



# **Aged care reform update – restrictive practices**

**This webinar will begin soon.**

# **Aged care reform update – restrictive practices**

**Zoom webinar – Wednesday 4 March, 6.30- 8:00pm**

# Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

# Learning outcomes

1. Explain the legislative requirements of restrictive practice for providers.
2. Describe psychotropic medications used in Aged Care, including informed consent, review, prescribing and deprescribing.

# Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Scan here to register for your next Primary Health Tasmania event



# Presenters



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# Behaviour support and Restrictive Practices in Aged Care

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4 March 2026





# Acknowledgement of Country

- Artwork by Dreamtime Creative





**Aged Care Quality  
and Safety  
Commission**

**We are the national  
regulator of aged care  
services.**

**We protect the health, safety, and rights of  
older Australians, ensure providers meet  
quality standards, manage complaints, and  
enforce compliance through monitoring,  
education, and regulating the aged care  
workforce.**

# Strengthened Quality Standards



- **Simplified, comprehensive, measurable**
  - from 8 to **7 standards**
  - from 42 requirements to 33 outcomes with **146 supporting actions**
- Strengthened **focus areas**
- Each standard has:
  - **intent** and **expectation statement**
  - **outcomes** and **actions**

## Change impact

- **13% new** expectations
- **63%** clarifying **current** expectations
- **24% aligned** to current requirements and legislation



## Overview of Restrictive Practice

- Only used as a last resort and discontinued when no longer a last resort.
- Must be assessed by an approved health practitioner.
- Alternative behaviour support strategies must be trialled.
- Proportionate to risk, in least restrictive form, and for shortest period.
- Continually monitored, reviewed and documented.
- Obtain informed consent from older person, or RPSDM.
- Comply with the Statement of Rights, Quality Standards, State or Territory laws, care and services plan, and behaviour support plan.

# Restrictive Practice

'any practice or intervention that has the effect of restricting the **rights** or **freedom of movement** of an individual'

Under the aged care legislation there are **five types** of restrictive practices:



Chemical



Environmental



Mechanical



Physical



Seclusion

# Environmental restraint

**Environmental restraint** is a practice or intervention that restricts, or that involves restricting, an individual's free access to all parts of the individual's environment (including items and activities) for the primary purpose of influencing the individual's behaviour.



Environmental

## Common Myths

- Only older people who have exit seeking behaviours or are trying to exit are subject to environmental restraint.
- If an older person is behind a locked door for security or safety, this is not considered an environmental restraint.
- If the front door is locked but the older person has free access to gardens, this is not environmental restraint.



# Physical restraint



Physical

**Physical restraint** is a practice or intervention that:

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

## Common Myths

- Holding an older person's hands while attending to personal care is not considered physical restraint.
- As long as the older person is not harmed, then it is not physical restraint.



# Mechanical Restraint

**Mechanical restraint** is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue an individual's movement for the primary purpose of influencing the individual's behaviour

But does **not** include the use of a device for therapeutic or non-behavioural purposes in relation to the individual.



**Mechanical**

## Common Myths

- Certain devices are restraint (e.g. bed rails, low beds).
- Bed Rails are banned by the Commission and cannot be used.
- A seat belt on a wheelchair is not a restraint.



# Seclusion

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



**Seclusion**

- (a) voluntary exit is prevented or not facilitated; or
- (b) it is implied that voluntary exit is not permitted; for the primary purpose of influencing the individual's behaviour.

## Common Myths

- Taking an older person to a lounge area if they are noisy or agitated is not seclusion.
- Seclusion does not apply if it's overnight.
- Seclusion used to teach a person a lesson is not a restrictive practice.



# Chemical restraint

**Chemical restraint** is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing an individual's behaviour, but does not include the use of medication prescribed for:

- (a) the treatment of, or to enable treatment of, the individual for:
  - (i) a diagnosed mental disorder; or
  - (ii) a physical illness; or
  - (iii) a physical condition; or
- (b) end of life care for the individual.



**Chemical**

## Common Myths

- the older person's diagnosis is the only factor that needs to be considered
- only as required (PRN) medication needs to be considered a RP
- BPSD, anxiety and agitation are considered a mental disorder
- a family member requesting a medication means it is not a chemical restraint.





