withdrawn the agreement; and
- each of whom has the requisite capacity to give the informed consent to the use of a restrictive practice.

This means that a care recipient can nominate more than one individual to be a restrictive practices nominee as part of a nominee group.

New subsection 5A(4) makes clear that a care recipient may make, vary or revoke a nomination only if they have the requisite capacity to do so.

The reference to ‘capacity’ in new subsections 5A(1) to (4) means that the individual has the mental or cognitive ability to make independent and supported informed decisions about consent to the use of a restrictive practice.

New subsection 5A(5) requires that a nomination, variation or revocation of a nomination to be made in writing.

New subsection 5A(6) has the effect of limiting the size of a nominee group to three members or less.

New subsection 5A(7) provides that a care recipient cannot make a nomination that includes more than one nominee group.

New subsections 5A(6) and (7) place limits on who a care recipient can nominate as their restrictive practices nominee. This is intended to balance the choice of the care recipient with the burden on approved providers in circumstances where they may need to contact a large number of individuals to facilitate their written consent to the nomination. This could result in significant delays to the determination of whether consent will be provided to the use of a restrictive practice.

New subsection 5A(8) provides that an individual can be nominated as an individual nominee or as a member of a nominee group but not both. The intention of this provision is to reduce complications that may arise if an individual had responsibilities as both an individual nominee and as a member of a nominee group.

New subsection 5A(9) requires that if a nomination or a varied nomination nominates more than one individual nominee, or both one or more individual nominees and a nominee group, the nomination or varied nomination must provide for an order of precedence in which the individual nominees and nominee group (as applicable) are nominated. In addition, when a nominee group is nominated, the nomination or varied nomination must also state the rules that will apply if members of the nominee group cannot agree on whether or not to give informed consent to the use of a restrictive practice. For example, a nomination may require all members of the nominee group to make a unanimous decision whether to give or refuse informed consent to the use of a restrictive practice, and where agreement cannot be reached, provide for a resolution mechanism (eg, the eldest takes precedence, or the restrictive practice cannot be used at all). The intent of this provision is to provide clarity in respect of the restrictive practices nominee when a dispute occurs.

New subsection 5A(10) provides that the care recipient may nominate, as an individual nominee or as a member of a nominee group, a member of service staff of an approved provider that provides aged care to the care recipient only if that individual also happens to be the partner or relative of the care recipient. Section 4 of the Quality of Care Principles defines the term “service staff” in relation to an aged care service, as staff (including volunteers) who access, or are reasonably likely to access, any premises where the operation or administration of the service occurs.

The intention of new subsection 5A(10) is to generally exclude service staff of the approved provider from being appointed as the restrictive practices nominee to minimise any risk of a conflict of interest arising where a decision has to be made regarding the use of a restrictive practice in relation to a care recipient receiving services from that approved provider.

Often partners or relatives of the care recipient may volunteer for the approved provider, and it is not uncommon, especially in rural and remote locations, that partners or relatives may be staff of the approved provider. New subsection 5A(10) ensures that in these situations the care recipient may nominate their family members .

A nomination by a care recipient of an individual nominee or nominee group will only be effective for the purpose of new section 5B if it complies with all of the relevant requirements as set out in new section 5A.

#### New section 5B – Meaning of *restrictive practices substitute decision-maker*

New section 5B sets out who is a “restrictive practices substitute decision-maker”. It provides that in the first instance, a restrictive practices substitute decision-maker for a restrictive practice in relation to a care recipient is an individual or body that has been appointed under the law of the State or Territory in which the care recipient is provided with aged care as the individual or body that can give informed consent to the use of the restrictive practice in relation to the care recipient if the care recipient lacks capacity to give that consent. If such an individual or body cannot be appointed

or there are significant delays in making the appointment, new section 5B then provides for a hierarchy of individuals or bodies who may be the restrictive practices substitute decision-maker depending on the circumstances.

New section 5B allows for certain individuals or bodies to be authorised to give (or refuse to give) informed consent to the use of a restrictive practice on a care recipient's behalf where the care recipient lacks the capacity to give that consent (or refusal). New sub-section 5B(2) is designed to address situations where an individual or body has not been appointed under the law of the State or Territory in which the care recipient is provided with aged care and either there are no clear mechanisms under that State and Territory law for an individual or a body to be appointed to give (or refuse to give) consent to the use of restrictive practices (where the care recipient lacks the capacity to make the decision themselves) or an application has been made for such an appointment but there is a significant delay in deciding the application.

This means that where an individual or body has not been so appointed, or an application for such an appointment is underway but a decision has not yet been made and this is not because of a significant delay, an approved provider cannot use a restrictive practice in relation to a care recipient who does not have the capacity to give that consent, except in an emergency.

The definition of restrictive practices substitute decision-maker under subsection 5B(1) substantially replicates the previous definition of "restrictive practices substitute decision-maker" that was replaced by item 2 above. It means that where a care recipient lacks capacity to give informed consent to the use of a restrictive practice and an individual or a body is authorised to give (or refuse to give) informed consent on behalf of that care recipient under the law of the State or Territory in which the care recipient is provided with aged care, then that individual or body is the restrictive practices substitute decision-maker.

If there is more than one person who has been appointed (whether jointly or otherwise) under the relevant State or Territory law as an individual or body who can give informed consent to the use of a restrictive practice, an approved provider should refer to the relevant State and Territory arrangements to determine the order of precedence. If the relevant State or Territory arrangements do not provide for an order of precedence, the restrictive practice cannot be used until the matter is resolved by the person or body that made the authorisation because it would be unclear who would be the restrictive practices substitute decision-maker.

These arrangements ensure that State and Territory laws that enable an individual or body to give consent to the use of restrictive practices on behalf of a person who does not have capacity to consent to the use of a restrictive practice themselves, are relied on in the first instance.

Subsection 5B(2) sets out arrangements for who is a "restrictive practices substitute decision-maker" under the Commonwealth aged care legal framework, where an individual or body has not been appointed under law of the State or Territory in which the care recipient is provided with aged care, and either:

- there is no clear mechanism for appointing such an individual or body under the law of the State or Territory; or
- an application has been made for an appointment under the law of the State or Territory but there is a significant delay in deciding the application.

