

# Restrictive Practices Reference Guide for the South Australian Disability Service Sector



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and Social Inclusion

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## Introduction

People with disability are often subject to practices that restrict their freedom, movement or ability to make decisions.

South Australians, irrespective of ability, are entitled to lead lives that are meaningful, participatory and self-determined.

Any use of a restrictive practice has the potential to cause long-term physical and psychological harm. The use of unauthorised restrictive practices is an infringement of a person's human and, in many cases, civil rights.

All Australian jurisdictions have developed policies, procedures and practices to reduce the dependence of disability service systems on the use of restrictive practices for addressing behaviours of concern.

These initiatives challenge the normalisation of restraint as a tool for addressing behaviours of concern. They further acknowledge that the use of restrictive practices is not therapeutic, nor an effective long-term strategy to address behaviours of concern and may constitute false imprisonment and/or battery.

The South Australian (SA) Government is committed to ensuring that the human rights of people with disability are upheld in the same manner as other members of the community. This is evidenced by changes to the *Disability Services Act 1993*, the introduction of the Department for Communities and Social Inclusion's (DCSI) Safeguarding policies and establishing the Office of the Senior Practitioner (OSP).

The OSP works with the South Australian disability services sector to look at how practices can be improved to move away from the use of restrictive practices and ensure the rights of people with disability are upheld. The OSP further seeks to prepare service providers for the *National Disability Insurance Scheme Quality and Safeguarding Framework*. This framework emphasises the reduction and elimination of the use of restrictive practices through multiple safeguarding measures, including reporting requirements and the use of positive behaviour support (PBS) practices.

*The Restrictive Practices Reference Guide for the South Australian Disability Service Sector* (Reference Guide) has been developed with sector representatives. It clarifies the restrictive practice requirements of disability service providers and outlines safeguarding mechanisms to eliminate opportunities for the use of restrictive practices.

If people with disability are supported to determine and lead positive lives, many of the factors that can lead to the emergence of behaviours of concern will be reduced. This will in turn reduce, and in many cases eliminate, the use of restrictive practices.

## Context

The DCSI is committed to ensuring people with disability live without unreasonable concerns for their safety. All people have the right to choice and autonomy and to be free from any practice that interferes with their ability to make decisions or that restricts their freedom.

Australia is a signatory to the *United Nations (UN) Convention on the Rights of Persons with Disabilities*, which states that the physical and mental integrity of people with disability must be protected on an equal basis with others. Australia also has obligations to implement laws and policies to minimise restrictive practices under the *UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*.

The *National Disability Strategy 2010–2020* outlines a need to review restrictive legislation and practices from a human rights perspective.

The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework) establishes nationally consistent overarching principles and strategies to guide work in the reduction, and where possible, elimination of the use of restrictive practices.

Standard 1 of the *National Standards for Disability Services* “promotes individual rights to freedom of expression, self-determination, decision-making and actively prevents abuse, harm, neglect and violence”.

The *Disability Services Act 1993* (the Act) reinforces the right of South Australians with disability to receive services and supports that involve the least restriction on their rights and opportunities.

## Scope

The suite of documents within this Reference Guide:

- Applies to all South Australian disability service providers who are members of the Department for Communities and Social Inclusion’s Disability Services Provider Panel and the National Disability Insurance Scheme’s Registration Pool. This includes registered or unregistered health practitioners and therapists providing services to people with disability.
- Applies to all staff who may be paid workers, volunteers, contractors or people on placements
- Use Board and Chief Executive Officer as terms that are intended to cover the equivalent leaders of disability service organisations, whether they may be sole trader, Director(s), or so on
- Is applicable to the safeguarding of adults and children with disability
- Operates in conjunction with any mandatory reporting requirements and all relevant legislation, policies, guidelines and standards.

This Reference Guide does not replace or limit service providers’ duty of care for the people they support or for compliance under legal directives such as Intervention Orders or limitations imposed by Supreme Court licensed conditions.

## Purpose

The purpose of the Restrictive Practices Reference Guide is to:

- Reinforce the importance of personal sovereignty – the capacity for people to lead lives of their choosing. It is based on the foundation of Australian law which provides every citizen, irrespective of disability, with rights that are a cornerstone of our society
- Provide a key reference to support South Australian disability service providers as they reduce and eliminate the use of restrictive practices
- Ensure that, in circumstances where it is necessary to use a restrictive practice, it is implemented legally, ethically, minimally, with sufficient safeguards and regular review
- Clarify that restrictive practices should only occur within the context of positive behaviour support planning and practice
- Inform service providers of the requirements they must meet, as listed under the [Reducing and Eliminating the use of Restrictive Practices in South Australia – The Code of Practice](#) (section highlighted in red on page 10)
- Ensure that South Australian services align with the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*. The National Disability Insurance Scheme (NDIS) roll-out of a quality and safeguarding system will be informed by this Framework.

## **Section 1: Safeguarding People with Disability – Restrictive Practices Policy**

The DCSI Safeguarding People with Disability – Restrictive Practices Policy is available on the DCSI website (refer to [Reference Documents and Links](#)).

The policy provides direction on the minimisation and where possible, elimination of the use of restrictive practices and seeks to ensure that any restrictive practice authorised and consented to be administered appropriately with the least infringement of the rights of people with disability.

Disability service providers are required to ensure that their policies, procedures, guidelines, standards and practices comply with this policy.

## Section 2: Reducing and Eliminating the use of Restrictive Practices in South Australia – The Code of Practice

### Scope

The Code of Practice sets out the mechanisms disability service providers must have in place to regulate, reduce and eliminate the use of restrictive practices in line with the documents contained in this Reference Guide.

### Definitions and Key Terms

Definitions and key terms associated with the Code of Practice are in the [Acronyms, Definitions, Reference Documents and Links](#) section.

### Restrictive Practices

#### Restrictive practices that require recording and reporting:

- Chemical restraint
- Detention
- Environmental restraint
- Mechanical restraint
- Physical restraint
- Seclusion (see note below).

#### Prohibited restrictive practices:

- Aversive restraint/interventions
- Exclusion
- Prone physical restraint
- Psycho-social restraint
- Supine physical restraint.

**Note:** Seclusion of an adult with disability must only be used if specifically authorised by the South Australian Civil and Administrative Tribunal (SACAT) under Section 32 of the *Guardianship and Administration Act 1993*. Seclusion of a child with disability must only be used if specifically authorised by their legal guardian.

If seclusion has been authorised, such seclusion must only occur within an environment that is safe, is non-threatening to the person and maintains the dignity of the person. Close supervision and monitoring must be used to ensure the safety and wellbeing of the person during the period of seclusion.

**Note:** Service providers must ensure that unauthorised and prohibited restrictive practices do not become a part of their organisational culture. When such practices are used it is **not** acceptable to claim that the Board, Chief Executive Officer or Management were unaware of their existence.

**Disability service providers must adhere to the following key requirements outlined in this Reference Guide. These include:**

- Meeting the Governance and Service Outcomes outlined below.  
The requirements specified within the Service Outcomes are further discussed in the section Service Provider Responsibilities: Safeguards to Minimise and Eliminate the use of Restrictive Practices.
- Meeting the Recording, Reporting and Monitoring requirements outlined in the section [Standards for Recording and Reporting of the use of Restrictive Practices](#).

## Governance

The organisation will ensure it meets its restrictive practice governance requirements through the actions of its Board, Chief Executive Officer and management by:

1. Ensuring a clear policy statement regarding practices for reducing and eliminating the use of restrictive practices is implemented.
2. Gaining the commitment of its staff to developing an organisational culture of accountability, transparency, supervision and reflective practice as essential elements for the reduction and elimination of the use of restrictive practices.
3. Ensuring that all levels of staff within the organisation are aware of their specific responsibilities with respect to reducing and eliminating the use of restrictive practices.
4. Allocating the resources required to ensure its workforce receives regular training that contributes to the reduction and elimination of the use of restrictive practices.
5. Investing in the development of positive behaviour support (PBS) competency within their organisation. More information is contained in the *Positive Behaviour Support Guide for the South Australian Disability Service Sector* (refer to [Reference Documents and Links](#)).
6. Ensuring the appointment of a restrictive practices compliance officer.
7. Ensuring the appointment of an internal Restrictive Practice Governance Committee that reports regularly to the Chief Executive Officer and Board.
8. Ensuring the implementation of restrictive practices recording and reporting requirements.
9. Ensuring active engagement practices facilitate the self-determination of the person with disability, their carer, guardian or family.
10. Demonstrating a continuous quality improvement approach to service provision, which includes evaluating the effectiveness of the organisation's restrictive and PBS practices, policies and procedures.

In the case of sole traders, relevant governance requirements will be met by the individual.

## Service Outcomes

Through implementing the governance and other requirements outlined in this Reference Guide, service providers will be expected to provide evidence that:

1. A clear policy statement on reducing the use of restrictive practices is in place. This will be consistent with the DCSI Safeguarding People with Disability – Restrictive Practices Policy (refer to [Reference Documents and Links](#)).
2. Where restrictive practices are implemented, the least restrictive option is used at all times.
3. A restrictive practices compliance officer has been appointed. This is discussed further in the section [Appointing a Restrictive Practices Compliance Officer](#) and [Implementing Restrictive Practice Governance Arrangements](#).
4. An internal Restrictive Practice Governance Committee is in place and reports regularly to the Chief Executive Officer and Board. This requirement is discussed further under [Implementing Restrictive Practice Governance Arrangements](#).
5. A positive behaviour support plan has been developed and implemented for each person with identified behaviours of concern for whom there is a prescribed restrictive practice in place.
6. Their current workforce has received regular training grounded in human rights, person-centred practices, positive behaviour support and least restrictive practice strategies.
7. A supervision system is in place to ensure staff, the person with disability, their carer, guardian or family receives adequate debriefing after the use of any restrictive practice.
8. A restrictive practice recording and reporting system has been implemented in line with the [Standards for Recording and Reporting of the Use of Restrictive Practices](#).
9. Up-to-date data is available that indicates the organisation's progress with reducing and eliminating its use of restrictive practices. This includes recording unmet need and/or non-compliance data, or reporting a 'nil' return. This data will be made available to external monitoring bodies upon request as outlined under the section [Monitoring of the use of Restrictive Practices](#).
10. People with disability, their families or guardians have been made aware that if a restrictive practice is used in the service they access, it will only be used minimally and legally.
11. People with disability, their families or guardians have been made aware of their right to complain about, or seek a review of, any use of a restrictive practice.
12. Regular reporting to the Board occurs on the organisation's progress towards minimising and eliminating its use of restrictive practices.

In the case of sole traders, relevant Service Outcomes will be met by the individual.

Service providers' progress with meeting these Service Outcomes will be subject to external monitoring as outlined in [Monitoring of the use of Restrictive Practices](#).

## No use of Restrictive Practices

If your organisation does not have any clients subject to a restrictive practice, you must ensure that systems and procedures are in place according to the [Governance](#) and [Service Outcomes](#) requirements and in line with your organisational structure.

Should any use of a restrictive practice occur, it is expected that each provider will have developed sufficient capacity in line with the [Governance](#) and [Service Outcome](#) requirements to identify and take reasonable steps to reduce and eliminate these practices. This will also assist providers in readiness for future requirements under the NDIS Quality and Safeguarding Framework (refer to [Reference Documents and Links](#)).

Further, if your organisation does not have any clients subject to a restrictive practice, you must report a 'nil' return in line with the section [Monitoring of the use of Restrictive Practices](#).

## Consent, Authorisation and Approval

Service providers will ensure that, when a person with disability is displaying behaviours of concern, responses to this behaviour will demonstrate community standards and respect for individual rights while managing evident risks.

Restrictive interventions are used:

- as a last resort only after imminent danger to a person is observed;
- when all other least restrictive options reasonably available have been tried or considered; and
- when least restrictive options have been found to be unsuitable in the circumstances.

Service providers are required to document all trials of least restrictive practices in the person's client file.

A restrictive practice may only be implemented when it has been appropriately approved. In the case of children with disability, their parents or guardians are required to consent to the use of a restrictive practice. Consent and approval requirements are contained in the [Restrictive Practices – Guideline for Assessing, Planning, Authorising and Consenting for Adults](#).