# Assessing and Identifying Restrictive Practices



**Individualised assessment** is essential to determining when a practice or intervention is a restrictive practice or not.

The individualised assessment process should consider the older person and their circumstances, including:

- the effect of the practice or intervention has on the individual
- if the practice or intervention would restrictive the individual's **rights** or **freedom of movement**
- the purpose/reason of the practice or intervention.



# Legislative requirements: informed consent for Restrictive Practice (residential)



Requirements for any restrictive practice in accordance with the *Aged Care Rules 2025*:

A **description** of the registered provider's consultation about the ongoing use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), with

- (i) the individual; or
- (ii) if the individual lacks the capacity to give informed consent to the ongoing use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

A **record** of the giving of informed consent to the ongoing use of the restrictive practice by:

- (i) the individual; or
- (ii) if the individual lacks capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.



# Informed Consent for Restrictive Practices

## An informed consent conversation should cover:

the proposed practice or intervention

the reasons the practice or intervention is proposed or assessed as necessary including how it will be used, its duration, frequency and intended outcome

the actual or potential risks of the practice/intervention and the behaviour relevant to the need for the use of the restrictive practice

the options and best practice alternative strategies

the risks and benefits of each option and what this might mean for the individual

the side effects, potential harms or impact, and what monitoring will occur

A best practice consent process must involve communicating understandable and sufficient information with the person (or if required their RPSDM).

The person making the decision must be able to:

- understand the information
- communicate their decision
- have opportunity to ask questions
- And this conversation/consultation must be appropriately documented.



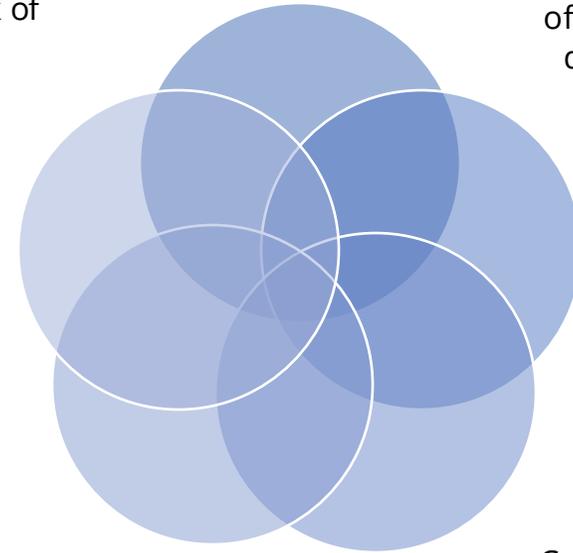


# Capacity

People are presumed to have capacity until found not to.

Lack of capacity cannot be presumed from a lack of consent.

For any action taken on the basis that a person doesn't have capacity, the burden of proof to prove they don't have capacity sits with you.



An older person's dignity of risk must always be respected.

Capacity can fluctuate and may be regained in some instances.



# Restrictive Practice Substitute Decision-Maker (RPSDM)

- Where an older person does not have capacity to provide informed consent.
- In the first instance, appointed under State or Territory laws.
- Where a State/Territory appointment framework does not exist, RPSDM appointed in accordance with the commonwealth legislative hierarchy.
- Priority is given to restrictive practices nominees appointed by the older person when they still had the capacity to consent.
- Commonwealth hierarchy in place to 1 December 2026, by which time all states and territories are to have systems in place.

# Commonwealth Interim Hierarchy – RP Consent

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1. Restrictive Practices Nominee

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2. Partner of Care Recipient

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3. Relative or Friend of Care Recipient who previously cared for them

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4. Relative or Friend of Care Recipient

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5. Medical Treatment Authority



# Invalid Consent Process - Example

## Restraint Authorisation Form

Name: Mr Bill Jones

It is Homely Home's policy to only use restrictive practices when needed and after alternative options have been tried.

I consent to the need for mechanical restraint for Mr Jones and have been advised of the safety risks.

Representative signature:



Medical Practitioner signature:



Date: 10/05/2025

This does **not** evidence appropriate consultation/discussion to show valid informed consent was obtained. Information is non-specific and generic.

Specific information about the restrictive practice is **not** included.

This form does **not** provide evidence that the informing or consent process was done properly.

