

Submission to Restraints Principles Review

Submission by the
Australian Physiotherapy Association

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Department of Health on the Restraint Principles Review.

The use of physical and chemical restraints within residential aged care is actively discouraged under legislation.

The APA supports using restraints as a “last resort”. However, current definitions capture many necessary safety aids as restraints – having an impact on the care of older people.

For example, applying brakes on a wheelchair may be a restraint but in many circumstances applying the brakes is enabling a person to walk. (See Case Study 2)

We are seeking clearer definitions and terminology to ensure older people don’t miss out on the care they need.

The use of restraints is often driven by a need to “manage” behavioural and psychological symptoms of dementia (BPSD). It is known that BPSD is often an expression of unmet needs such as pain, loneliness or need for intimacy, hunger, boredom and overstimulation¹. Prevention and pre-emptive practice, rather than reactive management is needed.

When considering the use of a restraint that there should be evidence of multidisciplinary assessments (inclusive of allied health) into possible triggers for the need for restraint, for example pain.

Appropriate process must be in place to ensure the use of restraints as a last resort. There should be evidence of alternative strategies that have been trialled and evaluated.

These assessments should be evidenced based and in line with what is considered “best practice”.

Consent must be obtained from the consumer and family when using any form of restrictive practice. There needs to be evidence of ongoing re-evaluation and any intended consequences related to the use of restraint.

By following this process we can protect the rights of the individual and ensure that restraint is only used as a last resort.

Unfortunately, therapeutic use of appropriate equipment to assist older people also falls within the definition of restraints. This may include moving a bed to provide greater space and enabling greater access opportunity in a room or the use of a hoist to reduce pain.

Auditing of facilities that produce tallies of restraint use do not provide a true representation of restraint. Each facility is different and is home to individuals with individual needs. For example, a “locked” facility cannot be compared to one that locks rooms on an ad hoc basis.

The APA encourages the use of person-centred multidisciplinary care planning with the consumer that explores the “intent to restrain” versus the “intent to enable” on an individual basis

Recommendations

Recommendation 1

Enable person-centred multidisciplinary assessment and care planning with the consumer that explores the “intent to restrain” versus the “intent to enable” on an individual basis

Recommendation 2

Recognise allied health as a professional group to work more fully across their scope of clinical knowledge and assess, provide guidance and evaluate restraint in RACF.

Recommendation 3

Align terminology with that used to support people living with disability and terminology moves towards the words “restrictive practice”

Recommendation 4

Align community and residential aged care standards with NDIS to support continuity of care with consistent terminology across both sectors.

The scope of physiotherapy for older Australians

The physiotherapy profession is a fundamental provider of high quality, safe services for ageing Australians and it is important they are able to access it when and how they need it.

Physiotherapists play a substantial role working with and supporting the older person in maximising their health, wellbeing and quality of life as they age.

A broad range of physiotherapist-led interventions is effective and cost-effective in improving physical ability and function.

Physiotherapy is effective and provides economic value in areas including:

- Maintaining and improving mobility
- Pain management
- Falls prevention and reduction
- Independence in activities of daily living
- Behavioural and psychological symptoms of dementia
- Improved functioning
- Optimising comfort
- Continence, and
- Quality of life and wellbeing

The profession's broad scope also includes the management of fatigue, shortness of breath, exercise tolerance, oedema, deconditioning, frailty, contractures, sleep and rest, skin integrity, and more across the ageing continuum, and including environments such as the RACF and community care setting.

A core element of this scope is assessment of a person's capacity to move, and keep moving.

It is important older people have access to physiotherapy care when and how they need it.

People living with dementia

There are an increasing number of older people living with dementia in the community and residential aged care facilities. Physiotherapists play an integral role in providing quality care services to these individuals.

Currently 52% of individuals living in residential aged care residences have a diagnosis of dementia with many more community members living with the life limiting condition (Harvey L et al, 2016)².

Physiotherapists have the skills and knowledge to support and prescribe activities and exercises for individuals living with dementia, considering factors such as fluctuating cognition and mobility.

For example, a physiotherapist may provide a person with dementia with practical tailored approaches to improve motor symptoms such as weakness, gait, balance and functional decline. Importantly, these interventions play a key role in preventing falls among people living with dementia.