All consents, authorisations and approvals for each use of a restrictive practice within an organisation will be managed by a restrictive practices compliance officer. The role of this officer is discussed further in [Appointing a Restrictive Practices Compliance Officer](#) and [Implementing Restrictive Practice Governance Arrangements](#).

Approved restrictive practices must be regularly reviewed no less than every six months. Reviews must also be documented by the service provider.

## Distinguishing Therapeutic or Safety Devices from Restrictive Practices

Some devices or practices used for therapeutic or safety purposes place constraints on a person's liberty. Disability service providers must consider whether the application of any specific safety or therapeutic device or practice is consistent with the person's human rights. Through individual support planning, disability service providers must respond to safety concerns in ways that, as far as practicable, promote the person's rights, autonomy and inclusion.

The use of a therapeutic device does not constitute a restrictive practice when its use is not objected to by the person and it is clinically prescribed for the purposes of:

- improving the quality of life of the person with disability, by preventing or minimising body shape distortions and directly-related secondary complications that result in pain, discomfort and poor health;
- ensuring the safety of someone assisting the person to participate in a desired task or activity through minimising factors that would impede the person, and thus enabling their engagement in an activity which would not otherwise be possible;
- providing treatment where, if there were no restriction of the person, an adverse health outcome would occur.

There is potential for therapeutic or safety devices or practices to be misused as a restrictive practice. Individual assessment and, if necessary, further consultation and review may be required to determine whether a device or practice is being used solely for therapeutic or safety purposes. If the primary purpose of the device or practice is to control or restrict the person's behaviour or free movement, it is considered a restrictive practice.

Where a person resists or objects to guiding a therapeutic or safety device or practice, its application is considered a restrictive practice. In such cases, the service provider must seek appropriate authorisation by SACAT and/or consent from the person or their guardian, carer or family.

For more information refer to [Restrictive Practices – Guideline for Assessing, Planning, Authorising and Consenting for Adults](#).

## Information Sharing Guidelines for Promoting Safety and Wellbeing

Sharing relevant information with families or other service providers can significantly reduce risks to the person with disability, their family and staff. It can also decrease the likelihood that a restrictive practice will be used.

Service providers are required to comply with *Ombudsman SA's Information Sharing Guidelines for promoting safety and wellbeing (ISG)*.

*When information about risk is not shared, workers operate in isolation, resulting in an incomplete understanding of the complex needs and interconnected circumstances of their clients.... The Information Sharing Guidelines for promoting safety and wellbeing (ISG) provide a mechanism for information sharing when it is believed a person is at risk of harm (from others or as a result of their own actions) and adverse outcomes can be expected...<sup>1</sup>*

All South Australian disability service providers must have an updated ISG Appendix in place (containing procedures for implementing the ISG within their own organisations). Providers must further ensure that their staff are appropriately trained and inducted into use of the updated ISG. For further information refer to Ombudsman SA's website ([www.ombudsman.sa.gov.au](http://www.ombudsman.sa.gov.au)).

## Withdrawal of Restrictive Practices

It can be dangerous to withdraw existing restrictive practices before safe and more respectful alternatives have been appropriately assessed for risk, trialled and demonstrated to be effective. Service providers must plan the withdrawal of restrictive practices to ensure it occurs in such a way that the safety of the person with disability, staff and relevant others is not compromised.

**Note:** Citing that it is dangerous to withdraw existing restrictive practices cannot be used as ongoing justification for a service provider not to have demonstrated active restrictive practice reduction efforts with each person subject to such practices.

## Service Provider Responsibilities: Safeguards to Minimise and Eliminate the use of Restrictive Practices

Disability service providers, including sole traders, are required to implement the following safeguards in line with their organisational structures and functions. This will assist providers to improve services and meet their responsibilities as outlined in the [Service Outcomes](#) section.

### Individual Support Plans

The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* states:

*Restrictive practice reduction tools need to be based on core assessment and prevention approaches, the results of which need to be integrated into each individual's support plan.<sup>2</sup>*

Disability support providers must ensure that each person in receipt of disability services has a current individual support plan in place. Individual support plans are usually undertaken by a client coordinator.

<sup>1</sup> Information Sharing Guidelines for promoting safety and wellbeing, Foreword, Ombudsman SA, 2013

<sup>2</sup> National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, p12, Department of Social Services, 2014

For people who have additional behaviour support needs, a positive behaviour support plan and positive behaviour support practice may also be required.

### **Positive Behaviour Support**

By investing in developing best practice positive behaviour support (PBS) capacity within their organisations and translating this into every day service provision, disability service providers will see a reduction in their use of restrictive practices.

Through functional behavioural assessment, a key component of PBS, the causes of a person's behaviours of concern may be identified and addressed before any suggestion of a restrictive practice is made.

Each adult who is subject to a prescribed restrictive practice and chemical restraint will have a PBS plan (PBSP) implemented. In the case of children subject to a restrictive practice, their parents or guardians are required to consent to the use of the practice and development of the PBSP.

For all people subject to a SACAT order that authorises the use of a restrictive practice, service providers are further expected to provide a PBSP to the Office of the Public Advocate.

The *Positive Behaviour Support Guide for the South Australian Disability Service Sector* (refer to [Reference Documents and Links](#)) has been developed by the OSP in collaboration with South Australian disability service providers and PBS practitioners.

The guide is intended to complement this Reference Guide and seeks to establish a common understanding of PBS. It also outlines key considerations for South Australian disability service providers in the review and/or initiation of PBS within their organisations.

### **Proactive Leadership from each Disability Service Provider's Board, Chief Executive Officer and Management**

Each service provider's Board, Chief Executive Officer and management are responsible for providing the leadership required to plan, prioritise, resource and monitor the effectiveness of their organisation's strategies for reducing and eliminating restrictive practices.

Each organisation's leaders further share a responsibility for influencing the cultural change required within their agencies to eliminate restrictive practices.

Specific requirements are within the [Governance](#) and [Service Outcomes](#) sections. Further content is within the *Positive Behaviour Support Guide for the South Australian Disability Service Sector* (refer to [Reference Documents and Links](#)).

### **Appointing a Restrictive Practices Compliance Officer**

Each disability service provider's Board will endorse the appointment of a restrictive practices compliance officer. This officer will liaise with the relevant internal client coordinator(s) to ensure that, where their organisation uses a restrictive practice, this occurs within the following framework prior to endorsing the practice.

- An appropriate practitioner has prescribed the restrictive practice
- Least restrictive alternatives to the restrictive practice have been explored, trialled and documented by relevant staff

- The restrictive practice can be used safely
- The appropriate authorisation and consent has been obtained by relevant staff
- All risks associated with the organisation's use of the restrictive practice have been considered and documented by relevant staff
- Recording and reporting requirements are met by staff
- A dated review process for each restrictive practice is in place
- Any PBS requirements associated with the use of the restrictive practice are in place and are being implemented consistently.

**Note:** The restrictive practices compliance officer must not be the same person as the practitioner prescribing the restrictive practice. Details on the requirements of prescribing practitioners are outlined in the [Guideline for Assessing, Planning, Authorising and Consenting for Adults](#)

### **Implementing Restrictive Practice Governance Arrangements**

Each disability service provider's Board will endorse the appointment of an appropriately skilled internal Governance Committee. This committee is tasked with the systemic reduction of restrictive practices across their organisation.

The restrictive practices compliance officer may sit on this committee or this role may be undertaken by appointed members of this committee. This is to the discretion of each service provider.

This committee will:

- Draw upon restrictive practice data sourced from its recording and reporting system to analyse trends, evaluate and report on the effectiveness of the organisation's restrictive practice reduction strategies
- Identify where there may be a reliance upon the use of restrictive practices within the organisation
- Support all levels of staff to understand their specific responsibilities for reducing and eliminating the use of restrictive practices
- Support PBS best practice within their organisation
- Make recommendations for improving risk management practices
- Make recommendations for improving the quality of their services
- Brief the Chief Executive (or equivalent) and Board on the progress of restrictive practice reduction across their organisation.

### **Recording and Reporting of the use of Restrictive Practices**

Disability service providers will record all uses of:

- chemical restraint;
- detention;
- environmental restraint;
- mechanical restraint;

- physical restraint; and
- seclusion

in line with the [Standards for Recording and Reporting of the use of Restrictive Practices](#).

Each recording system must be able to effectively capture and collate the organisation's restrictive practices data in a meaningful way for:

- flagging when an implemented restrictive practice has reached its review date
- assisting the role and function of its Restrictive Practice Governance Committee, including to identify and report on unmet need and flag non-compliance regarding meeting the requirements outlined in the [Service Outcomes](#)
- reporting to monitoring sources as highlighted in the [Monitoring of the use of Restrictive Practices](#) and the [Standards for Recording and Reporting of the use of Restrictive Practices](#) sections.

**Note:** If the use of a restrictive practice constitutes a critical incident refer to the DCSI Managing Critical Client Incidents Policy.

### **Monitoring of the use of Restrictive Practices**

The internal monitoring of an organisation's use of restrictive practices will be overseen by their appointed Restrictive Practices Governance Committee, Board, Chief Executive and Management.

The external monitoring of an organisation's use and recording of restrictive practices will occur via:

- The person with disability
- Families or guardians
- The Community Visitors Scheme (CVS), Department for Communities and Social Inclusion
- The Office of the Public Advocate (OPA)
- The Health and Community Services Complaints Commissioner (HCSCC)
- DCSI Investigations
- DCSI Incident Management
- The Office of the Senior Practitioner (OSP), Department for Communities and Social Inclusion
- The Contracting and Sector Liaison Unit (CSLU), Department for Communities and Social Inclusion

Through the course of their work, the CVS, OPA, HCSCC, DCSI Investigations, DCSI Incident Management and the OSP may request evidence from providers that demonstrates their compliance with the [Service Outcomes](#) in the Code of Practice.

For further information on the restrictive practice monitoring roles of these bodies, refer to the [Standards for Recording and Reporting of the use of Restrictive Practices](#).

## Training and Development of Staff

Disability service providers must ensure their staff receives ongoing training and education.

The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* states:

*There is good evidence to show that disability support workers who understand positive behaviour support, functional behaviour assessment as well as a focus on skills for trauma informed care, risk assessment, de-escalation, and restrictive practice alternatives are able to provide good support and reduce their use of restrictive practices with people who have complex needs.<sup>3</sup>*

Workforce training and development is essential for improving staff capacity to reduce and eliminate the use of restrictive practices. Training for staff may include, but is not limited to:

- Disability awareness
- The requirements of staff under relevant legislation, policies, procedures and guidelines
- Restrictive practices:
  - Definitions of, and how to identify, restrictive practices
  - The acceptable and prohibited parameters of using restrictive practices, including legal consent and authorisation arrangements
  - Person-centred, active support and least restrictive practice strategies
  - De-escalation strategies
  - Duty of care responsibilities
  - Restrictive practice reporting requirements
- Positive behaviour support
- Child development (where services are provided for children)

The Office of the Senior Practitioner has developed a restrictive practices awareness-raising package for training purposes. This resource is available to service providers for integration into their training programs for staff.

## Supervision and Debriefing

Restrictive practices are more likely to occur in cultures where staff are expected to operate in isolation and without the support of ongoing supervision.

Service providers will ensure that they implement a supervision system for staff to actively encourage transparency, reflective practice and for driving service improvements.

Ongoing staff supervision and support is also integral to achieving best practice in positive behaviour support.

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<sup>3</sup> National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, p11, Department of Social Services, 2014

Debriefing is a requirement outlined in the National Framework. Service providers will ensure staff, the person with disability, their families, carers, guardians and relevant others receive adequate debriefing after all incidences of the use of a restrictive practice.

Debriefing practices should seek to maintain the inherent dignity and uphold the wellbeing of the person subject to these practices. Debriefing and supervision practices should further seek to professionally support the staff involved in using these practices and where possible prevent further occurrences.

## Section 3: Standards for Recording and Reporting of the use of Restrictive Practices

Service providers are required to record all uses of chemical restraint, detention, environmental restraint, mechanical restraint, physical restraint and seclusion.