The intention of new subsection 5B(2) is to provide a mechanism to identify a “restrictive practices substitute decision-maker” where there is no clear mechanism under the relevant State or Territory law to appoint an individual or body that can give informed consent to the use of a restrictive practice in respect of a care recipient where that care recipient lacks the capacity to do so, or where an application has been made for such an appointment but there is a significant delay in deciding the application. In so doing, it authorises certain persons for the purposes of the use of restrictive practices in relation to a care recipient under the Aged Care Act and the Quality of Care Principles to be able to give (or refuse to give) informed consent to the use of a restrictive practice, when they would not otherwise have this authority under State and Territory laws. The wording of the provision also means as State and Territory laws are amended, those arrangements must be relied upon in the relevant jurisdiction in the first instance.

While some States and Territories have clear mechanisms to appoint a person who is a “restrictive practices substitute decision-maker”, others do not have any mechanism or there is ambiguity as to whether, under their laws, such a person or body can be appointed. The intent of this provision is to create a temporary mechanism to appoint a “restrictive practices substitute decision-maker” where state and territory laws do not have a clear mechanism to appoint a person who can consent to the use of a restrictive practice on behalf of another person. This means the table setting out the hierarchy can be used when a mechanism under State and Territory law to appoint a “restrictive practices substitute decision-maker” is ambiguous, uncertain, unclear, or unsettled.

This new section seeks to ensure that Commonwealth legislation does not override State and Territory laws where there are clear mechanisms for an individual or body to be appointed as a person who can give consent to the use of a restrictive practice on behalf of another person, while providing a pathway for approved providers trying to navigate complex and at times unclear state and territory legal arrangements

As this provision is only an interim measure, it is intended to encourage States and Territories to amend their laws to allow for an individual or body to be authorised to give informed consent to the use of a restrictive practice in relation to a care recipient where the care recipient lacks the capacity to give consent themselves.

An example of a clear mechanism would be clear laws that allow for a tribunal to appoint a person or body to make decisions about the use of a restrictive practice on another’s behalf.

The Government has received advice from State and Territory governments that in many jurisdictions, the relevant laws that authorise persons or bodies to give consent on another’s behalf may not allow, and in some cases prevent, the giving of consent across all forms of restrictive practices, or only some, depending on the jurisdiction.

New sub-section 5B(2) also makes clear that the table will only have effect to authorise other individuals as a “restrictive practices substitute decision-maker” where there is no individual or body appointed for a restrictive practice in relation to a care recipient under the law of a State or Territory in which the care recipient is being provided aged care and an application has been made for an appointment under the law of the State or Territory but there is a significant delay in deciding the application.

When determining whether a delay is “significant”, regard should be had to the relevant circumstances of the situation.

The intent of this provision is that this arrangement will only be in place for the period in which a decision regarding the appointment is pending. Once the decision about the appointment has been made, then the laws of the State or Territory will prevail, and the table will have no effect in relation to identifying a different person as the restrictive practices substitute decision-maker. This means that if the relevant body decides not to appoint the person the subject of the application, that the restrictive practice cannot be used. This recognises that in the jurisdictions that already have arrangements described in new subsection 5B(1), it can take some time for an appointment to occur.

If any item of the table applies and the individual identified in that item does not provide consent to the use of the restrictive practice, then the restrictive practice cannot be used. In these circumstances, approved providers cannot seek consent from another person listed below in the table in new subsection 5B(2).

Item 1 of the table in new subsection 5B(2) will only apply if there is a restrictive practices nominee (outlined in new section 5A, explained above) for the care recipient. In these circumstances, the restrictive practices substitute decision-maker in relation to the care recipient is that restrictive practices nominee.

Item 2 of the table in new subsection 5B(2), will apply if item 1 of the table does not apply. That is, if a care recipient does not have a restrictive practices nominee, but they do have a partner (including a spouse or de-facto partner) with whom they have a close continuing relationship, who has capacity to act as a restrictive practices substitute decision-maker, and has agreed in writing to be a restrictive practices substitute decision-maker for the care recipient (and has not withdrawn that agreement), then the restrictive practices substitute decision-maker for the care recipient is that partner.

New item 3 of the table in new subsection 5B(2) will only apply where items 1 and 2 do not apply. This allows a relative or friend of the care recipient who meets the following criteria, to be that care recipient’s restrictive practices substitute decision-maker:

- the relative or friend:
  - was the care recipient’s carer on an unpaid basis immediately before the care recipient entered into aged care of a kind specified in section 15DA of the Quality of Care Principles (being residential care or flexible care in the form of short-term restorative care provided in a residential care setting); and

- who has a personal interest in the care recipient’s welfare on an unpaid basis; and
- has a close continuing relationship with the care recipient; and
- has agreed, in writing, to be a restrictive practices substitute decision-maker for the restrictive practice in relation to the care recipient (and has not withdrawn that agreement); and
- has capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the care recipient.

Where there is more than one such relative or friend, then the eldest of those individuals (highest age) is the restrictive practices substitute decision-maker. For example, if the care recipient has two sisters who equally meet the definition in Column 1 of item 3 of the table in new subsection 5B(2), and one sister was born in the year 1966, and the other in the year 1959, then the sister born in the year 1959 is the eldest and therefore the restrictive practices substitute decision-maker. However, it should be noted that all the criteria in Column 1 must be met by both individuals before deferring to the eldest. For example, if the eldest child of the care recipient was not a carer for the care recipient immediately prior to their entry into residential aged care, although the youngest child of the care recipient was, then the youngest child would be the restrictive practices substitute decision-maker, provided all the other criteria in Column 1 have been met.

These arrangements provide a simple non-discretionary way for approved providers to easily determine the restrictive practices substitute decision-maker for a care recipient. The arrangements also provide legal certainty around who can give (or refuse to give) informed consent to the use of a restrictive practice on a care recipient’s behalf. This is important to the consideration of the immunity arrangements under section 54-11 of the Aged Care Act (inserted by the Royal Commission Response Act).

“Unpaid basis” and “personal interest” are further clarified in new subsections 5B(3) and (4), explained below.

Item 4 of the table in new subsection 5B(2) is the fourth tier and is only applicable where items 1, 2, and 3 do not apply. If items 1, 2, and 3 do not apply, but the care recipient has a relative or friend who meets the following criteria, then that individual is the restrictive practices substitute decision-maker in relation to the care recipient:

- the relative or friend has:
  - a personal interest in the care recipient’s welfare on an unpaid basis; and
  - a close continuing relationship with the care recipient; and
  - agreed in writing to be a restrictive practices substitute decision-maker for the restrictive practice in relation to the care recipient (and has not withdrawn that agreement); and
  - capacity to act as a restrictive practices substitute decision-maker for the restrictive practice in relation to the care recipient.