Research shows that physiotherapy prescribed exercise delivered to individuals with dementia in residential aged care residences have demonstrated significant improvements in cognition, agitation, mood, mobility and functional ability (Brett L et al, 2016)³.

Dementia is an independent risk factor for falls and for serious injury such as head injury or hip fracture from falls. However, research shows people with dementia had longer lengths of stay in hospital, except for people with dementia with hip fractures. This population had less in-hospital rehabilitation than people without dementia and shorter LOS, an average of seven days (Harvey L et al, 2016)⁴.

Despite evidence that people living with dementia can benefit from rehabilitation if they already live in residential aged care they are often denied the chance (Kaambwa B et al, 2017)⁵.

Physiotherapists also work closely with those living with dementia to look for root causes of adverse responsive behaviours that may lead to medical restraint, such as pain. We know that pain is often underdiagnosed and poorly treated in older people living in residential aged care residences, particularly for those people living with dementia⁶.

1. Has there been any impact of the Restraints Principles on the work of allied health professionals in residential aged care?

- a. *Have your members' work practices when visiting or interacting with providers changed as a direct result of the introduction of the Restraints Principles?*
- b. *Have your members' work practices changed when interacting with residents/families/consumers?*
- c. *Has there been a change in the use of physical / chemical restraint? Have you observed changes that providers have made to management and direct care practices to operationalise the Restraints Principles?*
- d. *Has this impacted the care and services delivered to consumers?*
- e. *Has this impacted the care and services your members deliver to the consumers at the provider?*
- f. *Have there been any unintended consequences of the introduction of the Restraints Principles?*

Physiotherapists have noticed a positive awareness about the use of restraint within Residential Aged Care Facilities (RACF). Overall, RACF have been moving towards reducing the use of physical and chemical restraint.

Physiotherapists have been invited to comment on whether a device is safe to use, whether one device is preferred over the other or if it is considered a restraint.

However, this is more of a “one off” and limited assessment and not using a physiotherapist as part of the assessment and management planning multidisciplinary team (MDT), including to implement interventions that may reduce or eliminate the need for restraint.

Physiotherapists who have been part of a comprehensive MDT, applying an individualised biopsychosocial person-centred approach, have commented on excellent consumer outcomes:

- minimising or completely eliminating the need for restrictive practices
- contributing to improved health and wellbeing of the consumer, and
- improved quality of life.

There are also reported benefits involving family, other residents and family and staff.

The APA suggests that the use of physiotherapists, in a “one-off” manner is related to Aged Care Funding Instrument (ACFI), which does not fund assessments and interventions that prevent or minimise the use of restraint.

The use of restraints is often driven by a need to “manage” behavioural and psychological symptoms of dementia (BPSD). It is known that BPSD is often an expression of unmet needs

such as pain, loneliness or need for intimacy, hunger, boredom and overstimulation⁷. Prevention and pre-emptive practice, rather than reactive management is needed.

Exercise widely recognised as a validated therapy and preventative intervention for pain, falls, sleep hygiene and mental health⁸.

A physiotherapist simply walking outdoors with an older person assists in managing pain, preventing falls, promoting sleep and promoting feelings of self-worth. However, this is not an intervention that is funded under ACFI.

An unintended consequence of discouraging the use of restraints that physiotherapists have encountered is that some equipment designed to enable a person is being classified as restraint.

A half-bed rail in the community setting may be deemed as an enabling device but in RACF is classified as a form of restraint. This has ignited many confusing and frustrating conversations with consumers and family when they feel they are unable to access a device in RACF that they have used for some time in the community setting.

To combat this issue, the APA encourages the use of person-centred multidisciplinary assessment and care planning with the consumer that explores the “intent to restrain” versus the “intent to enable” on an individual basis.

Physiotherapists also have recognised that RACF are fearful of being “labelled” as using restraint. Our current Quality Indicators summate restraint and although this may be essential for data collection it does not always give a true representation of restraint.

For example, two forms of restraint may be marked in the case of a person living in a locked facility with their bed against the wall. The bed against the wall may be an enabling action to create more space for the person to move freely within their room and it may be their choice. In this scenario, there should be one form of restraint marked, the locked facility.