Implementing [minimum requirements](#) for data collection will result in disability service providers using their existing incident management systems to:

- Register each person for whom there is a PBSP or other plan in place which includes the use of a prescribed restrictive practice
- Record each use of a planned episodic restrictive practice
- Record each unplanned emergency use of a restrictive practice.

### Recording Restrictive Practices

Scenarios for Recording the use of Restrictive Practices	Information to be Recorded in line with the <a href="#">Minimum Requirements</a> for Restrictive Practice Data Collection
<p><i>For each person for whom there is a plan in place that includes a restrictive practice:</i>  <b>The Restrictive Practices Register.</b></p>	<p><a href="#">(A) Demographics of each person subject to any use of a restrictive practice.</a>  <a href="#">(B) Registering the details of each person who has a plan in place.</a></p>
<p><i>For each person for whom there is a plan in place that includes a restrictive practice and that practice is used by staff:</i> <b>Recording an Episodic Restrictive Practice.</b>  <b>Note:</b> An episodic use of a restrictive practice is when an intervention (for example, PRN medication), is an authorised restrictive practice that is documented in the person's plan and used only when there is an occurrence of the identified behaviour of concern.</p>	<p>As highlighted above, the demographics and plan details of each person for whom there is an authorised use of a restrictive practice will be registered.            Every use of an episodic restrictive practice by a service provider must be recorded in line with:  <a href="#">(D) Information to record after any use of a restrictive practice.</a>            This will be recorded within 24 hours of the restrictive practice occurring.</p>
<p><i>If the person has an authorised restrictive practice within their plan and a different restrictive practice is used in an emergency:</i>  <b>Recording the emergency use of a restrictive practice.</b></p>	<p>Any unplanned emergency use of a restrictive practice must be recorded against <b>(A)</b> the demographic and <b>(B)</b> plan details of that person your organisation has previously registered            Each emergency use of a restrictive practice must be recorded by an organisation in line with:  <a href="#">(D) Information to record after any use of a Restrictive Practice.</a>            This will be recorded within 24 hours of the restrictive practice occurring.</p>

Scenarios for Recording the use of Restrictive Practices	Information to be Recorded in line with the <a href="#">Minimum Requirements</a> for Restrictive Practice Data Collection
<p><i>If the person does not have an authorised restrictive practice recorded in their plan and an emergency restrictive practice is used by staff: <b>Recording an emergency use of a restrictive practice.</b></i></p> <p><i>Note: If your restrictive practice data highlights that an emergency restraint is being used often, this may indicate that the person needs a PBSP or a review of their current plan. Either course of action must directly address the situation for which the restraint is being used and determine the least restrictive options for future events. The data may also indicate that staff requires further training and support.</i></p>	<p>It is likely that the service provider will be registering a new restrictive practice record for the person.</p> <p>When recording this type of an emergency use of a restrictive practice providers will record:</p> <p><a href="#">(A) Demographics of each person subject to any use of a restrictive practice.</a></p> <p><a href="#">(C) When the person does not have an authorised restrictive practice within their plan and an emergency restrictive practice is used.</a></p> <p>and</p> <p><a href="#">(D) Information to record after any use of a Restrictive Practice.</a></p> <p>This will be recorded within 24 hours of the restrictive practice occurring.</p> <p>Any future use of a restrictive practice with a person will be recorded against, and linked to, their registered demographics.</p>

## Minimum Requirements for Restrictive Practice Data Collection

All uses of planned or unplanned restrictive practices will be recorded in service providers' existing incident management systems. The minimum requirements for restrictive practice data collection correspond to the table above.

### (A) Demographics of the person subject to any use of a restrictive practice.

- Full name
- Gender
- Date of birth
- Address
- Disability type
- Whether the person identifies as an Aboriginal or Torres Strait Islander

### (B) Registering the details of each person's plan in place.

- What PBSP (or other plan) is currently in place for the person?
- The date that the current plan was implemented (or register the date by which the organisation will implement a PBSP for the person).
- The person's plan review date (no more than six months since the previous review).

- The date that the restrictive practice(s) in this person's plan will be reviewed (no more than six months since the previous review).
- The name of the staff member or restrictive practices compliance officer responsible for monitoring the implementation, effectiveness and review of this person's plan.
- Where documented evidence will be found that the relevant Guardianship, Legal Orders, authorisations and consents are in place and have been followed for each use of a restrictive practice with a person.
- The name of the person's appointed guardian(s), as relevant.
- All relevant authorisation and consent expiry dates.

**(C) When the person does not have an authorised restrictive practice within their plan and an emergency restrictive practice is used.**

- If the person is subject to an emergency use of a restrictive practice on more than one occasion, the date by which the organisation will implement a PBSP for the person will be recorded. Alternatively the organisation must reference evidence that the process of completing a PBSP is currently underway.

Appropriate authorisation and consents must be sought and documented within this plan.

**Note:** If the person is subject to a once-off emergency use of a restrictive practice that is unlikely to re-occur, there may not be a need to incorporate this restrictive practice into a PBSP (or other plan). If this is the case, the process undertaken and rationale must be documented in the person's client file.

**(D) Information to record after any use of a restrictive practice.**

- Whether the restrictive practice was episodic and part of the person's plan or an emergency use of a restrictive practice.
- There is documented evidence that least restrictive alternatives were explored before the restrictive practice was used.
- Type used (detention, environmental, chemical, mechanical, physical restraint, seclusion).
- The date, time and location where the use of a restrictive practice(s) occurred.
- The service type(s) that the person was using at the time of the restrictive practice.
- The name and title of the restrictive practices compliance officer.
- The name of the person responsible for supervising the staff member(s) involved and monitoring each use of a restrictive practice with the person.
- The name(s) of the staff member(s) who used the restrictive practice.
- Documented evidence that debriefing and feedback was provided after the event to the person with disability, their family, guardian or carer and the staff member(s) involved.

## Monitoring and Reporting

Restrictive practice recording systems must have the capacity to report information as requested by the following stakeholders.

External Monitors	Disability Service Providers' Reporting Responsibilities to External Monitors
Office of the Senior Practitioner (OSP), DCSI	<p>Through the course of ongoing visits with providers, the OSP will monitor the progress of each organisation towards building their internal restrictive practice reduction capacity and reducing their overall use of restrictive practices.</p> <p>The OSP will require evidence in line with the Service Outcomes, including evidence that a restrictive practice recording and reporting system has been implemented and is operational.</p> <p><b>Note:</b> If your organisation has no people subject to a restrictive practice you are required to report a nil return.</p>
People with disability, families, carers and guardians	<p>The OSP encourages service providers to assist people with disability, their families, carers and guardians to understand the nature of restrictive practices, consent, authorisation and the responsibilities of service providers outlined in this Reference Guide.</p> <p>People with disability, their families, carers and guardians may further wish to discuss an organisation's use of restrictive practices, view the person's plan and relevant restrictive practices reporting documentation as a mechanism for addressing the use of these practices.</p> <p>Information sharing permissions for family members, carers and guardians must be in place as per the wishes of the person with disability, the <i>Guardianship and Administration Act 1993</i> or Ombudsman SA's <i>Information Sharing Guidelines for promoting safety and wellbeing</i>.</p> <p>Providers of disability services for children are required to share information about all incidents of restrictive practices with the child's parent(s) or guardian. Further to this, providers are required to share positive behaviour support (or other) plans with the child's parent(s) or guardian.</p>
The Office of the Public Advocate (OPA), AGD	<p>The OSP and the OPA have endorsed a protocol for the sharing of information in respect to organisations' use of restrictive practices with, and the implementation of, PBSPs for people under Guardianship.</p>
The Contracting and Sector Liaison Unit (CSLU), DCSI	<p>Through the course of contract management activities of members of the Department for Communities and Social Inclusion's Disability Service Provider Panel and National Disability Insurance Scheme's Registration Pool, the CSLU representative may request evidence from service providers regarding their progress towards meeting the Service Outcomes.</p> <p>Any information gathered by the CSLU about an organisation's use of restrictive practices can be shared with the OSP.</p>

External Monitors	Disability Service Providers' Reporting Responsibilities to External Monitors
DCSI Investigations	<p>The DCSI Investigations conducts investigations into serious care concerns involving people with disability who receive services from members of the Department for Communities and Social Inclusion's Disability Services Provider Panel and National Disability Insurance Scheme's Registration Pool.</p> <p>South Australian disability service providers must fully cooperate with investigations and in turn seek the cooperation of their staff, volunteers, agents and sub-contractors.</p>
DCSI Incident Management	<p>DCSI Incident Management reviews complaints and incidents in disability service organisations that are not deemed serious care concerns by DCSI Investigations. The team responds to matters to identify risks and/or systemic issues, and promotes service improvement to ensure the services provided are consistent with legislative and contractual obligations.</p>
Community Visitors Scheme (CVS), AGD	<p>The OSP, CVS and HCSCC have endorsed protocols for the monitoring and sharing of information in respect to disability service providers' use of restrictive practices.</p> <p>Through the course of visits to supported accommodation, respite and day option settings, the CVS representative may identify, through observation, practices that appear to be restrictions on people's freedom.</p>
Health and Community Services Complaints Commissioner (HCSCC)	<p>Should a representative of the DCSI Investigations, DCSI Incident Management, CVS or HCSCC, within the scope of their roles, identify the use of a restrictive practice by a service provider, they may request a copy of the person's plan.</p> <p>The DCSI Investigations, DCSI Incident Management, CVS or HCSCC representative may further seek discussions with a Chief Executive Officer or Board and/or evidence from providers regarding their progress with meeting the Service Outcomes.</p> <p><b>Note:</b> Any information gathered by these agencies about an organisation's use of restrictive practices can be shared with the OSP.</p>

Internal Monitors	Internal Monitoring Responsibilities of Chief Executive Officers and Boards
The Chief Executive Officer and Board	<p>The OSP expects that each service provider's Board, Chief Executive Officer and Management lead its staff in the identification, reduction and elimination of restrictive practices in line with the Governance and Service Outcomes sections.</p> <p>The Board is responsible for ensuring that the organisation's service users are receiving quality service outcomes and that the organisation's staff is not using potentially unlawful restrictive practices.</p>

<b>Internal Monitors</b>	<b>Internal Monitoring Responsibilities of Chief Executive Officers and Boards</b>
	<p>In line with their organisational structures and functions, the Board will ensure that a restrictive practices recording and reporting system, restrictive practices compliance officer and restrictive practice governance arrangements are implemented to address individual and systemic restrictive practice reduction.</p> <p>Through the course of the monitoring activities outlined here, the OSP, CSLU, DCSI Investigations, DCSI Incident Management, OPA and the HCSCC may seek to discuss, with a Chief Executive Officer or Board, their organisation's use of restrictive practices and compliance with the Service Outcomes.</p>

## Section 4: Restrictive Practices – Guideline for Assessing, Planning, Authorising and Consenting for Adults

The use of restrictive practices is to be minimised and, where possible, eliminated. Where it is deemed that the use of a restrictive practice is necessary to protect the person with disability or others, it is important that appropriate authorisations and consents for its use are obtained.

The use of restrictive practices without these authorisations and consents is illegal and could leave a person or organisation implementing these practices open to civil and/or criminal proceedings.

The following tables outline the authorisation and consent requirements for the use of restrictive practices for adults with disability in South Australia. Also provided is:

- The list of restrictive practices that must not be used under any circumstances
- Restrictive practices that require the consent of an appointed guardian with relevant powers from Section 32 of the *Guardianship and Administration Act 1993*
- Restrictive practices that require the consent of an appointed guardian, substitute decision-maker or person responsible
- Devices commonly used for therapeutic or safety purposes
- Potential risks of restrictive practices, recommended controls to assist in minimising risks, authorisation requirements (the list is not exhaustive), and examples of what restrictive practice means.
- This information should be read in conjunction with:
  - *Guardian Consent for Restrictive Practices in Disability Settings Policy, Office of the Public Advocate*
  - *Consent to Medical Treatment and Palliative Care Act 1995*
  - *Guardianship and Administration Act 1993*

### Consent by the Individual

In all instances, an person with decision-making capacity must have all decisions regarding the use of restrictive practices deferred to them. In some circumstances, a person can consent in advance to the use of a restrictive practice. Care must be taken to ensure that such consent is voluntary and not the subject of undue influence by people on whom the person with disability relies.