Column 2 of item 4 of the table in new subsection 5B(2) also clarifies that if there is more than one such relative or friend, then the eldest of those individuals (meaning of eldest explained above) is the restrictive practices substitute decision-maker.

The requirement in items 2, 3 and 4 of the table in new subsection 5B(2) that the partner, or relative or friend (as applicable) must have agreed in writing aims to ensure that the individual is willing to fulfil the role of a restrictive practices substitute decision-maker. If the partner, relative or friend (as the case may be) does not agree in writing (for example, they only provide verbal agreement), then those respective items in the table would not be applicable.

In referring to “capacity” in items 2, 3, and 4 of the table in new subsection 5B(2), the intent is that the relevant restrictive practices substitute decision-maker must have the mental or cognitive ability to make a decision regarding the use of a restrictive practice in order to meet the criteria.

References to “close continuing relationship” in the arrangements under items 2, 3 and 4 of the table in new subsection 5B(2) are intended to include relationships where the individual and the care recipient maintain regular contact, in person, through letters or forms of electronic communication (such as telephone, emails, or social media platforms), and the individual displays genuine care and interest in the well-being and preferences of the care recipient through these communications.

Item 5 of the table in new subsection 5B(2) provides that under the sixth and final tier of the hierarchy of consent arrangements, if items 1, 2, 3 and 4 of the table do not apply, but there is a medical treatment authority for the care recipient (definition inserted by item 1 of Schedule 1 to the Amendment Principles, explained above), the restrictive practices substitute decision-maker for the care recipient is that medical treatment authority.

If item 5 applies and the medical treatment authority does not provide consent to the use of a restrictive practice, then the restrictive practice cannot be used.

Column 2 of item 5 also provides that if there are two or more medical treatment authorities under the laws of the State or Territory in which the care recipient is provided with aged care, and the relevant laws provide an order of precedence for these medical treatment authorities, then the individual or body that takes precedence under that law is the restrictive practices substitute decision-maker in relation to the care recipient.

However, if there are two or more medical treatment authorities under the laws of the State or Territory in which the care recipient is provided with aged care, and the laws do not provide for an order of precedence for these medical treatment authorities, but only one of the medical treatment authorities is an individual (that is, a natural person, as opposed to a body or entity), then that individual is the restrictive practices substitute decision-maker for the care recipient.

Lastly, if there are two or more medical treatment authorities under the laws of the State or Territory in which the care recipient is provided with aged care, and the laws do not provide for an order of precedence for these medical treatment authorities, and more than one of the medical treatment authorities is an individual, then the eldest of these individuals is the restrictive practices substitute decision-maker for the care recipient.



The effect of the arrangements under item 6 of the table in new subsection 5B(2) provide authority for an individual or body to consent to the use of restrictive practices in relation to a care recipient, where they are already able to consent to medical treatment, (however described) in relation to the care recipient under the applicable State or Territory laws.

This means, for example, if the care recipient resides in Victoria, and an individual or body has been appointed as a guardian with the power to make medical treatment decisions (as defined by the *Medical Treatment Planning and Decisions Act 2016* (Vic)) for the care recipient, then that individual or body is also authorised under the Quality of Care Principles to make an informed consent decision about the use of a restrictive practice in relation to the care recipient, if the care recipient does not have capacity to provide consent themselves.

This provision applies regardless of whether the use of a restrictive practice is considered to be ‘medical treatment’ (however described) under the law of the relevant State or Territory.

New subsection 5B(3) provides that for the purposes of the reference to “unpaid basis” in respect to paragraph (a) of column 1 of item 3 of the table, a person was the care recipient’s carer on an unpaid basis if:

- the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) as a carer for the care recipient; and
- no payment or benefit other than one or more of the following was or will be made or given to the person for being a carer for the care recipient:
  - a carer payment or equivalent benefit;
  - payment in kind; or
  - a payment or benefit as a beneficiary under the care recipient’s will.

An example of a person delivering care on an “unpaid basis” is a neighbour who cooks, cleans and provides daily basic care to the person and also receives a carers allowance from the government.

New subsection 5B(4) provides that for the purposes of the reference to “unpaid basis” in respect to paragraph (b) of column 1 of item 3 and paragraph (a) of column 1 of item 4 in the table, a person (who is a relative or friend) has a personal interest in the care recipient’s welfare on an unpaid basis if:

- the person was not employed, hired, retained or contracted (whether directly or through an employment or recruiting agency) to have that interest, including as a carer or support person; and
- no payment or benefit other than one or more of the following is or will be made or given to the person for having the interest:
  - a carer payment or equivalent benefit;
  - payment in kind; or
  - a payment or benefit as a beneficiary under the care recipient’s will.

The arrangements under new section 5B will not affect the use of a restrictive practice that has already occurred in accordance with the requirements for the provision of consent that existed at that time, including in relation to who is a “restrictive practices substitute decision-maker”, in the Quality of Care Principles.

If none of the items in the table in new subsection 5B(2) apply, and the care recipient does not have capacity to consent to the use of a restrictive practice themselves, restrictive practices cannot be used by the approved provider in relation to that care recipient. The approved provider should deal with this situation in the same way that they would if an individual or body authorised to provide informed consent denies consent to the use of a restrictive practice.

In cases where there is no clear mechanism under state or territory law, where no person is able to give (or refuses to give) consent to the use of a restrictive practice, and such use is necessary to ensure the welfare of the care recipient or others, approved providers should seek the appointment of a medical treatment authority under the relevant State or Territory laws. Once an individual or body has been appointed as the medical treatment authority under the relevant State and Territory laws an approved provider can rely on that person to be the restrictive practices substitute decision-maker in accordance with item 5 of the table in new subsection 5B(2) for the purposes of the Commonwealth legal framework.

In respect of item 5 of the table in new subsection 5B(2), each State and Territory has its own arrangements for a medical treatment authority to be appointed, as summarised in Table 1, and these arrangements may be revised from time to time.