Once again, the APA encourages the use of person-centred multidisciplinary care planning with the consumer that explores the “intent to restrain” versus the “intent to enable” on an individual basis.

The APA suggests it would be helpful to include examples in the Restraint scenarios (from the ACQSC), that clearly articulate and demonstrate best practice, with a multidisciplinary approach inclusive of allied health.

2. Has there been any impact of the Restraints Principles on the work of allied health professionals in residential aged care? – Repeat question

3. Do changes need to be made to the Restraints Principles?

- a. *Do you think the Restraints Principles cover all the critical matters about use of restraints?*
- b. *Are there other critical matters that you think should be addressed by the Restraint Principles?*
- c. *Are changes needed to ensure protection of human rights?*
- d. *Do the Restraint Principles promote consumer dignity and choice?*
- e. *Are additional supports needed for providers or consumers to minimise the use of restraint?*
- f. *Are changes needed to the Restraints Principles to better achieve their intended purpose of minimising restraint?*

The APA strongly feels that allied health, including physiotherapy, should be stated as a professional body that can assess and evaluate on the use of restraint.

In certain organisations, it is common practice that allied health are requested in RACF to work more fully across their scope of clinical knowledge and assess, provide guidance and evaluate restraint. However, in the current legislation, they are not a recognised professional group to do so.

The APA advocates for multi-disciplinary care as a basic requirement before reaching the “last resort” and in the facilitation of person-centred care and that, this MDT approach must include allied health.

The APA suggest that the terminology moves towards “restrictive practice.” This would align restraint better with the terminology used to support people living with disability.

Both community and residential aged care are governed under the same standards. The APA support continuity of care for people from the Community to Residential Aged Care and familiar, similar terminology and language continuity is one part of this process.

We also want to highlight restrictive practice encompasses all types of restraint. It extends beyond giving attention to just “objects,” and supports a mind-shift towards the consideration of actions and practice and adopts a human rights approach.

Under the current legislation, limiting someone’s social outings may be overlooked as a form of restraint.

The APA once again supports the importance of a person-centred multidisciplinary approach in partnership with the consumer to evaluate whether a process is restraining or enabling.

Our current approach is a very “black or white” one, frequently lacking clinical reasoning (from lack of an MDT approach) and the APA are concerned that people are denied practices or devices that they may use to enable and improve their quality of life.

This is a direct conflict with many of the rights set out in the Charter of Aged Care Rights, including the right to:

- safe and high quality care and services
- be treated with dignity and respect and
- have control over and make choices about my care, and personal and social life, including where the choices involve personal risk
- humane consumer dignity and choice.

The APA believes that “intent to restrain” should be terminology within the principles.

The APA recommends that when considering the use of a restraint that there should be evidence of multidisciplinary assessments (inclusive of allied health) into possible triggers for the need for restraint for example pain.

There should be evidence of alternative strategies that have been trialled and evaluated.

These assessments should be evidenced based and in line with what is considered “best practice”. Consent must be obtained from the consumer and family when using any form of restrictive practice. There needs to be evidenced of ongoing re-evaluation and any unintended consequences related to the use of restraint. By following this process, we can protect the rights of the individual and ensure that restraint is only used as a last resort.

4. Are you aware of regulations in other jurisdictions that could inform the use of restraint in aged care?

a. What can the aged care sector learn from other sectors that are working to minimise restraint, for example, the NDIS, mental health, and healthcare sectors?

As stated previously NDIS when supporting people living with disability uses the terms “restrictive practice” not physical or chemical restraint. There are many more sub-heading under restrictive practice.

We need to consider what is considered best practice for promoting mental health, well-being, adopt those strategies and request for funding so those strategies can be effectively implemented into Aged Care.

The NDIS mandates the use of a minimum of two allied health practitioners.

The following case studies illustrate the ambiguity of restraint and times and the challenges under the current funding instrument.

Case studies

The following case studies illustrate the ambiguity of restraint and times and the challenges under the current funding instrument.

Case study 1 – intent to restrain or intent to enable

In both the following case studies by adopting a person-centred multidisciplinary care plan it assists in the clinical justification for the practice and the consumer's goals being met.