These are practices that conflict with person-centred principles, are demeaning, not acceptable or are dangerous. They represent a risk to people's human rights, personal dignity and/or safety.

## Prohibited Restrictive Practices

There is a range of restrictive practices that are prohibited and not to be used by providers of disability services. These practices conflict with person-centred principles, are demeaning and unacceptable. They also represent a risk to people's human rights, personal dignity and safety.

### Psycho-social Restraints

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Practitioner	Consent
<ul style="list-style-type: none"> <li>• Demeaning tone of voice.</li> <li>• Threatening negative consequences – “...if you do that again, you are not...”</li> <li>• Manipulation.</li> </ul>	<ul style="list-style-type: none"> <li>• Punishment being used by staff.</li> <li>• Emotional trauma.</li> <li>• Risk to human rights and personal dignity.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.
<ul style="list-style-type: none"> <li>• Leaving people in bed.</li> <li>• Putting people to bed early.</li> </ul>	<ul style="list-style-type: none"> <li>• Punishment being used by staff.</li> <li>• Loss of freedom.</li> <li>• Denial of activities.</li> <li>• Emotional trauma.</li> <li>• Escalation of behaviour (secondary to boredom).</li> <li>• Risk to human rights and personal dignity.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.
<ul style="list-style-type: none"> <li>• Immobilisation of mobility devices:               <ul style="list-style-type: none"> <li>– use of brakes</li> <li>– disengaging motor.</li> </ul> </li> <li>• Deliberately delaying or failing to charge the battery of the device.</li> </ul>	<ul style="list-style-type: none"> <li>• Punishment being used by staff.</li> <li>• Loss of freedom.</li> <li>• Denial of activities.</li> <li>• Emotional trauma.</li> <li>• Escalation of behaviour.</li> <li>• Risk to human rights, personal dignity and choice.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.

<b>Restrictive Practice Example</b>	<b>Potential Risks</b>	<b>Recommended Controls</b>	<b>Prescribing Practitioner</b>	<b>Consent</b>
Withholding basic human rights: <ul style="list-style-type: none"> <li>• Food/drinks*</li> <li>• Shelter/warmth/cooling</li> <li>• Clothing, shoes</li> <li>• Person's goods/belongings*</li> <li>• Positive social interaction</li> <li>• Favoured activity</li> <li>• Communication devices.</li> </ul>	<ul style="list-style-type: none"> <li>• Punishment being used by staff.</li> <li>• Loss of freedom.</li> <li>• Denial of activities.</li> <li>• Emotional trauma.</li> <li>• Escalation of behaviour.</li> <li>• Diminished capacity to communicate needs, etc.</li> <li>• Risk to human rights, personal dignity and choice.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.

**\*Restricting or removing access to certain types of or amounts of food/drink and/or goods/personal belongings may be appropriate in certain circumstances.** Refer to section on [Environmental Restraints](#).

#### **Aversive Interventions**

<b>Restrictive Practice Example</b>	<b>Potential Risks</b>	<b>Recommended Controls</b>	<b>Prescribing Practitioner</b>	<b>Consent</b>
<ul style="list-style-type: none"> <li>• Application of electric shocks to the person.</li> <li>• Use of water spray to the face.</li> </ul>	<ul style="list-style-type: none"> <li>• Punishment being used by staff.</li> <li>• Loss of freedom.</li> <li>• Denial of activities.</li> <li>• Emotional trauma.</li> <li>• Escalation of behaviour.</li> <li>• Diminished capacity to communicate needs, etc.</li> <li>• Risk to human rights, personal dignity and choice.</li> <li>• Physical harm.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.

## Exclusion

<b>Restrictive Practice Example</b>	<b>Potential Risks</b>	<b>Recommended controls</b>	<b>Prescribing Practitioner</b>	<b>Consent</b>
<ul style="list-style-type: none"> <li>Preventing a person from participating in, or being part of, an activity or decision.</li> <li>Deliberately ignoring or not including a person in an activity or decision.</li> <li>Punishment by denying participation in a group or activity.</li> </ul>	<ul style="list-style-type: none"> <li>Punishment being used by staff.</li> <li>Loss of freedom.</li> <li>Denial of activities.</li> <li>Emotional trauma.</li> <li>Escalation of behaviour.</li> <li>Diminished capacity to communicate needs.</li> <li>Risk to human rights, personal dignity and choice.</li> </ul>	Staff education, supervision and management.	Not to be used.	Not to be used.

## Prone and Supine Physical Restraints

<b>Restrictive Practice Example</b>	<b>Potential Risks</b>	<b>Recommended Controls</b>	<b>Prescribing Practitioner</b>	<b>Consent</b>
<ul style="list-style-type: none"> <li>Taking or holding someone to the floor using your own body weight: <ul style="list-style-type: none"> <li>– face down (supine restraint)</li> <li>– face up (prone restraint).</li> </ul> </li> <li>Holding someone's neck.</li> </ul>	<ul style="list-style-type: none"> <li>Death.</li> <li>Serious injury.</li> <li>Emotional trauma.</li> <li>Escalation of behaviour.</li> </ul>	Staff education, supervision and management. Development of safer alternatives.	Not to be used.	Not to be used.

## Restrictive Practices Requiring the Consent of an Appointed Guardian with Relevant Powers as per Section 32 of the Guardianship and Administration Act 1993

These restrictive practices are significantly restrictive, require endorsement from senior management and/or the restrictive practices compliance officer, may be resisted by the person, and generally require the consent of an appointed guardian with relevant Section 32 powers and an appropriately authorised PBSP.

**Note:** Where an appointed guardian with relevant Section 32 powers provides consent and the restrictive practices compliance officer provides approval and a referral is submitted as soon as practicable to a PBS practitioner to write a PBSP, interim short-term restrictive practices to ensure the health, safety and/or welfare of the person and/or others may be developed and implemented by the relevant team. These interim restrictive practices must be accompanied by relevant support plans and follow the completion of a risk assessment.

### Physical Restraint

#### Section 32 (1) (c) of the Act states:

*The Tribunal...may, by order, authorise the persons from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and wellbeing of the person.*

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Forcibly holding a person or part of their body</b></p> <p>Requires powers as per Section 32 (1) (c). For example:</p> <ul style="list-style-type: none"> <li>holding a person's arm or leg whilst treatment is applied</li> <li>holding a person whilst essential personal tasks are being performed.</li> </ul>	<ul style="list-style-type: none"> <li>Injury/death to the person or others.</li> <li>Risk to human rights and personal dignity.</li> </ul>	<ul style="list-style-type: none"> <li>Avoidance/last resort.</li> <li>Conduct risk assessment.</li> <li>Adherence to PBSP.</li> <li>Staff training.</li> <li>Limited use.</li> <li>Regular review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Mechanical Restraints

### Section 32 (1) (c) of the Act states:

*The Tribunal...may, by order, authorise the persons from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and wellbeing of the person.*

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Practitioner	Consent and Endorsement
<p><b>The use of restrictive clothing</b></p> <p>Only considered a mechanical restraint when the person objects to its use and requires powers as per Section 32 (1) (c).</p>	<ul style="list-style-type: none"> <li>• Emotional trauma.</li> <li>• Violation of human rights.</li> <li>• Loss of independence and/or skills (for example, self-toileting).</li> </ul>	<ul style="list-style-type: none"> <li>• Contenance review.</li> <li>• Trial of least restrictive alternatives.</li> <li>• Use correct size.</li> <li>• Minimise use.</li> <li>• Regular review and trial of alternatives.</li> <li>• Conduct risk assessment.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Practitioner	Consent and Endorsement
<p><b>Cuffing or strapping to modify or control behaviour</b></p> <p>For example, during the performance of care tasks and/or to prevent self-injury or harm to others requires powers as per Section 32 (1) (c).</p>	<ul style="list-style-type: none"> <li>• Emotional trauma.</li> <li>• Physical injury.</li> <li>• Violation of human rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Not to be used for behaviour management unless specifically authorised with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</li> <li>• Regular review, with a major review occurring within a maximum period of 6 months.</li> <li>• Explain before use.</li> <li>• Conduct risk assessment.</li> <li>• Limit use.</li> <li>• Short-term use only (that is, for the duration of care tasks, or for prescribed periods during the day/night).</li> <li>• When used without direct supervision (for example, splints) clear monitoring arrangements taking into account safety aspects need to be made.</li> <li>• Ensure adequate padding.</li> <li>• Use correct size.</li> <li>• Last resort.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Physiotherapist or occupational therapist (where adaptive equipment is used):</b> Prescribes adaptive equipment, obtains consent, develops relevant support plans and contributes to risk assessment.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Practitioner	Consent and Endorsement
<p><b>The use of seatbelt buckle guards in vehicles</b></p> <p>When travelling in vehicles it is a legal requirement for all people to wear a seatbelt at all times. Staff are not permitted to transport anyone not using a seatbelt. Under most circumstances, this does not require consent or authorisation as seatbelts are a requirement under the law. However, there are some circumstances where all least restrictive alternatives have been trialled and a person still actively and consistently objects to wearing a vehicle seatbelt. To enable safe transportation to continue it is suggested that, with appropriate consent, the person be trialled with the use of a seat belt buckle guard. If the person consents to the use of the seat belt buckle guard and does not object to its use, it is to be considered a safety restraint. However, if the person consistently tries to remove or persistently and consistently objects to the seat belt buckle guard, the seat belt buckle guard may then be considered to be a mechanical restraint and continued use may require the additional authorisation of an appointed guardian with relevant powers as per Section 32 (1) (c)</p>	<ul style="list-style-type: none"> <li>• Emotional trauma.</li> <li>• Violation of human rights.</li> <li>• Physical injury.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Regular review.</li> <li>• Trial of least restrictive alternatives: <ul style="list-style-type: none"> <li>– education</li> <li>– negotiation</li> <li>– using public transport.</li> </ul> </li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP.</p> <p><b>GP:</b> Prescribes the seat belt buckle guard.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Directing a Person Where to Live (Accommodation) – Seclusion and Detention

### Section 32 (1) (a) of the Act states:

*...an appropriate authority...may by order direct that the person reside with a specified person or in a specified place; or with such person or in such place as the appropriate authority from time to time thinks fit...*

### Section 32 (4) (a) of the Act states:

*...the appropriate authority or a member of the police force may enter any premises and take the person, or cause him or her to be taken, using only such force as is reasonably necessary for the purpose, to the place in which he or she is to be placed or detained, and any person who assists the appropriate authority or member of the police force in the matter incurs no liability for doing so...*

### Section 32 (4) (b) of the Act states:

*...the person in charge of the premises in which a person is being detained pursuant to the order may take, or cause to be taken, such action as is reasonably necessary for the purpose of preventing the person from leaving the premises or for bringing the person back should he or she leave without lawful authority or excuse...*