Table 1: State and Territory medical treatment authority arrangements as at the date of commencement of this instrument

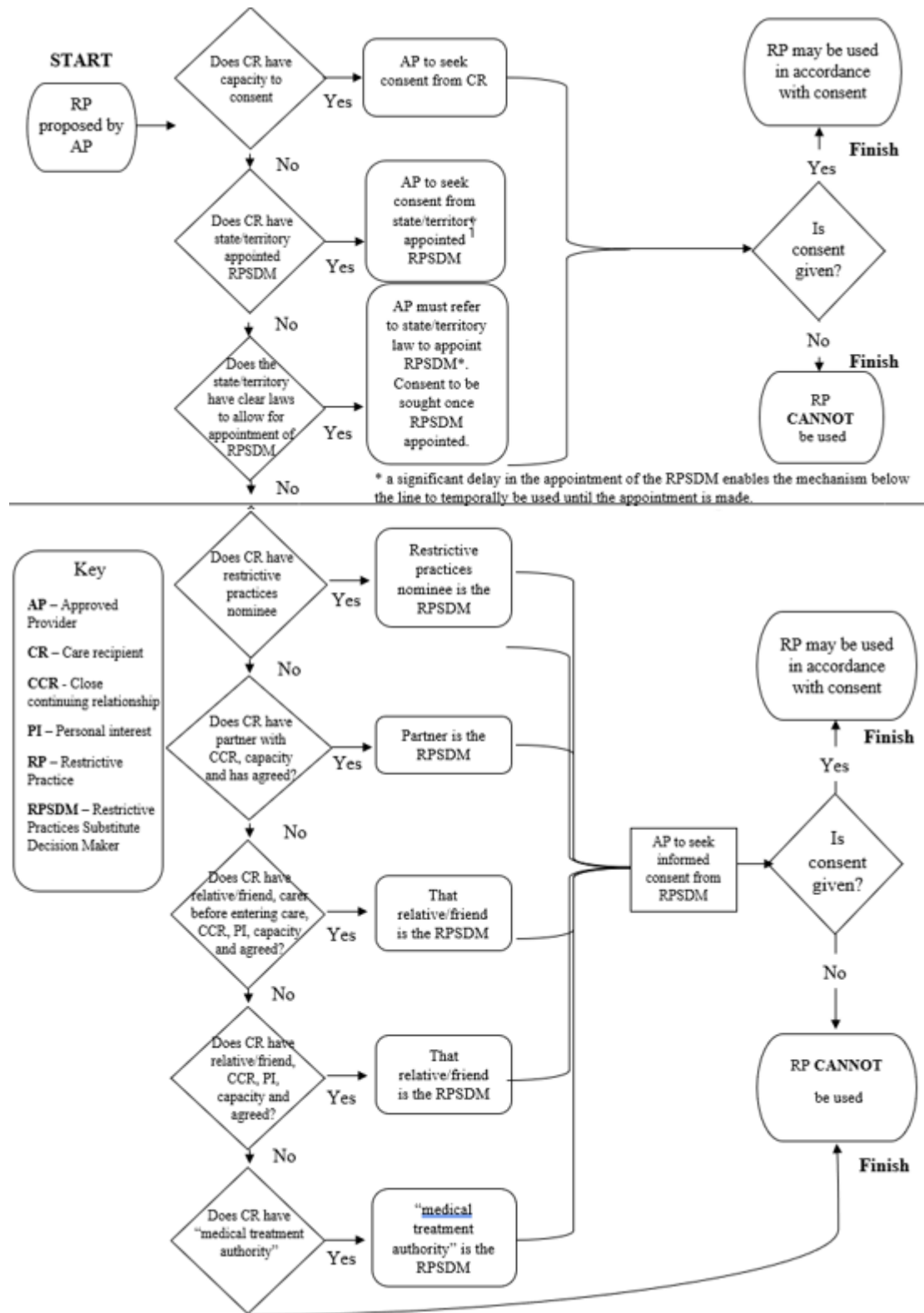
	<b>Terminology</b>	<b>Relevant law</b>
<b>Australian Capital Territory</b>	Guardian with authority to consent to medical procedure or treatment	<i>Guardianship and Management of Property Act 1991 (ACT)</i>
<b>New South Wales</b>	Guardian with authority to consent to medical or dental treatment	<i>Guardianship Act 1987 (NSW)</i>
<b>Northern Territory</b>	Adult guardian with authority to consent to health care action or decision-maker appointed under an Advance Personal Plan made by the care recipient	<i>Guardianship of Adults Act 2016 (NT) / Advance Personal Planning Act 2013 (NT)</i>
<b>Queensland</b>	Guardian for an adult with impaired capacity for personal matters (including health matters) or attorney for personal matters (including health matters) under an Enduring Power of Attorney	<i>Guardianship and Administration Act 2000 (Qld) / Powers of Attorney Act 1998 (Qld)</i>
<b>South Australia</b>	Guardian with authority to provide consent to medical treatment	<i>Guardianship and Administration Act 1993 (SA)</i>
<b>Tasmania</b>	Guardian with authority to consent to medical or dental treatment	<i>Guardianship and Administration Act 1995 (Tas)</i>

	<b>Terminology</b>	<b>Relevant law</b>
<b>Victoria</b>	Guardian with the power to make medical treatment decisions	<i>Medical Treatment Planning and Decisions Act 2016 (Vic)</i>
<b>Western Australia</b>	Enduring guardian or guardian authorised to make a treatment decision	<i>Guardianship and Administration Act 1990 (WA)</i>

If there is a genuine emergency, restrictive practices are able to be used by an approved provider without consent first being sought from the restrictive practices substitute decision-maker if the use is in accordance with section 15FA of the Quality of Care Principles as amended (see below). However, following that use, the approved provider must determine who the restrictive practices substitute decision-maker is in order to notify them of the use of the restrictive practice in accordance with section 15GB of the Quality of Care Principles as amended (see below).

At a high level, noting that there are several other requirements under the Quality of Care Principles which must be met (including where the restrictive practice is chemical restraint), Figure 1 summarises the arrangements under the table in new subsection 5B(2). As Figure 1 simplifies the arrangements, it does not include all the requirements, for example the requirement that a friend or relative must have the requisite capacity.

Figure 1: Consent to use of a restrictive practice



**Item 4** inserts new subsection (e) at the end of section 15D of the Quality of Care Principles. Section 15D sets out the purpose of Part 4A of the Quality of Care Principles (regarding behaviour support and restrictive practices for residential care and certain flexible care). Item 4 provides that Part 4A also specifies persons and bodies in relation to the giving of informed consent to the use of restrictive practices in relation to care recipients. This is a consequential amendment to reflect the amendments made to Part 4A by the Amendment Principles.

**Items 5 and 6** make amendments to subsection 15FA(1)(f) of the Quality of Care Principles to clarify that approved providers must ensure informed consent is given for the specific details of the use of the proposed restrictive practice.

Item 5 inserts the words “, and how it is to be used (including its duration, frequency and intended outcome),” after “use of the restrictive practice” in paragraph 15FA(1)(f) of the Quality of Care Principles.