Only signing a consent form can indicate informed consent is **not** valid.



# Understanding Restrictive Practice Requirements - Residential

Restrictive Practice	Informed consent: individual or RPSDM	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Monitor</li> <li>• Review</li> <li>• Evaluate &amp;</li> <li>• Documented</li> </ul>	Behaviour Support Plan	Alternative strategies considered, trialled and used	RP used as a... <ul style="list-style-type: none"> <li>• last resort</li> <li>• least restrictive</li> <li>• shortest period</li> </ul>	Who can assess the need for the restrictive practice?
Chemical	✓	✓	✓	✓	✓	Medical Practitioner Nurse Practitioner
Environmental	✓	✓	✓	✓	✓	Approved health practitioner
Mechanical	✓	✓	✓	✓	✓	Approved health practitioner
Physical	✓	✓	✓	✓	✓	Approved health practitioner
Seclusion	✓	✓	✓	✓	✓	Approved health practitioner

In accordance with the *Aged Care Rules 2025*, an approved health practitioner means a **medical practitioner, nurse practitioner or registered nurse**.





# Funding for Dementia Behaviour Support

- Three tiers of national dementia behaviour support programs:
  - Tier 1: DBMAS (\$113.8 million from 2024-25 to 2027-28)
  - Tier 2: SBRT (\$89.8 million from 2024-25 to 2027-28)
  - Tier 3: Specialist Dementia Care Program (\$183.8 million from 2024-25 to 2027-28)
- Complemented by the Hospital to Aged Care Dementia Support Program (\$54 million from 2024-25 to 2027-28), and Dementia Training Program (\$67.4 million from 2024-25 to 2027-28).



# Best Practice Behaviour Support Planning

Behaviour Support Plans (BSP) are required for...

(1) any individual who experiences changed behaviour (defined by Dementia Support Australia (2021) as 'any behaviour which causes stress, worry, risk of or actual harm to the person, carers, family members or those around them')

**and/or**

(2) any individual who may require the use of restrictive practices as part of their care to manage clearly articulated risks of harm.



## Practice reminder:

It is **best practice** to have a behaviour support plan for all older people who require behaviour support.

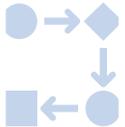


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# Person-centred Behaviour Support Plans (BSP)

## Provider responsibilities

 Informed by comprehensive and ongoing assessment to create a cohesive, fit-for-purpose and meaningful plan

 Comprehensive information about the individual and changed behaviours

 Outlines person-centred strategies that consider and support unique and individualised needs and preferences

 Reviewed and updated on a regular basis, and after a change in the individual's circumstances



### **If a Restrictive Practice is used, the BSP must set out:**

- The assessment and information about the restrictive practice being used
- Information that guides staff on the use of the restrictive practice, including how it is to be used, its duration, frequency, intended outcome, monitoring and review
- Details of any engagement from external support services
- Evidence of valid informed consent



# Case study One

- Mr Brown, 79 Year old male, residing in RACF
- Mr Brown has diagnosis of depression, osteoarthritis and Alzheimer's Disease
- An incident occurred on 20/01/26 where Mr Brown became agitated and physically hit another older person in the head. Staff moved Mr Brown away but could not de-escalate his behaviours with reassurance and distraction strategies.
- The RACF emailed the GP to review Mr Brown due to the incident and his escalating behaviours.
- The GP reviewed Mr Brown at the RACF and following assessment prescribed Risperidone for a short period of time and requested 2 weeks of behaviour monitoring.
- The RACF requested the GP to complete and sign several documents about the medication.

**What are the responsibilities of the GP in this scenario?**



# Case study Two

- Mrs Smit, 86 year old female, admitted to hospital from the community with BSPD and delirium.
- Mrs Smit's daughter is the appointed substitute decision-maker.
- The daughter made the decision for Mrs Smit to be discharged to a RACF due to her gradual decline and increased care needs requiring 24/7 support.
- On admission, the GP had a comprehensive care consultation with the daughter to review Mrs Smit's medical history, medications and current treatment plan.
- The service called the GP and requested an "appropriate diagnosis" to be listed for the quetiapine prescribed on Mrs Smit's medication chart.