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Authority	Consent and Endorsement
<p><b>Directing a person where to live/placement</b></p> <p>Section 32 (4) (a) does include the authority to return a person to the accommodation by police. However, if this is a regular occurrence then explore alternatives. Relevant powers as per Section 32 (4) (b) may also need to be applied for.</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Escalation of behaviours of concern.</li> <li>• Physical injury.</li> <li>• Emotional trauma.</li> <li>• Risk to human rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Adherence to the PBSP.</li> <li>• Emergency protocol.</li> <li>• Electronic keypads/locks where required.</li> <li>• Regular review.</li> </ul>	<p>SACAT via a Guardianship Order with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> or by way of a relevant court order.</p>	<p><b>Consent:</b> An appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Detention</b></p> <p>Actively preventing a person from leaving their accommodation usually requires relevant powers as per Section 32 (4) (b) and Section 32 (4) (a). This gives authorisation to detain the person at the place they have been directed to live or stay.</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Escalation of behaviour.</li> <li>• Physical injury.</li> <li>• Emotional trauma.</li> <li>• Injury/death in the event of an emergency.</li> <li>• Risk to human rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Adherence to PBSP.</li> <li>• Planned accompanied outings/access to community.</li> <li>• Regular monitoring.</li> <li>• Modify environment to prevent injury.</li> <li>• Emergency protocol.</li> <li>• Electronic keypads/locks where required.</li> <li>• Regular review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p>	<p><b>Consent:</b> An appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>
<p><b>Seclusion</b></p> <p>Confining a person to a locked room or area against their will require relevant powers as per Section 32 (4) (b).</p>	<ul style="list-style-type: none"> <li>• Self-harm.</li> <li>• Emotional trauma.</li> <li>• Escalation of behaviour.</li> <li>• Injury/death in the event of an emergency.</li> <li>• Risk to human rights and personal dignity.</li> <li>• Deprivation.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Document and undertake regular frequent monitoring including welfare checks.</li> <li>• Adherence to the PBSP.</li> <li>• Time limited.</li> <li>• Modify environment to prevent injury.</li> <li>• Regular review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Compelling a Person to Comply with Medical Treatment

That is, concealing medication in food/drink, taking blood from a person against their will and giving injections to a person against their will. **Where the treatment is regular psychiatric treatment it is generally more appropriate to consider applying for a community treatment order through SACAT.**

### Section 32 (1) (c) of the Act states:

*...may, by order, authorise the persons from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person.*

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Hiding medication in a person's food or drink (including via PEG feeds)</b> For the primary purpose of overriding consent as the primary purpose (as distinct from preventing the risk of choking).</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Emotional trauma.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Adherence to the PBSP.</li> <li>• Regular review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> or relevant court order.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>The use of physical force</b> In order to administer medical treatment (such as, holding a person to take blood against their will, give injections to a person against their will or force a person to undergo a medical procedure) requires relevant powers as per Section 32 (1) (c).</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Emotional trauma.</li> <li>• Injury</li> <li>• Threat to human rights and personal dignity.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Adherence to the PBSP.</li> <li>• Regular review.</li> <li>• Use of familiar staff.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> An appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> or relevant court order.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Restrictive Practices Requiring the Consent of an Appointed Guardian, Substitute Decision-maker or Person Responsible (other than staff of a disability service provider who cannot consent to chemical restraint)

### Chemical Restraints

**Chemical Restraints:** Restrictive practices requiring the consent of an appointed guardian, substitute decision-maker, or person responsible (other than staff of a disability service provider who cannot consent to chemical restraint). This list is not exhaustive.

If a person resists or objects to the administration of any medication, then the additional consent of an appointed guardian with relevant Section 32 powers is also required. (Staff of a disability service provider are unable to consent.)

**Note:** Where a medical practitioner or psychiatrist has prescribed medication for the purposes of managing a person's behaviour (as distinct from prescribing evidenced-based pharmaceutical treatment for a diagnosed medical/psychiatric condition or pre-procedural sedation for the primary purpose of reducing the person's anxiety about a procedure), a PBSP must also be created to support management of that behaviour.

The PBS Practitioner authorised to draft the PBSP must liaise with the prescribing medical practitioner or psychiatrist to ensure optimal integration of the two strategies (medication and behaviour support plan) and support the minimisation of medication being used for behaviour management.

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Anti-convulsant medication</b></p> <p>When not prescribed for epilepsy management or a relevant psychiatric diagnosis (for example, bi-polar affective disorder, schizophrenia, schizoaffective disorder) such as:</p> <ul style="list-style-type: none"> <li>• Carbamazepine</li> <li>• Sodium Valproate</li> <li>• Lamotrigine.</li> </ul>	<p>Refer to individual product information, but may include sedation, causing swallowing difficulties (dysphagia), falls and pressure areas leading to ulcers.</p>	<p>Refer to the individual product information but generally should include:</p> <ul style="list-style-type: none"> <li>• Observation including monitoring for side effects (when medication commenced, increased, or ceased).</li> <li>• Awareness of toxicity symptoms.</li> <li>• Regular medical review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian.</p> <p>If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Anti-histamines</b> When prescribed for the principle purpose of sedation, for example:</p> <ul style="list-style-type: none"> <li>• Phenergan</li> <li>• Vallergran.</li> </ul>	<p>Refer to individual product information, but may include:</p> <ul style="list-style-type: none"> <li>• Sedation (causing dysphagia, falls and pressure areas).</li> </ul>	<p>Refer to the individual product information but generally would include:</p> <ul style="list-style-type: none"> <li>• Observation including monitoring for side effects (when medication commenced, increased, or ceased).</li> <li>• Awareness of toxicity symptoms.</li> <li>• Regular medical review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian.</p> <p>If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Anti-psychotics</b> When there is no relevant psychiatric diagnosis, for example:</p> <ul style="list-style-type: none"> <li>• Olanzapine</li> <li>• Risperidone</li> <li>• Quetiapine</li> <li>• Haloperidol.</li> <li>• Aripiprozale</li> <li>• Chlorpromazine</li> <li>• Pericyazine.</li> </ul>	<p>Refer to product information but may include:</p> <ul style="list-style-type: none"> <li>• Extra-pyramidal side effects that include: <ul style="list-style-type: none"> <li>– Drooling</li> <li>– Stiffness.</li> </ul> </li> <li>• Sedation (causing dysphagia, falls, and pressure areas).</li> <li>• Agitation.</li> </ul>	<p>Refer to the individual product information but generally should include:</p> <ul style="list-style-type: none"> <li>• Observation including monitoring for side effects (when medication commenced, increased, or ceased).</li> <li>• Awareness of toxicity symptoms.</li> <li>• Regular medical review.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian.</p> <p>If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Benzodiazepines</b></p> <p>May be prescribed short-term for severe symptoms in a number of conditions (including anxiety, psychosis, bi-polar, schizophrenia, epilepsy, severe obsessive compulsive disorder (OCD), and periods of medication changeover). At times, Benzodiazepines may be prescribed long-term for some chronic psychiatric conditions.</p> <p>Some common Benzodiazepines are:</p> <ul style="list-style-type: none"> <li>• Diazepam</li> <li>• Clonazepam</li> <li>• Temazepam</li> <li>• Midazolam</li> </ul> <p>(when not prescribed for seizure management) Medazolam and other sedatives can be used to override consent to, and/or enforce compliance with medical treatment. If this is the case, then this requires relevant powers as per Section 32.</p>	<p>Refer to individual product information but may include:</p> <ul style="list-style-type: none"> <li>• Respiratory depression</li> <li>• Excessive sedation</li> <li>• Confusion</li> <li>• Disinhibition/ agitation.</li> </ul> <ul style="list-style-type: none"> <li>• Midazolam can cause rapid and severe respiratory depression.</li> </ul>	<p>Refer to the individual product information but generally would include:</p> <ul style="list-style-type: none"> <li>• Observation including monitoring for side effects (when medication commenced, increased, or ceased).</li> <li>• Awareness of toxicity symptoms.</li> <li>• Regular medical review.</li> <li>• Avoid continuous use.</li> </ul>	<p>Medical practitioner or psychiatrist.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian.</p> <p>If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Hormonal manipulation (female)</b></p> <p>Menstruation suppressants must not be used for the primary purpose of enforced contraception unless specifically authorised by an order of SACAT as using suppressants in this way represents a violation of a person's human right to experience full sexuality and fertility.</p> <p>Menstruation suppressants must not be used for the primary purpose of staff convenience.</p> <p>Menstruation suppressants may be used for the purposes of avoiding pregnancy or menstruation when freely consented to by the person concerned.</p> <p>Menstruation suppressants may be recommended for health reasons such as painful periods or psychological reasons such as mood management, or for extreme distress/confusion during menstruation. However, other least restrictive alternatives must always be considered and the use of menstrual suppressants must be regularly reviewed.</p>	<p>Refer to individual product information but may include:</p> <ul style="list-style-type: none"> <li>• Emotional trauma.</li> <li>• Depression</li> <li>• Menstrual irregularity</li> <li>• Loss of fertility.</li> </ul>	<p>Refer to the individual product information but generally should include:</p> <ul style="list-style-type: none"> <li>• Counselling prior to use.</li> <li>• Careful initial titration.</li> <li>• Regular review of dosage.</li> <li>• Regular review of need for therapy.</li> <li>• Additional hormonal therapy.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent. Their relative or guardian can give consent to menstruation suppression if the primary purpose is for health or psychological reasons and if the person is not objecting.</p> <p>If the person is resisting or objecting to the use of menstruation suppressants for the primary purpose of health or psychological reasons then the use of this medication, the consent of an appointed guardian with relevant powers, usually Section 32 (1) (c), of the <i>Guardianship and Administration Act 1993</i>.</p> <p>If menstruation suppressants are being used for the primary purpose of suppressing fertility and the person objects, the issue must be taken to SACAT for a decision.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Hormonal manipulation (male)</b> (When used for the primary purpose of reducing a person's sex-drive.)</p>	<p>Refer to the individual product information but generally may include:</p> <ul style="list-style-type: none"> <li>• Change in secondary sexual characteristics.</li> <li>• Depression.</li> <li>• Liver disease.</li> <li>• Reduction in sex drive.</li> <li>• Loss of fertility.</li> </ul>	<p>Refer to the individual product information but generally should include:</p> <ul style="list-style-type: none"> <li>• Counselling prior to use.</li> <li>• Careful initial titration.</li> <li>• Regular review of dosage.</li> <li>• Regular review of need for therapy.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>Community nurse (where involved in the administration of the medical treatment):</b> Contributes to the PBSP and the risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian. If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required or authority provided via a relevant court order.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Anti-depressants</b></p> <p>Very rarely used as a chemical restraint. Most commonly would be amitriptyline, which is sometimes used as a behavioural restraint due to its sedative properties.</p>	<p>Refer to product information, but usually:</p> <ul style="list-style-type: none"> <li>• Sedation.</li> <li>• Falls.</li> </ul>	<p>Refer to the individual product information but generally would include:</p> <ul style="list-style-type: none"> <li>• Observation including monitoring for side effects (when medication commenced, increased, or ceased).</li> <li>• Regular medical review.</li> </ul>	<p><b>Medical practitioner/ psychiatrist (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p> <p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p>	<p><b>Consent:</b> Person with capacity to give consent or their relative or guardian. If the person is resisting or objecting to the medication, the consent of an appointed guardian with relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> is also required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

**Environmental Restraints (this is not an exhaustive list)**

**Note:** It is important to note that a ‘person responsible’ as defined under the *Consent to Medical Treatment and Palliative Care Act 1995* cannot consent to restricting or preventing free access to food/drink/other items owned by the person for whom they are consenting. However, an appointed guardian for lifestyle can consent to the restriction of certain food/drink/other items for health safety and/or welfare reasons even when the person objects. However, in circumstances where force or significant coercion is required to prevent access to the desired item(s) consideration may be given to powers as per Section 32 of the *Guardianship and Administration 1993*, usually Section 32 (1) (c).

<b>Restrictive Practice Example</b>	<b>Potential Risks</b>	<b>Recommended Controls</b>	<b>Prescribing Person(s)</b>	<b>Consent and Endorsement</b>
<p><b>Locked fridges, cupboards, kitchens etc</b> For example, a device or physical barrier, <b>to which the person objects</b>, that restricts or prevents access to certain food/drink/other items that could cause harm</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Emotional trauma.</li> <li>• Behaviour escalation.</li> <li>• Risk to human rights and personal dignity.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Ensure safe alternatives are available.</li> <li>• Supported access to restricted area.</li> <li>• Regular monitoring.</li> <li>• Modify environment to prevent injury.</li> <li>• Regular review that includes a trial of least restrictive alternatives.</li> </ul>	<p><b>PBS practitioner:</b> Develops the PBSP, contributes to the risk assessment.</p> <p><b>Medical practitioner (where the restrictive practice is being used to administer medical treatment):</b> Prescribes the medical treatment and contributes to the PBSP and risk assessment as required.</p>	<p><b>Consent:</b> Person with capacity to give consent or their appointed guardian. Where force or coercion is used, powers as per Section 32 of the <i>Guardianship and Administration 1993</i>, usually Section 32 (1) (c), is required.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Devices and/or Practices used for Therapeutic or Safety Purposes

Therapeutic or safety devices and/or practices used primarily for a person's safety (for example, lap belts, bed rails, splints, restrictive clothing, locked kitchens etc) are not considered restrictive practices where the person does not resist or object to their use. If a person is unable to consent for themselves, consent can be provided by the person's guardian, substitute decision-maker, medical agent or enduring guardian.