Item 6 inserts new paragraph (fa) after paragraph 15FA(1)(f) that provides that the use of the restrictive practice is required to be in accordance with the informed consent mentioned in paragraph 15FA(1)(f).

These amendments firstly clarify that to use a restrictive practice in relation to a care recipient, informed consent must be given not only to the use of the restrictive practice but also how it will be used and second require the use of the restrictive practice to be in accordance with the consent given.

This requires that consent to the use of the restrictive practice be appropriately specific and is an important safeguard to protect the health and well-being of care recipients. For example, where the care recipient has consented to the use of bed rails between 10:00pm and 7:00am on weekdays, the approved provider does not have the authority to use bed rails in respect of that care recipient in any other circumstances, without first seeking further consent from the care recipient or restrictive practices substitute decision-maker (if applicable).

The amendments made by items 5 and 6 also assist to limit the scope of the immunity arrangements under section 54-11 of the Aged Care Act (inserted by the Royal Commission Response Act) and ensure these arrangements will not apply in circumstances where the use of a restrictive practice does not align with the specific consent that was provided.

For example, if the care recipient has given informed consent to the use of a lap belt (mechanical restraint) in the evenings before going to bed, and the approved provider continues to use the lap belt the next morning, then the use of restrictive practices is not consistent with the consent that was provided and therefore the approved provider and other individuals who used, or assisted in the use of the restrictive practice, would not be protected by the immunity provision under section 54-11.

**Item 7** inserts “(fa)” after “(f)” in subsection 15FA(2) of the Quality of Care Principles. Subsection 15FA(2) sets out which requirements do not apply to the use of a restrictive practice in relation to a care recipient if the use is necessary in an emergency. The amendments made by item 7 clarify that the new requirement under paragraph 15FA(1)(fa) (inserted by item 6, explained above) does not apply in these circumstances.

**Item 8** inserts new subparagraph (iv) at the end of paragraph 15FC(1)(a) of the Quality of Care Principles. Section 15FC of the Quality of Care Principles sets out additional requirements that apply in respect of the use of chemical restraints. New subparagraph 15FC(1)(a)(iv) introduces an additional requirement that the approved provider must be satisfied that a medical practitioner or nurse practitioner has obtained informed consent to the prescribing of the medication for the purpose of using the chemical restraint. This amendment is related to the amendments made by item 11 of Schedule 1 to the Amendment Principles (explained below) and, effectively retains the existing requirement that the approved provider must be satisfied that informed consent to the prescribing of medication in relation to the use of a restrictive practice that is a chemical restraint has been obtained.

It is not intended that where the health or nurse practitioner advises the approved provider that they have received the necessary consent to the prescription of the medication, the approved provider would be required to investigate the advice further, unless they are not satisfied with the advice, based on any other information available to them. If the approved provider has any concerns about the consent that has been given to the prescription of medication for use as a chemical restraint, they should raise this with the relevant regulator of the practitioner.

**Item 9** inserts the words “for the purpose of using the chemical restraint” after “medication” in subparagraph 15FC(1)(b)(v) of the Quality of Care Principles. Existing subparagraph 15FC(1)(b)(v) provides that the behaviour support plan for the care recipient must include information (if any) provided to the medical practitioner or nurse practitioner that informed their decision to prescribe the medication. The amendments made by item 9 makes clear that informed consent must be obtained for the prescribing of medication specifically for the purpose of using it as a chemical restraint. This reflects the amendments made in item 8 above.

**Item 10** inserts new subparagraphs (va) and (vb) after subparagraph 15FC(1)(b)(v) of the Quality of Care Principles. Paragraph 15FC(1)(b) provides matters that must be documented in the behaviour support plan for the care recipient in relation to use of a restrictive practice that is a chemical restraint.

New subparagraph 15FC(1)(b)(va) provides that the behaviour support plan must document that the approved provider is satisfied that the practitioner (being a medical or nurse practitioner) obtained informed consent as outlined in paragraph 15FA(1)(f) of the Quality of Care Principles to the prescribing of the medication for the purposes of chemical restraint.

New subparagraph 15FC(1)(b)(vb) provides that the behaviour support plan must document the details of the prescription for the prescribed medication, including its name, dosage and when it may be used. The amendments made by item 10 are related to the amendments made by items 5 and 8 of Schedule 1 to the Amendment Principles above (that is ensuring that these new requirements are documented in the behaviour support plan) and item 11 of Schedule 1 to the Amendment Principles discussed below (which relates to additional requirements for use of a chemical restraint).

**Item 11** repeals existing paragraph 15FC(1)(c) (not including the note) and substitutes new subparagraph 15FC(1)(c) in its place. Existing paragraph 15FC(1)(c) provides that in order for an approved provider to use a restrictive practice that is a chemical restraint, the approved provider must be satisfied that informed consent to the prescribing of the medication has been given by the care recipient or, if the care recipient lacks capacity to give consent, the restrictive practices substitute decision-maker. This provision is repealed as the effect of this paragraph now appears at new paragraph 15FC(1)(a)(iv) (introduced by item 8 above).

New paragraph 15FC(1)(c) now provides that in order for an approved provider to use a restrictive practice that is chemical restraint, the use of the medication for the purpose of chemical restraint must be in accordance with the prescription mentioned in new subparagraph 15FC(1)(b)(vb) (inserted by item 10 of Schedule 1 to the Amendment Principles, explained above). Importantly, an effect of this amendment is that if the approved provider or other persons use restrictive practices that are inconsistent with the details of the prescription, the immunity arrangements under section 54-11 of the Aged Care Act will not apply.

For example, if the prescription states that the medication should be provided once per day, and the approved provider administers the medication twice in one day then the use of the medication for the purpose of using the chemical restraint was not used in accordance with the prescription, the provider and other individuals who used, or assisted in the use of the restrictive practice would not be protected by the immunity provision under section 54-11 of the Aged Care Act.

This amendment also removes the requirement that a “restrictive practice substitute decision-maker” is the individual or body that consents to the prescribing of medication for the use as a chemical restraint. Items 2 and 3 of the Amendment Principles revise the definition of the term “restrictive practices substitute decision-maker” so that the term no longer solely relies on State and Territory laws.