**What is the role of the prescriber and the provider in this scenario?**



# Resources



Webinars

<https://www.youtube.com/watch?v=0bezRKNi5wc>  
[https://www.youtube.com/watch?v=Np\\_KeUjMXCA](https://www.youtube.com/watch?v=Np_KeUjMXCA)



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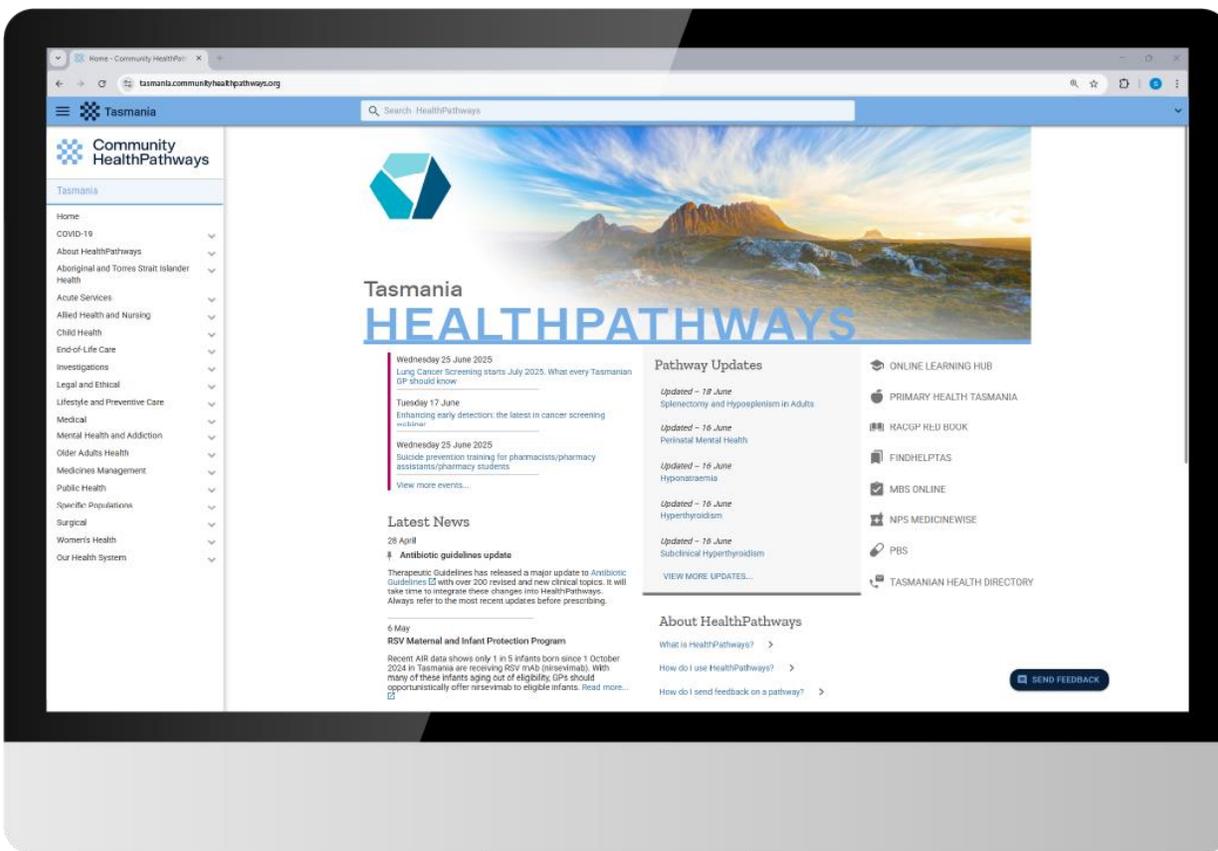
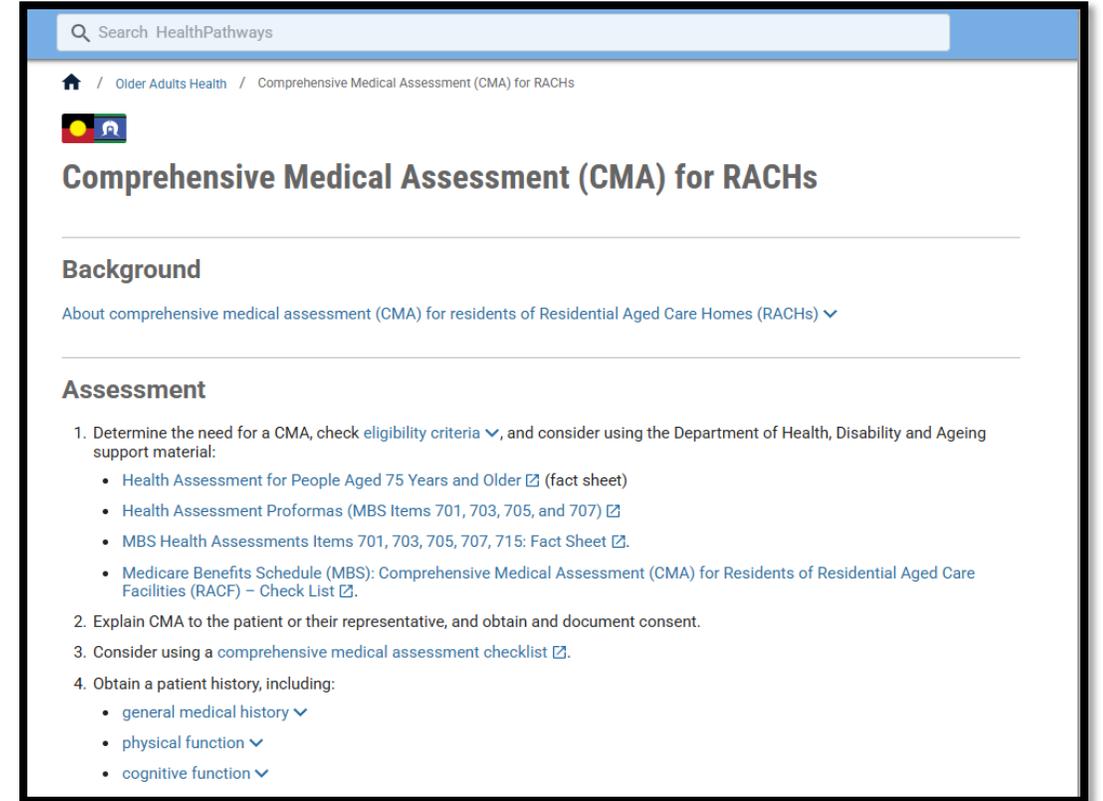
**Q&A**