If a therapeutic or safety device is applied and the person resists or objects, relevant powers as per Section 32 of the *Guardianship and Administration Act 1993* are required.

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Bed rails</b></p>	<ul style="list-style-type: none"> <li>• Strangulation.</li> <li>• Falls.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Lower bed.</li> <li>• Use floor padding.</li> <li>• Use knee brace or remove canopy when client is sitting in bed.</li> </ul>	<p>Physiotherapist, occupational therapist <b>or</b> registered nurse.</p>	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible.</p> <p>If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<b>Devices used to assist the person when eating, drinking, during oral hygiene procedure, including posture restraining devices</b>	<ul style="list-style-type: none"> <li>• Emotional trauma.</li> <li>• Loss of dignity.</li> <li>• Physical injury.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment</li> <li>• Follow meal time management plan/support plan.</li> <li>• Explain prior to use.</li> <li>• Limit use.</li> <li>• Ensure adequate padding.</li> </ul>	Speech therapist, physiotherapist, occupational therapist <b>or</b> registered nurse.	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible. If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>
<b>Seat belt/harness/wheelchair trays</b>	<ul style="list-style-type: none"> <li>• Strangulation.</li> <li>• Other injuries.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment</li> <li>• Use pommel or harness.</li> <li>• Prevent loosening of belt.</li> <li>• Use anti-slip material.</li> <li>• Use anti-tipping mechanisms.</li> <li>• Use 'tilt in space' chairs.</li> </ul>	Physiotherapist, occupational therapist <b>or</b> registered nurse.	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible. If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<b>Bed canopy</b>	<ul style="list-style-type: none"> <li>• Strangulation.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment</li> <li>• Lower bed.</li> <li>• Use floor padding.</li> <li>• Use knee brace or remove canopy when client is sitting in bed.</li> </ul>	Physiotherapist, occupational therapist <b>or</b> registered nurse.	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible. If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>
<b>Restrictive clothing</b>	<ul style="list-style-type: none"> <li>• Impaired skin integrity.</li> <li>• Emotional trauma.</li> <li>• Risk to human rights and personal dignity.</li> <li>• Loss of skills (such as continence).</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment</li> <li>• Continence review.</li> <li>• Trial of alternatives prior to use.</li> <li>• Explain prior to use.</li> <li>• Customised to fit.</li> <li>• Limit period of use.</li> <li>• Regular review.</li> </ul>	Client coordinator.	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible. If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Sensor alarms</b></p>	<ul style="list-style-type: none"> <li>Mats – tripping risk, electrocution.</li> <li>Restriction of free movement.</li> </ul>	<ul style="list-style-type: none"> <li>Conduct risk assessment</li> <li>Addition of non-slip aids.</li> <li>Daily check of power cords.</li> <li>If the sensor mat is being used to enable staff to enforce detention then relevant Section 32 powers may also be required. Refer to section on Detention.</li> </ul>	<p>Client coordinator.</p>	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible.</p> <p>If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Detention</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>
<p><b>Cuffing or strapping prescribed for safety purposes</b></p> <p>For example, during sling transfers for managing involuntary movements.</p>	<ul style="list-style-type: none"> <li>Emotional trauma.</li> <li>Physical injury.</li> <li>Restriction of free movement.</li> </ul>	<ul style="list-style-type: none"> <li>Conduct risk assessment</li> <li>Explain prior to use.</li> <li>Limit use.</li> <li>Ensure adequate padding.</li> <li>Use correct size.</li> <li>Not to be used for behaviour management unless specifically authorised under relevant Section 32 orders with 6 monthly review. Refer to Mechanical Restraints.</li> </ul>	<p>Physiotherapist, occupational therapist <b>or</b> registered nurse.</p>	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible.</p> <p>If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Detention</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

Restrictive Practice Example	Potential Risks	Recommended Controls	Prescribing Person(s)	Consent and Endorsement
<p><b>Locked house</b> As a safety precaution for people who are at risk of wandering or absconding.</p>	<ul style="list-style-type: none"> <li>• Loss of freedom and choice.</li> <li>• Escalation of behaviour.</li> <li>• Physical injury.</li> <li>• Emotional trauma.</li> <li>• Injury/death in the event of an emergency.</li> <li>• Risk to human rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment (including fire safety risk assessment).</li> <li>• Adherence to PBSP.</li> <li>• Planned accompanied outings/access.</li> <li>• Regular monitoring.</li> <li>• Modify environment to prevent injury.</li> <li>• Emergency protocol.</li> <li>• Electronic keypads/locks.</li> </ul>	<p>Client coordinator.</p>	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible.</p> <p>If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Detention</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>
<p><b>Splints</b></p>	<ul style="list-style-type: none"> <li>• Pressure areas.</li> <li>• Pain/discomfort.</li> <li>• Injury to others.</li> <li>• Risk to human rights.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct risk assessment.</li> <li>• Explain prior to use.</li> <li>• Customised to fit.</li> <li>• Limit period of use.</li> <li>• Pain relief.</li> </ul>	<p>Physiotherapist GP, occupational therapist <b>or</b> orthotist.</p>	<p><b>Consent:</b> Person with capacity to give consent or their guardian, substitute decision-maker or person responsible.</p> <p>If the person is resisting or objecting to the restriction then relevant powers as per Section 32 of the <i>Guardianship and Administration Act 1993</i> must be obtained. See section on <a href="#">Mechanical Restraints</a>.</p> <p><b>Endorsement:</b> The delegated restrictive practices compliance officer.</p>

## Acronyms, Definitions, Reference Documents and Links

### Acronyms

<b>AGD</b>	Attorney General's Department
<b>CSLU</b>	Contracting and Sector Liaison Unit
<b>CVS</b>	Community Visitors Scheme
<b>DCSI</b>	Department for Communities and Social Inclusion
<b>GP</b>	General practitioner
<b>HCSCC</b>	Health and Community Services Complaints Commissioner
<b>ISG</b>	Information Sharing Guidelines
<b>NDIS</b>	National Disability Insurance Scheme
<b>OPA</b>	Office of the Public Advocate
<b>OSP</b>	Office of the Senior Practitioner (DCSI)
<b>PBS</b>	Positive behaviour support
<b>PBSP</b>	Positive behaviour support plan
<b>PRN</b>	Pro re nata (meaning 'as required')
<b>RN</b>	Registered nurse
<b>SA</b>	South Australia
<b>SACAT</b>	South Australian Civil and Administrative Tribunal
<b>UN</b>	United Nations

## Definitions

### A

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**Administration Order** – When a person is not able to make decisions about financial/legal matters, the South Australian Civil and Administrative Tribunal (SACAT) may grant an Administration Order so that an administrator will be appointed to make decisions on financial/legal matters for the person.

An **administrator** is a person appointed by order of the South Australian Civil and Administrative Tribunal (SACAT) to make financial and legal decisions for a person with mental incapacity.

**Advance care directive** is a legal form where a person, 18 years of age or over, is able to write down (or where unable to do so have written down on his or her behalf) his or her instructions, wishes and preferences for future health care, accommodation and personal matters and/or to appoint one or more substitute decision makers who can make decisions on the person's behalf in any period of impaired decision making capacity, or as determined by the person.

**Anticipatory Direction** is a legally binding document completed prior to 1 July 2014, in which an adult who is of sound mind, records their wishes and directions with respect to end of life medical treatment. It allows the person to state the kind of treatment he/she wants, or does not want, once he/she is in the terminal phase of a terminal illness or in a persistent vegetative state but is unable to make those wishes known at the time. It does not involve the appointment of another person, and must be followed by those responsible for the person's medical care (Section 7, *Consent to Medical Treatment and Palliative Care Act 1995*).

An **attorney** is appointed under a Power of Attorney, by a person who has mental capacity, to manage their financial and legal affairs. The person nominates who they wish to manage their affairs and under what circumstances.

**Aversive interventions** (or restraints) are practices that use unpleasant physical, sensory or verbal stimuli in an attempt to reduce a person's undesired behaviour. Aversive interventions include but are not limited to the use of a water spray to the face or electric shocks to the skin in response to a behaviour of concern.

### B

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**Bed canopy** is the application of a fabric device tied firmly over a bed frame to form a canopy over the recumbent person's trunk and legs that allows localised movement but prevents the person from leaving the bed.

**Behaviours of concern** are behaviours of such intensity, frequency or duration as to threaten the quality of life and/or safety of the individual or others, and may seriously limit or deny the use of ordinary community facilities, limit or deny lifestyle opportunities, impede positive interactions with others in their environment, and are likely to lead to responses that are restrictive, aversive or result in exclusion.

**Belting/cuffing/harnessing/strapping** is the application of any material, strap or device to any part of the body, head, neck, limbs, fingers, or toes, intended to restrict free movement of that body part.

**Binding** refusal is a refusal of a particular medical treatment outlined in an advance care directive.

## C

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**Capacity** is the ability of a person to make effective and informed choices and decisions and communicate their intentions or wishes in some manner. A person is presumed to have capacity unless proven otherwise.

**Care concerns** are defined as acts or situations where there has been a failure by the staff, volunteer, contractor, or person on placement to meet an agreed minimum standard of care which may jeopardise the wellbeing of or cause harm to a person with disability. Care concerns can be minor, moderate or serious. (See Safeguarding People with Disability – Management of Care Concerns Policy for further information.)

**Chemical restraint** is the use of any medication for the primary purpose of influencing or controlling a person's behaviour, movement or normal bodily function for a non-therapeutic reason. Chemical restraint does not include the administration of:

- Medication prescribed by a medical practitioner for the treatment of a diagnosed mental illness, a physical illness or physical condition
- Pre-procedural medication for the principal purpose of reducing that person's anxiety regarding the procedure, and where the person is not resisting the medication.

A **client coordinator** is a person within an agency who is responsible for developing an individual support plan for a person with disability. When the use of a restrictive practice is considered essential, the client coordinator will further ensure the development of a risk assessment for the person; ensure that a positive behaviour support plan is developed; and facilitate, obtain and record the required authorisations and consents. This will occur in liaison with the organisation's appointed restrictive practices compliance officer.

**Consent** is the act of agreeing to (giving permission for) certain actions affecting one or more aspects of one's life. Commonly these include legal, financial, health, lifestyle and social aspects. The individual can refuse or withdraw consent. (Refer to Informed Consent.)

A **consent issue** is a situation where a consent decision needs to be made.

**Critical client incident** is an event (or alleged event) that occurs as a result of, or during the delivery of services directly provided or funded by DCSI, and has caused, or is likely to cause, significant negative impact to the health, safety or welfare of a client or service recipient. Critical client incidents will usually require a crisis response, incident management, coordination and consideration of a range of risks and sensibilities. Definition from the DCSI's Managing Critical Client Incidents Policy.

## D

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**Dental treatment** means treatment or procedures carried out by a dentist in the course of dental practice (Section 3, *Guardianship and Administration Act 1993*).

**Debriefing** will occur following the use of a restrictive practice. An immediate 'post event' debriefing should be completed on site led by the appropriate senior person member on duty. The goal of this immediate debriefing is to ensure that everyone is safe, that satisfactory information is available to inform the later structured debriefing process and that the person subject to the restraint is safe and being appropriately monitored. Formal debriefing should occur within days after the event and include all involved, the treatment team and relevant administrative staff.<sup>4</sup>

**Detention** is a situation where a person, who wishes to do so, is actively prevented from leaving the place where they receive disability services. Detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent them from exercising freedom of movement.

**Dignity of risk** refers to the right of all people with disability to make an informed choice to experience life and take advantage of opportunities for learning, developing competencies and independence and, in doing so, take calculated risks.