**Item 12** omits the words “paragraph (1)(b) and (c)” from subsection 15FC(2) of the Quality of Care Principles and substitutes “subparagraph (1)(a)(iv) and paragraph (1)(b)” in its place. Subsection 15FC(2) specifies the requirements that do not apply to the use of a restrictive practice that is chemical restraint in relation to a care recipient where the use is necessary in an emergency. Specifying subparagraph (1)(a)(iv), as inserted by item 8 of Schedule 1 (explained above), will mean that approved providers are not required to be satisfied that a medical or nurse practitioner obtained informed consent to the prescribing of medication for the purpose of using a chemical restraint only in an emergency. These exclusions are intended to allow approved providers to respond to an emergency situation where a care recipient or other person may be at risk of immediate harm. As stated in subsection 15FC(3), this

exemption only applies while the emergency exists. After the emergency has passed, the approved provider should then document the reasons why the use of the restrictive practice was necessary and review the behaviour that triggered the emergency and document this in the care recipient's care and services plan. This must be completed as soon as practicable after the restrictive practice starts to be used.

The removal of the reference to paragraph 15FC(1)(c) is consequential to the amendments made by item 11 of Schedule 1 to the Amendment Principles, which repeals and replaces paragraph 15FC(1)(c). The revised requirement outlined in paragraph 15FC(1)(c) must now be complied with in relation to the use of a restrictive practice as a chemical restraint, even in an emergency.

**Item 13** omits the words “paragraph 15FC(1)(b)” from paragraph 15GB(d) of the Quality of Care Principles and substitutes “subparagraphs 15FC(1)(b)(i) to (v) and (vb) to (vii)” in its place. Section 15GB provides for the requirements of approved providers where a restrictive practice is used in relation to a care recipient and the use is necessary in an emergency situation. These requirements must be satisfied as soon as practicable after the restrictive practice starts to be used. Paragraph 15GB(d) specifies the matters that must be documented in the behaviour support plan for the care recipient if the restrictive practice is chemical restraint.

The amendments made by item 13 are consequential to the amendments made by item 12 and has the effect of continuing the previous arrangements. The amendments to item 12 ensure that the correct provision is referenced as the requirement to be satisfied that informed consent has been obtained by a medical practitioner or nurse practitioner has moved to paragraph 15FC(1)(a)(iv). This is because providers will not be required to be satisfied that a medical or nurse practitioner has obtained informed consent to the prescribing of medication for the purpose of using a chemical restraint in an emergency, approved providers will not be required to document such consent in the care recipient's behaviour support plan. All other matters listed in paragraph 15FC(1)(b) must be documented in the care recipient's behaviour support plan.

**Item 14** inserts new section 15GC at the end of Division 4 of Part 4A of the Quality of Care Principles.

#### New section 15GC – Responsibilities relating to nominations of restrictive practices nominee.

New section 15GC provides new responsibilities for approved providers in relation to the nomination of restrictive practices nominees (see new section 5A inserted by item 3 to Schedule 1).

New subsection 15GC(1) provides that the approved provider must take reasonable steps to ensure that the care recipient is not subject to coercion or duress in making, varying or revoking a nomination of a restrictive practices nominee under new section 5A (discussed above) or in the case of an individual or body nominated, to take reasonable steps to ensure that their agreement or withdrawal of agreement to the nomination is not subject to coercion or duress. For example, if an approved provider becomes aware that an individual is coercing a care recipient to nominate them as a restrictive practices nominee, the approved provider should take reasonable steps to



intervene, such as linking the care recipient with the necessary supports to consider making a nomination prior to any nomination being made. This responsibility is intended to provide additional safeguards to care recipients while the interim measures are in force and is intended to further ensure effective and valid consent is sought to the use of a restrictive practice.

To the extent that an approved provider considers a nomination of a restrictive practices nominee may have been or was obtained under duress or coercion, the approved provider should not rely on that nomination for the purposes of obtaining consent to the use of a restrictive practice. If the approved provider does rely on this consent, they may not have the benefit of the immunity arrangements under section 54-11 of the Aged Care Act because there is a question regarding whether consent in these circumstances is legally effective.

New subsection 15GC(2) provides that if a care recipient nominates an individual to be a restrictive practices nominee (whether as an individual or as part of a group) in accordance with new section 5A introduced by item 3 of Schedule 1 to the Amending Principles above, then the approved provider must assist the care recipient to:

- notify the individual of the nomination; and
- give the individual a copy of the nomination (as it must be made in writing under new paragraphs 5A(2)(b) and (3)(b)); and
- seek the individual's agreement, in writing, to act as a restrictive practices nominee for a restrictive practice in relation to the care recipient (in accordance with new paragraphs 5A(2)(b) or (3)(b)).

When seeking an individual's agreement to be a nominee, it is good practice to provide the individual with the details of the proposed restrictive practice and outline the responsibilities and limitations of the role of restrictive practices nominee.

New subsection 15GC(3) provides that where a care recipient nominates a restrictive practice nominee (whether as an individual nominee or as a member of a group nominee) under new section 5A, the approved provider must keep a record of the nomination, or whether the nomination has been varied or withdrawn. This will ensure that in the event that use of a restrictive practice is proposed to be used and the care recipient lacks the capacity to provide informed consent themselves, the approved provider will have a record of the nomination and be able to easily identify the relevant person who is the restrictive practices substitute decision-maker if item 2 of the table in new subsection 5B(1) applies. This will also assist the Commission in determining whether an approved provider has complied with its obligations.

**Item 15** inserts new Division 6 at the end of Part 4A of the Quality of Care Principles.

New Division 6 sets out the individuals and bodies who can give consent to the use of a restrictive practice in relation to a care recipient in respect of which the immunity provision in section 54-11 of the Aged Care Act will apply. That is, a person or body that is a restrictive practices decision-maker under any of the items in the table in new subsection 5B(2). This means that the immunity will not apply in respect consent given by a person who appointed under a State or Territory law in the manner described under new subsection 5B(1). This is because the intent of these

amendments is to allow for persons otherwise not authorised under State and Territory laws to give consent to the use of a restrictive practice in respect of a care recipient.

#### New section 15J – Giving of informed consent by certain persons or bodies

New section 15J is made for the purposes of subsection 54-11(2)(a) of the Aged Care Act and provides that a person or body identified in items of the table in new subsection 5B(2) are “persons or bodies” for the purposes of section 54-11 of the Aged Care Act.

Section 54-11 of the Aged Care Act (inserted by the Royal Commission Response Act) provides immunity from civil or criminal liability in relation to the use of a restrictive practice in particular circumstances and where certain conditions are met.