# Tasmanian HealthPathways

is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

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Home / Older Adults Health / Comprehensive Medical Assessment (CMA) for RACHs

## Comprehensive Medical Assessment (CMA) for RACHs

### Background

About comprehensive medical assessment (CMA) for residents of Residential Aged Care Homes (RACHs) ▾

### Assessment

- Determine the need for a CMA, check [eligibility criteria](#) ▾, and consider using the Department of Health, Disability and Ageing support material:
  - [Health Assessment for People Aged 75 Years and Older](#) (fact sheet)
  - [Health Assessment Proformas \(MBS Items 701, 703, 705, and 707\)](#)
  - [MBS Health Assessments Items 701, 703, 705, 707, 715: Fact Sheet](#)
  - [Medicare Benefits Schedule \(MBS\): Comprehensive Medical Assessment \(CMA\) for Residents of Residential Aged Care Facilities \(RACF\) – Check List](#)
- Explain CMA to the patient or their representative, and obtain and document consent.
- Consider using a [comprehensive medical assessment checklist](#).
- Obtain a patient history, including:
  - [general medical history](#) ▾
  - [physical function](#) ▾
  - [cognitive function](#) ▾



**tasmania.communityhealthpathways.org**

# Aged Care Reform series

## Aged Care Reform Update for GPs: New Strengthened Aged Care Quality Standards

### Resource List

Aged Care Reform Update for GPs New Strengthened Aged Care Quality Standards



Aged Care for Tasmanian GPs series - Primary Health Tasmania powerpoint



Online learning - Alis | Aged Care Quality and Safety Commission



Now available to view on Primary  
Health Tasmania's Learning Hub

Password: phlearning



# Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact [events@primaryhealthtas.com.au](mailto:events@primaryhealthtas.com.au)

**Thank you**



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