**Duty of care** is the legal requirement of exercising a reasonable standard of care while performing any acts (including acts of omission) that could foreseeably harm others. What constitutes a reasonable standard of care is generally based on what is reasonable to expect from the person's peers in the same situation and possessing equivalent skills, training and qualifications. A breach of duty of care requires that the resultant harm was 'reasonably foreseeable', as determined in the context of the circumstances.

## E

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An **emergency** is a situation that is unforeseen and requires an immediate response\* such as:

- Acute short-term illness of client/carer
- Injury (for example, falls)
- Adverse reaction to extreme weather conditions
- Contingence emergency.

In most instances, an emergency response should not take more than two hours.

\*In the event of fire, break-in or any matter requiring community emergency services, the first contact should be to the appropriate emergency service such as police, ambulance, fire (phone: 000).

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<sup>4</sup> National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, p12, Department of Social Services, 2014

**Emergency treatment** is regulated by Section 13 *Consent to Medical Treatment and Palliative Care Act 1995* that refers to the conditions under which a medical practitioner can proceed with treatment without consent of the patient or a third party.

- “(1) Subject to subsection (3), a medical practitioner may lawfully administer medical treatment to a person (the ‘patient’) if—*
- (a) the patient is incapable of consenting; and*
  - (b) the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health and that opinion is supported by the written opinion of another medical practitioner who has personally examined the patient; and*
  - (c) the patient (if of or over 16 years of age) has not, to the best of the medical practitioner's knowledge, refused to consent to the treatment.*
- (2) A supporting opinion is not necessary under subsection (1) if in the circumstances of the case it is not practicable to obtain such an opinion.)*
- (3) If—*
- (a) the patient has appointed a medical agent; and*
  - (b) the medical practitioner proposing to administer the treatment is aware of the appointment and of the conditions and directions contained in the medical power of attorney; and*
  - (c) the medical agent is available to decide whether the medical treatment should be administered, the medical treatment may not be administered without the agent's consent.*
- (4) If no such medical agent is available and a guardian of the patient is available, the medical treatment may not be administered without the guardian's consent.*
- (5) If the patient is a child, and a parent or guardian of the child is available to decide whether the medical treatment should be administered, the parent's or guardian's consent to the treatment must be sought but the child's health and wellbeing are paramount and if the parent or guardian refuses consent, the treatment may be administered despite the refusal if it is in the best interests of the child's health and wellbeing.”*

**End-of-life care** is the form of palliative care that is appropriate when the person is in his/her final days or weeks of life. End-of-life care requires that the person's care decisions are reviewed more frequently and that the goals of care are more sharply focused on the person's physical, emotional and spiritual needs and the support of the family.

An **Enduring Attorney** is someone formally appointed by an adult person with mental capacity to make legal and financial (but not health, lifestyle) decisions of that person if that person becomes unable to make those decisions in the future due to mental incapacity.

An **Enduring Guardian**, is someone formally appointed prior to 1 July 2014, by an adult person with mental capacity to make lifestyle and health care decisions if that person becomes unable to make those decisions in the future due to mental incapacity (see Part 3, *Guardianship and Administration Act 1993*).

An **Enduring Power of Attorney** is a legally binding document completed by a person with capacity that appoints an Enduring Attorney to make legal and financial decisions. More than one person can be appointed to make decisions. These decisions can be made jointly, separately or in some form of hierarchy.

An **Enduring Power of Guardianship** is a legally binding document, completed before 1 July 2014, that appoints an Enduring Guardian of 18 years or over as a surrogate health and lifestyle decision-maker and allows for the inclusion of an instructional health care and life-style plan that takes effect following loss of capacity (*Guardianship and Administration Act 1993*). Several Enduring Guardians can be appointed to act separately or jointly.

**Environmental modifications** are changes made to the person's environment, including the use of physical or other barriers, for safety or therapeutic purposes. An environmental modification becomes an environmental restraint if a person resists or objects to its implementation.

**Environmental restraint** is the use of physical or other barriers to prevent the person's free access to parts of their environment for the primary purpose of influencing or controlling that person's behaviour (for example, preventing someone who actively wishes to do so from accessing certain foods that pose a significant safety risk, such as allergic reaction).

**Exclusion** is the act of preventing a person from participating in or being part of an activity or decision, or deliberately ignoring or not including a person in an activity or decision.

## G

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**Guardian** means a person appointed as guardian of an adult by order of the South Australian Civil and Administrative Tribunal, under the *Guardianship and Administration Act 1993*. A guardian is responsible for making decisions on behalf of a person about accommodation and/or health care and/or lifestyle matters.

**Guiding Legislative Principles** – Four legislative principles act as a guide when making decisions for a person with a mental incapacity (see Section 5, *Guardianship and Administration Act 1993*):

- (1) What the wishes of the person would have been if he or she had not become mentally incapacitated (where this can be determined)
- (2) The present wishes of the person, if these can be expressed

- (3) Whether or not existing informal arrangements for the treatment and care of the person are adequate, and should not be disturbed
- (4) Which decision or order would be the least restrictive of the person's rights and personal autonomy, whilst still ensuring his or her proper care and protection.

## H

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**Health practitioners** who provide services to the clients of disability service providers and who **are registered** with and regulated by Australian Health Practitioner Regulation Agency (AHPRA) include:

- Dental practitioners (including dentists, dental hygienists, dental prosthetists and dental therapists)
- Medical practitioners
- Nurses and midwives
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists
- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners (including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers)
- Medical radiation practitioners (including diagnostic radiographers, radiation therapists and nuclear medicine technologists)
- Occupational therapists.

**Health practitioners** who provide services to clients of disability service providers and who are **unregistered** include, but are not limited to:

- Art therapists
- Dietitians
- Music therapists
- Social workers
- Speech pathologists
- Sex education counsellors
- General and grief counsellors/therapists
- Hypnotherapists
- Naturopaths
- Developmental educators
- Massage therapists.

**Immobilisation of electric mobility devices with the intent of limiting independent mobilisation** includes one or more of the following: the use of remote controls, the disengagement of the drive shaft, the application of brakes and/or the failure to charge the battery of the mobility device.

**Impaired decision-making capacity** refers to the inability of a person to make a particular decision at a particular time because he or she is incapable of:

- understanding any information that may be relevant to the decision; or
- retaining such information; or
- using such information in the course of making a decision; or
- communicating his or her decision in any manner; or
- by reason of being comatose or otherwise unconscious, is unable to make a particular decision about his or her medical treatment.

The principle of **informal arrangements** is provided in section 5(c) of the *Guardianship and Administration Act 1993*:

*“Consideration must, in the case of the making or affirming of a guardianship or administration order, be given to the adequacy of existing informal arrangements for the care of the person or the management of his or her financial affairs and to the desirability of not disturbing those arrangements.”*

An informal arrangement means that the person with mental incapacity has a “*capable, caring family member or friend who can assist them in making decisions*”.  
(Office of the Public Advocate, Fact Sheet #4, Guardianship Orders, April 2011)

(See also definition, Guiding Legislative Principles.)

**Informed consent** is the act of agreeing to or giving permission for certain actions affecting one or more aspects of one’s life (for example, legal, financial, health, lifestyle and social). To be informed a person must be given information about the proposed activity relative to the individual situation including potential for an adverse outcome, other options and the possible results of alternative action or no action. For consent to be effective, the person should be able to communicate an understanding of the proposed activity. Consent can be refused or withdrawn at any time.

The **Individual Support Plan** is the operative part of the client’s record set, used by support staff as a day-to-day reference to provide consistent, appropriate, individualised and timely support services. It may comprise three sections:

- A Personal Support Plan is completed by the client coordinator, and includes lifestyle and person-centred activity plans and records.
- A Health Care Plan is completed either by the client coordinator in consultation with/or by a general practitioner, allied health service provider, or other health practitioners, and includes specific health support plans and directives of a low to moderate health support risk.

- A Health Plan is completed by a registered nurse (RN), and includes specific health support plans and directives in relation to complex and moderate to high health support risks.

## L

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**Least restrictive alternatives** are the actions that involve the least infringement on the fewest rights. Before any restrictive practice is implemented, there should be a thorough investigation of alternatives that would have less impact on the freedom of the individual. These should be trialled and only after there is evidence that they do not provide for the safety of the individual or others, should a more restrictive alternative be considered. This should be documented in the relevant client plan/record and the ongoing use of the intervention regularly reviewed.

**Liaison person** – When the South Australian Civil and Administration Tribunal appoints an organisation (for example, Public Trustee) as the administrator of a person with a mental incapacity, it can also appoint a liaison person as part of the Administration Order. A liaison person is appointed to keep the administrator informed of the needs of the protected person, to provide information to the administrator and to assist the person to communicate their views to the administrator. A liaison person acts as a ‘go-between’ between the administrator and the protected person. They also play an important advocacy role. He or she can make suggestions to the administrator about how to best spend the protected person’s money to ensure that his or her needs are being met and to improve the quality of his or her life.

**Lifestyle** refers to a broad range of activities such as work, leisure, recreation, assistance with daily living, cleaning, mobility, social interactions and friendship and relationships.

## M

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**Mechanical restraint** refers to the use of a device to prevent, restrict or subdue a person’s free movement for the primary purpose of influencing or controlling that person’s behaviour. Mechanical restraint does not include the use of devices for therapeutic purposes (for example, splints) or for safety purposes not primarily related to behaviour (for example, seat belts, wheelchair trays or bed rails to prevent injury from falls, devices to enable the safe transportation of a person). However, a therapeutic or safety device is considered a mechanical restraint if a person resists or objects to its use.

A **Medical Agent** is someone formally appointed, prior to 1 July 2014, by an adult person with mental capacity to make health care (but not lifestyle or other decisions) decisions if that person becomes unable to make those decisions in the future due to mental incapacity (see medical power of attorney, Division 3, *Consent to Medical Treatment and Palliative Care Act 1995*).

**Medical Power of Attorney** is a legally binding document completed before 1 July 2014, that appoints a Medical Agent of 18 years or over as a surrogate health decision maker and allows for the inclusion of instructional health care plan that takes place following the loss of capacity (*Consent to Medical Treatment and Palliative Care Act 1995*). More than one Medical Agent can be appointed but only one may act at time in order of appointment.

**Medical treatment** means the provision by a medical practitioner of physical, surgical or psychological therapy to a person (including the provision of such therapy for the purposes of preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life) and includes the prescription or supply of drugs (Section 3, *Guardianship and Administration Act 1993*).

**Mental capacity** is the ability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs. This means having the ability to assess risks and benefits and appreciate and comprehend the nature and quality of the act that is to be done or has been done.

**Mental incapacity** is the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of:

- any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration of the brain or mind; or
- any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever.

(Section 3, *Guardianship and Administration Act 1993*.)

## **P**

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**Person-centred approaches** are the processes of working with a person to help identify and achieve things that they want, drawing on the supports and resources that are available around each person. The person with disability is at the centre of all decisions regarding their need for, and access to, services and supports.

As interpreted in the *Consent to Medical Treatment and Palliative Care Act 1995*:

*“Person responsible for a patient means—*

- if a guardian has been appointed in respect of the patient, and his or her powers as guardian have not been limited so as to exclude the giving of a consent contemplated by this Part and he or she is available and willing to make a decision as to such consent—that guardian; or*
- if paragraph (a) does not apply, but a prescribed relative of the patient who has a close and continuing relationship with the patient is available and willing to make a decision as to a consent contemplated by this Part—that prescribed relative; or*
- if paragraphs (a) or (b) do not apply, but an adult friend of the patient who has a close and continuing relationship with the patient is available and willing to make a decision as to a consent contemplated by this Part—that friend; or*
- if paragraphs (a), (b) or (c) do not apply, but an adult who is charged with overseeing the ongoing day-to-day supervision, care and well-being of the patient is available and willing to make a decision as to a consent contemplated by this Part—that person; or*

- (e) *if none of the preceding paragraphs apply, or otherwise with the permission of the Tribunal—the Tribunal on the application of:*
- (i) *a prescribed relative of the patient; or*
  - (ii) *the medical practitioner proposing to give the treatment; or*
  - (iii) *any other person who the Tribunal is satisfied has a proper interest in the matter.”*

**Physical restraint** is the use of any part of a person’s body to prevent, restrict or subdue free movement of another person’s body for the primary purpose of controlling that person’s behaviour. Physical restraint does not include brief physical contact to guide or redirect a person away from immediate potential harm or injury consistent with a service provider’s duty of care to that person or physical assistance with activities of daily living.