As above, section 54-11 of the Aged Care Act is not intended to provide a broad immunity against other claims in respect of the use of a restrictive practice, for example, criminal negligence. Rather, it is intended to enable approved providers and those involved in the use of restrictive practices to rely on the consent from a restrictive practices substitute decision-maker where there may be a lack of clarity in local laws regarding who can give consent to the use of a restrictive practice where a care recipient does not have capacity to make a decision in relation to this matter. As such, it is appropriate that certain persons be identified to ensure arrangements for obtaining consent are appropriate and to limit the operation of the immunity.

Amendments made by items 5, 6 and 11 of Schedule 1 to the Amendment Principles also introduce additional requirements to ensure that the immunity arrangements only apply in appropriate circumstances. This includes ensuring that a restrictive practice may only be used in accordance with the consent that has been provided (including duration, frequency and intended outcome), and that chemical restraint must be used as prescribed by the medical or nurse practitioner (e.g. the type of medication, dosage and when it may be used). These amendments will further protect the health and safety of aged care recipients.

#### **Schedule 2 – Amendments commencing 1 April 2023**

The amendments made by Schedule 2 to the Amendment Principles commence on 1 April 2023. This is intended to allow sufficient time for approved providers to meet the additional behaviour support plan requirements introduced through this Schedule.

Under the existing arrangements (which commenced on 1 September 2021), an approved provider must ensure that a behaviour support plan is included in the care and services plan of a care recipient that requires behaviour supports. The approved provider must ensure that the behaviour support plan is prepared, reviewed and revised in accordance with the requirements and that it sets out the matters specified in the Quality of Care Principles.

The behaviour support plan arrangements promote a shift by approved providers to put in place processes, procedures and strategies to avoid the use of restrictive practices wherever possible. This aims to promote better management of care for care recipients who require behaviour supports and encourage careful assessment, planning and partnerships to enable effective responses to behaviour.

## *Quality of Care Principles*

**Item 1** inserts new subparagraph (ea) after paragraph 15HC(e) of the Quality of Care Principles. Paragraph 15HC sets out the information required to be documented in a care recipient's behaviour support plan if use of a restrictive practice has been assessed as necessary. New subparagraph 15HC(ea) provides that if a care recipient lacks the capacity to give informed consent to the use of a restrictive practice, then the behaviour support plan must document the name of the restrictive practices substitute decision-maker and whether new subsection 5B(1) or an item of the table in new subsection 5B(2) applies (inserted by item 3 of Schedule 1 to the Amending Principles, explained above) and why that item applies.

The amendments are intended to ensure approved providers are appropriately documenting the restrictive practices substitute decision-maker from whom consent is sought in respect of the use of restrictive practices. This will assist the Commission to effectively monitor compliance with the restrictive practices consent requirements.

**Item 2** inserts the words “and how it is to be used (including its duration, frequency and intended outcome),” after “use of the restrictive practice” in paragraph 15HC(g) of the Quality of Care Principles. Paragraph 15HC(g) currently requires that the behaviour support plan must include a record of the giving of informed consent to the use of the restrictive practice.

This amendment strengthens the requirements regarding the record keeping requirements and in terms of the use of restrictive practices more generally by requiring specific details regarding the use of a restrictive practice to be included in the behaviour support plan.

As outlined above, these amendments are intended to assist the Commission to effectively monitor compliance with the restrictive practices consent requirements. It is also crucial that this information be included in the behaviour support plan to assist in determining whether the immunity arrangements apply (i.e. if the record of consent does not align with the use of restrictive practices, the immunity would not apply).

**Item 3** repeals and replaces the note following section 15HC of the Quality of Care Principles. Currently the note clarifies that assessments mentioned in sections 15FB and 15FC of the Quality of Care Principles must be documented in the behaviour support plan. The new note makes clear that other matters are required to be documented in the behaviour support plan in accordance with sections 15FB and 15FC.

**Item 4** inserts new subparagraph (v) at the end of paragraph 15HD(a) and provides that the behaviour support plan must include information regarding whether the use of a restrictive practice was in accordance with the informed consent set out under new paragraph 15HC(g) (amended by item 2 of Schedule 2 to the Amendment Principles, explained above).

**Item 5** inserts the words “, and how it is to be used (including its duration, frequency and intended outcome),” after “about the ongoing use of the restrictive practice” in paragraph 15HE(d) of the Quality of Care Principles. Paragraph 15HE(d) currently requires that the behaviour support plan must set out a description of the approved provider’s consultation with the care recipient or restrictive practices substitute decision-maker about the ongoing use of a restrictive practice. This amendment makes it clear that informed consent to the ongoing use of the restrictive practice must include the details of its use and relates to item 5 of Schedule 1 to the Amendment Principles.

### **Schedule 3 – Amendments commencing two years after registration**

The amendments made by Schedule 3 of the Amendment Principles commence two years after the Amendment Principles are registered. The amendments repeal or amend a number of the amendments introduced by Schedule 1 to the Amendment Principles as these are not intended to be ongoing and are intended to only be in force while State and Territory governments establish clear arrangements for the provision of substituted consent to the use of restrictive practices (where they do not already exist). It is intended that this will allow sufficient time for States and Territories to establish their own arrangements and procedures for the authorisation of substituted consent for the use of restrictive practices (where they do not already exist).

#### ***Quality of Care Principles***

**Item 1** repeals the defined terms “individual nominee”, “medical treatment authority”, “nominee group” and “restrictive practices nominee” from section 4 of the Quality of Care Principles. This amendment is consequential to the amendment made by items 2 and 3 of Schedule 3 to the Amendment Principles, explained below.

**Item 2** repeals the definition of “restrictive practices substitute decision-maker” and replaces it with the definition that was in place prior to the commencement of the amendments made by Schedule 1 to the Amendment Principles. The effect of this item, read with the other items of Schedule 3 to the Amendment Principles (below) is to end the interim measures introduced by Schedule 1 to the Amendment Principles by effectively reinstating a definition of “restrictive practices substitute decision-maker” that is substantially similar to the existing definition.

**Item 3** repeals new sections 5A, 5B and 15GC of the Quality of Care Principles introduced by items 3 and 14 of Schedule 1 to the Amending Principles (explained above). This is a consequential amendment to item 2 of Schedule 3 to the Amending Principles.

**Item 4** repeals paragraph 15HC(ea) of the Quality of Care Principles introduced by item 1 of Schedule 2 to the Amendment Principles (explained above), and substitutes new paragraph 15HC(ea) which provides that if the care recipient lacks the capacity to give informed consent to the use of the restrictive practice, then the behaviour support plan must document the name of the restrictive practices substitute decision-maker for the restrictive practice in relation to the care recipient.