A man living with moderate dementia has fallen between his bed and the sliding glass door/window in the night when attempting to go to the toilet. With consultation with his family the bed was changed to be positioned up against the wall, this made a clear obvious path of how to access the toilet.

The intent was to enable the person to find the bathroom, however, under current recommendations the bed against the wall may be classified as a restraint.

Case Study 2 - intent to restrain or intent to enable

A person uses a self-propelled wheelchair during the day, the person is able to stand and walk short distances but not long distances. The person requires the brakes applied to the wheelchair to push safely to stand from a stable surface.

The RACF says they cannot apply the brakes to the wheelchair, as it is a restraint.

In certain circumstances, brakes on a wheelchair may be a restraint but in this circumstance, applying the brakes is enabling someone to walk.

Case Study 3 - ACFI is a barrier to minimising restraint

Scenario 1 A carer gives a spoon full of food to a person the person gets upset, annoyed and pushes the food off the table. A person may be given a medication to attempt to control this behaviour.

Scenario 2 The carer talks to the person, sits beside them, places the spoon and food in front of them. The carer points to the spoon, points to the food, talks about the food and may even model by eating their own food. The person “copies” and eats the food themselves.

Scenario 1 receives a much higher funding under ACFI than scenario 2 even though the same amount of resources (carer) are involved. A RACF is exposed to funding loss by documenting strategies explained in scenario 2.

Conclusion

The APA is committed to improving the quality of care provided to older Australians. We would welcome the opportunity to work closely with the Department of Health in further revision of the Principles and implementation of the outcomes.

Australian Physiotherapy Association

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 28,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

References

- ¹ Peisah (2019) Amised opportunity to improve practice around the use of restraints and consent in residential aged care: Limitations of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 Australian Journal of Ageing DOI: 10.1111/ajag.12757
- ² The National Centre for Social and Economic Modelling NATSEM (2016) Economic Cost of Dementia in Australia 2016–2056 Harvey L, Mitchell R, Brodaty H, Draper B, Close J (2016) Differing trends in fall-related fracture and non-fracture injuries in older people with and without dementia. *Archives of Gerontology and Geriatrics* 67: 61-67.
- ³ Brett L, Traynor V, Steapley P. Effects of physical exercise on health and well-being of individuals living with a dementia in nursing homes: A systematic review. *Journal of American Medical Directors Association*. 2016;17:104-16.
- ⁴ Harvey L, Mitchell R, Brodaty H, Draper B, Close J (2016) Differing trends in fall-related fracture and non-fracture injuries in older people with and without dementia. *Archives of Gerontology and Geriatrics* 67: 61-67.
- ⁵ Kaambwa B, Ratcliffe J, Killington M, Liu E., Cameron I, Kurrle S, Davies O, Crotty M (2017) Is hip fracture rehabilitation for nursing home residents cost-effective? Results from an RCT *Innovation in Ageing* (1)946
- ⁶ http://www.health.nsw.gov.au/Hospitals/Going_To_hospital/cost-of-care/Pages/default.aspx
- ⁷ Peisah (2019) Amised opportunity to improve practice around the use of restraints and consent in residential aged care: Limitations of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 Australian Journal of Ageing DOI: 10.1111/ajag.12757
- ⁸ <https://www.healthdirect.gov.au/physical-activity-guidelines-for-older-adults>

Further references

The following references and links maybe useful resources in the restraint review process.

Bellenger et al 2018 Prevention of physical restraint use among nursing home residents in Australia International Journal of Older people Nursing: DOI:10.1111/opn.12218

<https://www.mentalhealthcommission.gov.au/Mental-health-Reform/Reducing-restrictive-practices>

<https://www.legislation.gov.au/Details/F2019L00511>

<https://www.agedcarequality.gov.au/media/87628>

<https://www.agedcarequality.gov.au/resources/psychotropic-medications-used-australia-information-aged-care>

<https://www.agedcarequality.gov.au/resources/self-assessment-tool-psychotropic-medications>

<https://www.agedcarequality.gov.au/resources/scenarios-involving-physical-andor-chemical-restraint>

<https://www.ndiscommission.gov.au/regulated-restrictive-practices>

<https://www.healthdirect.gov.au/physical-activity-guidelines-for-older-adults>