**Positive behaviour support** is a set of research-based strategies used to increase quality of life and decrease behaviours of concern by teaching new skills and making changes in a person’s environment. Positive behaviour support strategies are considered effective when interventions increase a person’s success, personal satisfaction and the enhancement of positive social interactions across work, academic, recreational and community settings. Valued outcomes include increase in quality of life as defined by the person’s unique preference and needs and positive lifestyle changes that increase social belonging.

A **positive behaviour support plan** provides support staff (and relevant others) with strategies designed to deliver a level of behaviour support appropriate to the individual needs of the person. If a person is displaying behaviours of concern and key stakeholders agree that it acceptable to intervene for changing the individual’s behavior, a Behaviour Support Plan will be developed by a positive behaviour support practitioner and consented to by the person or their substitute decision maker.

A **positive behaviour support practitioner** in South Australia is (1) a qualified developmental educator **or** (2) a person with an undergraduate degree with a recognised behavioural component **and** completion of a recognised, accredited positive behaviour support training program **and/or** a minimum of two years’ positive behaviour support experience.

**Pre-procedural** refers to a preparation given to a person before clinical procedures such as dental, podiatry, scans, x-rays and tracheostomy changes to help provide optimal conditions and enable the person to remain as comfortable as possible during the procedure.

The following persons are prescribed relatives of a person:

- A person who is legally married to the patient
- An adult domestic partner of the patient (within the meaning of the *Family Relationship Act 1975* and whether declares as such under that Act or not)
- An adult related to the person by blood or marriage
- An adult related to the person by reason of adoption
- An adult of Aboriginal or Torres Strait Islander descent who is related to the person according to Aboriginal kinship rules or Torres Strait Islander kinship rules (as the case requires).

The **Prescribing Person/Practitioner** is the appropriately qualified staff member who prescribes a restrictive practice and seeks the required authorisation to use the practice as set out in the **Restrictive Practices: Guideline for Assessing, Planning, Authorisation and Consent for Adults**.

**PRN medication (PRN)** is an acronym for 'pro-re-nata' a Latin phrase used in medicine to mean 'medication given as needed' or 'as the situation arises' (that is, the times of administration are determined by the needs of the person and not given at scheduled times, for example, analgesia for pain or fever, Ventolin for asthma, antihistamine for allergies, midazolam for seizures). PRN may also be used for chemical restraint (see definition of chemical restraint).

**Prone physical restraint** occurs when the individual is restrained lying face down.

**Protected person** means the person who is the subject of a Guardianship or Administration Order under Part 1, Section 3 of the *Guardianship and Administration Act 1993*.

**Psycho-social restraint** is the use of inappropriate strategies based on power or control to influence a person's behaviour. This includes but is not limited to directing the person's behaviour through voice tone, commands or threats and the use of punishment, including ignoring the person and withholding basic human rights, such as positive social interaction, personal belongings or a favoured activity.

## R

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The **restrictive practices compliance officer** is the person delegated by the Board to assess and where relevant endorse the disability service provider's use of a restrictive practice. Before endorsing the organisation's use of a restrictive practice, the restrictive practices compliance officer will ensure and document that particular requirements have been followed. In some organisations the compliance officer will sit on the Restrictive Practice Governance Committee. The restrictive practices compliance officer must not be the same person as the prescriber of the restrictive practice.

**Restrictive clothing** is customised clothing specifically designed to prevent the person from accessing any area of his/her body.

**Restrictive practices** refer to any practice, device or action that removes or restricts another person's freedom, movement or ability to make a decision. This includes detention, seclusion, exclusion, aversive intervention, chemical restraint, physical restraint, mechanical restraint and environmental restraint. Restrictive practices do not include therapeutic or safety devices/practices, where the device or practice is being used for its intended purpose and the person is not resisting or objecting to its use.

**Review** (by a medical practitioner), in relation to medication or treatment, means to:

- Assess the person's response to a medication regimen
- Decide whether to continue the medication for a further period
- Decide whether to continue the regimen without alteration or to modify the regimen
- If medication is to be continued, due consideration must be given to the effect, dose and frequency of such medication or treatment.

## S

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The **South Australian Civil and Administrative Tribunal (SACAT)** is a state tribunal that helps people in South Australia to resolve issues within specific areas of law, either through agreement at a conference, conciliation or mediation, or through a decision of the Tribunal at hearing. SACAT took over from the Guardianship Board the functions the Board exercised in respect to the *Guardianship and Administration Act 1993*.

**Safety device/practice** refers to a device or practice used for safety purposes not primarily related to behaviour (for example, lap belts or bed rails to prevent accidental falls or devices to enable the safe transportation of a person). This also includes environmental modifications for safety purposes, such as sensor mats and 'Walkabout' alarms.

**Seclusion** refers to the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is denied, prevented or not facilitated.

**Section 32 order** is an order that allows the enforcement of a guardian's decisions. It is made on application to South Australian Civil and Administrative Tribunal (SACAT) by a guardian (or enduring guardian) when the health or safety of a person is seriously at risk. If granted, Section 32 powers enable a guardian to give consent to the specific use of those powers. This can be in the form of a direction statement issued by the guardian that provides more specific detail (for example, where a person is to be detained and the details of the detention, including the circumstances of when a person can leave a facility). However, it is the actual SACAT order that gives the legal authority for the staff to administer a restrictive practice.

**Section 32 powers** are additional special powers that may only be applied to a person if it is authorised by South Australian Civil and Administrative Tribunal (SACAT) (formerly the Guardianship Board) on the application of the person's guardian. Section 32 can authorise the placement or detention of a person (Section 32 (1) (a) and (1) (b)) or authorise the persons involved in the care of the protected person to use such force as reasonably necessary for the purpose of proper medical or dental treatment, day-to-day care and wellbeing of the person (Section 32 (1) (c)).

Any use of force for treatment and day-to-day care must be approved by a guardian with Section 32 powers prior to being exercised. This may be in the form of an agreed behaviour management or treatment plan, or by the consent of that guardian to discrete episodes.

Section 32 of the *Guardianship and Administration Act 1993* states:

- “(1) The Tribunal, on application made by an appropriate authority in request of a person whom this section applies–*
- (a) may, by order, direct that the protected person reside–*
    - (i) with a specified person or in a specified place; or*
    - (ii) with such person or in such place as the appropriate authority from time to time thinks fit,*
- (whether or not the person or place is a person with whom, or the place in which, the person usually resides) according to the terms of the Tribunal's order; and*

- (b) *may, by order, authorise the detention of the person in the place in which he or she will reside; and*
  - (c) *may, by order, authorise the persons from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and wellbeing of the person.*
- (2) *The Tribunal cannot make an order under subsection (1) unless it is satisfied that, if such an order were not to be made and carried out, the health or safety of the person or the safety of others would be seriously at risk.”*

Section 32 powers should only be used as a last resort. They should only be used when the restrictive practice, detention or treatment of the person is required persistently over a consistent period of time. This situation could occur if the person is refusing to move residence or to have necessary treatment, and by doing so, is putting either his or her own health or safety, or the safety of others, seriously at risk.

Section 32 powers should only be considered in cases where reasonable discussion and persuasion has been ineffective. In all cases the least restrictive alternative should be pursued.

(Section 32 Powers Fact Sheet 11, Office of the Public Advocate.)

**Sensor alarm** is any device, electrical or mechanical, designed to alert staff to the mobility of a person.

A **splint** is a device prescribed by an appropriate clinician for therapeutic reasons, but once applied restricts the movement of the limb to which it is applied.

**Substitute decision-maker** is an adult appointed under an advance care directive who can make decisions about health care, end of life, living arrangements and other personal matters on behalf of a person during a period of impaired decision-making capacity, whether for a short time or permanently. In this document, it includes substitute decision-makers appointed under the former Enduring Power of Guardianship and Medical Power of Attorney.

**Supported decision-making** is the process of providing information, resources and tools needed to enable a person to make their own decisions.

**Support staff** refers to all staff that support one or more people in a direct interactive role.

**Supervision** is the responsibility of the service unit manager or delegate and may be both direct and indirect. Supervision requires evidence of reporting and recording of all aspects of intervention by both support staff and the service unit manager or delegate in compliance with the Individual and/or positive behaviour support plan.

**Supine physical restraint** is highly restrictive hold when a person uses their own body weight to hold someone face up.

## T

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**Therapeutic** use shall mean use in, or in connection with:

**Therapeutic device/practice** is a device or practice recommended by an appropriate health practitioner for the purpose of maintaining or restoring health or for the treatment of an illness or condition (for example, splints).

## Reference Documents and Links

### Legislation

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[Advance Care Directives Act 2013](#)

[Consent to Medical Treatment and Palliative Care Act 1995](#)

[Criminal Law Consolidation Act 1935](#)

[Guardianship and Administration Act 1993](#)

[Mental Health Act 2009](#)

[Powers of Attorney and Agency Act 1984](#)

### Department for Communities and Social Inclusion

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[Positive Behaviour Support Guide for the South Australian Disability Service Sector](#)

[Safeguarding People with Disability – Overarching](#) Policy

[Safeguarding People with Disability – Management of Care Concerns](#) Policy

[Safeguarding People with Disability – Restrictive Practices](#) Policy

[Safeguarding People with Disability – Supported Decision-Making and Consent](#) Policy

### Department of Social Services

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[Decision-Making Tool: Supporting a Restraint-Free Environment](#)

[National Standards for Disability Services](#)

[NDIS Quality and Safeguarding Framework](#)

### South Australian Civil and Administrative Tribunal

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[Administration](#)

[Applications](#)

[What is a Guardianship Order?](#)

[SACAT](#)

## **Office of the Public Advocate**

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[Administration Orders](#)

[Advance Directives](#)

[Assisting Someone with Decision Making](#)

[Consent to Medical and Dental Treatment for People with Mental Incapacity](#)

[Guardianship Orders](#)

[Informal Arrangements for People with Impaired Decision-Making Capacity](#)

[Making Decisions for Others](#)

[Restrictive Practices](#)

[Guardian Consent for Restrictive Practices in Residential Aged Care Setting](#) Policy

[Guardian Consent for Restrictive Practices in Disability Settings](#) Policy

[Special Powers](#)

[Substitute Decision Making](#)

## **Ombudsman South Australia**

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[Information Sharing Guidelines](#)

## **Health and Community Services Complaints Commissioner**

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[Code of Conduct for Unregistered Health Practitioners](#)

## **Nursing and Midwifery Board of Australia**

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[Framework for assessing standards for practice for registered nurses, enrolled nurses and midwives](#)

## **Other**

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[Universal Declaration of Human Rights](#)

## Resources

### Office of the Senior Practitioner, DCSI

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The Office of the Senior Practitioner works with disability service providers across the sector to look at how practices can be improved to ensure the rights of people with disability are upheld. It has a key focus on the minimisation and where possible, elimination of restrictive practices within disability services.

This role of Disability Senior Practitioner in South Australia is held by Professor Richard Bruggemann. The Office of the Senior Practitioner can be emailed at [OfficeoftheSeniorPractitioner@sa.gov.au](mailto:OfficeoftheSeniorPractitioner@sa.gov.au)

### Office of the Public Advocate

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The Office of the Public Advocate (OPA) provides an information service that can assist disability service providers to understand their responsibilities in relation to the rights of people with disability who have impaired decision-making capacity.

OPA can be telephoned on (08) 8342 8200 and 1800 066 969 (Country SA) or emailed at [opa@agd.sa.gov.au](mailto:opa@agd.sa.gov.au)

OPA's Guardian Consent for Restrictive Practices in Disability Settings Policy can be accessed here via [www.opa.sa.gov.au](http://www.opa.sa.gov.au)