These amendments are consequential to the amendments made by items 2 and 3 of Schedule 3 to the Amendment Principles (explained above).

**Item 5** repeals new Division 6 of Part 4A of the Quality of Care Principles introduced by item 15 of Schedule 1 to the Amendment Principles (explained above). With items 2 and 3 of Schedule 3 to the Amendment Principles, this amendment has the effect of ending the interim measures introduced to address unexpected outcomes in relation to the interaction of restrictive practices consent arrangements with State and Territory guardianship and consent laws.

## Statement of Compatibility with Human Rights

*Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011*

### ***Quality of Care Amendment (Restrictive Practices) Principles 2022***

This legislative instrument is compatible with human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

#### **Overview of the Instrument**

The *Quality of Care Amendment (Restrictive Practices) Principles 2022* (Amendment Principles) amend the *Quality of Care Principles 2014* (Quality of Care Principles) to establish clear arrangements in the Commonwealth aged care legal framework that allow for certain individuals and bodies to be authorised to provide informed consent to the use of a restrictive practice in relation to a care recipient where the laws of the State or Territory in which the recipient receives aged care may not authorise an individual or body to provide consent on behalf of a care recipient. These arrangements will only apply where the care recipient lacks capacity to make an informed decision themselves.

These amendments aim to strengthen protections for care recipients from abuse associated with the unregulated use of restrictive practices, reduce the risk of unwarranted use of restrictive practices and reduce the risk of harm to care recipients.

The Amendment Principles also make consequential amendments needed to ensure the effective operation of the alternative consent arrangements, and to also ensure that immunity arrangements, introduced in the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Royal Commission Response Act) apply in appropriate, limited circumstances. This instrument is a legislative instrument for the purposes of the *Legislation Act 2003*.

#### **Human rights implications**

The Amendment Principles engage the following rights:

- the right not to be subjected to cruel, inhuman or degrading treatment under Article 7 of the *International Covenant on Civil and Political Rights* (ICCPR), and Article 15 of the *Convention on the Rights of Persons with Disabilities* (CRPD), and Articles 1 and 2 of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT);
- the right to security of the person and freedom from arbitrary detention under Article 9 of the ICCPR and Article 14 of the CPRD; and
- the right to health under Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), and Article 25 of the CRPD.

### Right not to be subjected to cruel, inhuman and degrading treatment

The Amendment Principles engage the right not to be subjected to cruel, inhuman or degrading treatment outlined in Article 7 of the ICCPR and Article 15 of the CRPD, and Articles 1 and 2 of the CAT. The Amendment Principles introduce arrangements that allow for certain individuals or bodies to consent to the use of a restrictive practice. They provide clarity regarding alternative arrangements for the provision of consent to the use of a restrictive practice where State and Territory laws may be unclear. The amendments also aim to ensure that approved providers can request and obtain consent to the use of restrictive practices when required. The use of restrictive practices in relation to care recipients are intended to be used only where necessary to prevent harm to care recipients and others (including other care recipients) and should not be used to subject an individual to cruel, inhuman or degrading treatment.

Without clear consent arrangements, there is a heightened risk that a restrictive practice may be used without the appropriate consent. The amendments are designed to ensure the policy's original intention can be achieved, which is that if a care recipient is not able to consent to the use of restrictive practices, consent should be sought from an appropriate person who is clearly authorised to provide that consent.

These amendments also sit alongside the robust and extensive existing requirements under the Quality of Care Principles. These requirements afford care recipients protections to ensure that restrictive practices are only ever to be used as a last resort, for the shortest time and in the least restrictive form, to prevent harm to the care recipient. Furthermore, approved providers must have tried alternative methods prior to use of restrictive practices and are required to regularly monitor and review any use of restrictive practices and any consideration or use is required to be documented in a behaviour support plan.

### Right to security of the person and freedom from arbitrary detention

Article 9 of the ICCPR and Article 14 of the CRPD provide for the right to liberty and security of the person, which requires that an individual not be subjected to arrest and detention, except as provided for by law, and provided that the law itself and the manner of its execution are not arbitrary. This right is engaged because the Amendment Principles relate to the authority to provide consent to the use of restrictive practices which may, in some circumstances, amount to detention. However, it is not intended that any detention as a result of the use of a restrictive practice be arbitrary and the existing and new arrangements are aimed at limiting the use of restrictive practices to certain circumstances, including as a last resort to protect the care recipient and others from harm, and with the required consent from one of the specified persons (where the care recipient lacks the requisite capacity).

The Amendment Principles also promote this right by reinforcing existing safeguards that seek to ensure that restrictive practices are not used in an arbitrary manner. If clear consent arrangements and requirements exist at the Commonwealth level in circumstances where State and Territory legislation does not empower anyone to consent to the use of restrictive practices, then the risk of a restrictive practice being used in relation to a care recipient without consent from an authorised person is reduced. Furthermore, if a person authorised under these new consent arrangements does not consent to restrictive practices being used, then an approved provider cannot use restrictive practices. These requirements reduce the risk of restrictive practices

being used arbitrarily or in the absence of consent. The combination of the existing requirements and the amendments will ensure that restrictive practices are only used as a necessary and proportionate response in particular circumstances.

#### Right to health

The Amendment Principles also promote the right to health under Article 12 of the ICESCR and Article 25 of the CRPD by ensuring there are mechanisms available to ensure greater protections in relation to the physical and mental health of individuals receiving aged care. The Amendment Principles have this effect by allowing for restrictive practices to be used in circumstances where consent is provided, and the use will prevent harm to the care recipient and others. This may include, for example, circumstances where mechanical restraints, such as bed rails, are used to reduce the risk of a care recipient falling out of their bed overnight.

The Amendment Principles address limitations with current consent arrangements and provide alternative arrangements so that restrictive practices are able to be used in necessary circumstances, in accordance with the Quality of Care Principles. This promotes the right to health by allowing for interventions that reduce the risk of harm to care recipients and others in residential aged care.

#### **Conclusion**

The Amendment Principles are consistent with human rights because they promote the protection of human rights of aged care recipients by implementing measures to ensure greater protection from cruel, inhuman or degrading treatment. To the extent these amendments limit the human rights discussed above, the limitations are not impermissible, serve a legitimate objective and are reasonable, necessary and proportionate to protect other rights and vulnerable individuals.

**Circulated by the authority of the Minister for Aged Care,  
the Hon Anika Wells MP**