Aged Care - Working with People with Challenging Behaviours in Residential Aged Care Facilities

Summary  Population ageing will result in increased demand for health and aged care services. Thus, it will be critical to increase the capacity of a range of services to provide appropriate care and support for older people with complex care needs. This document, Guidelines for Working with People with Challenging Behaviours in Residential Aged Care Facilities - using appropriate interventions and minimising restraint, aims to improve long term care options for older people with severe behavioural and psychological symptoms associated with dementia and/or mental illness and support residential aged care staff in providing quality care for their residents. This document constitutes a substantially revised version of earlier guidelines, the Best Practice Model for the use of Psychotropic Medication and Guidelines on the Management of Challenging Behaviour in Residential Aged Care Facilities in NSW.

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Secretary, NSW Health
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
Guidelines for working with people with challenging behaviours in residential aged care facilities – using appropriate interventions and minimising restraint
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The rapid ageing of the Australian community will result in an increased demand for health and aged care services. In this context, it is critical to enhance the capacity of a range of services to provide appropriate care and support for older people with complex care needs. There are, in particular, specific issues and challenges in caring for older Australians in residential aged care facilities experiencing behavioural disturbances associated with dementia and/or mental illness.

The Guidelines for working with people with challenging behaviours in residential aged care facilities have been developed for clinical staff working in these facilities in NSW to guide them in caring for residents with challenging behaviours while ensuring the residents live their lives with dignity and within a secure place of residence.

The Guidelines propose clear procedures for the assessment and the development of care plans and for ensuring the rights of the resident are upheld by residential aged care facilities. The document will assist residential aged care facilities to review their practices, policies and protocols regarding the issues of restraint, medication use and management of challenging behaviour to ensure they reflect the evidence base and the views and experiences of the community as a whole. The Guidelines will also assist in improving staff skills in caring for older people within these environments.

These guidelines are one of a number of initiatives being undertaken by NSW Health to improve long term care options for older people with severe behavioural and psychological symptoms associated with dementia and/or mental illness. Other key initiatives include: a report on best practice models to facilitate appropriate assessment, management and long term care for older people with severe behavioural disturbance, entitled The management and accommodation of older people with severely and persistently challenging behaviour, and a review of NSW Health’s CADE Units to inform policy and planning regarding the role of these units in the continuum of care for older people with severe behavioural disturbance. These initiatives are intended to support and complement the development of Specialist Mental Health Services for Older People (SMHSOP) across NSW, guided by a ten year Service Plan for SMHSOP.

The Guidelines for working with people with challenging behaviours in residential aged care facilities have been developed by key specialists in the field of aged care and I would like to take this opportunity to thank them for their dedication in working towards improved clinical management of Australia’s ageing population. The Guidelines will build on the last decade of reform in aged care in NSW to improve the quality of care for older people with complex care needs living in residential aged care facilities.

Robyn Kruk
Director General, NSW Health
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SECTION 1

Introduction

The Guidelines for working with people with challenging behaviours in residential aged care facilities constitute a substantially revised version of earlier guidelines originally released by NSW Health in October 2000, entitled The best practice model for the use of psychotropic medication and guidelines on the management of challenging behaviour in residential aged care facilities in NSW. The purpose of this earlier document, including a training manual, was to inform the safe practice of physical and chemical restraint in the management of challenging behaviour in residential aged care facilities in NSW.

In 2003, the Older People’s Mental Health Planning Group, convened by NSW Health, recommended the review of the document to update the current relevancy of the material to reflect changes in practices and policies that have taken place since the document was first written and to present the information in a more user-friendly, consumer driven format.

The Guidelines for working with people with challenging behaviours in residential aged care facilities recognise the rights of older Australians, living in residential aged care facilities (RACFs), to quality health services and a dignified, independent and secure life. To ensure this right is met, residential aged care facilities need to be resourced and managed appropriately to ensure that the dignity of all residents is maintained to the greatest degree possible.

The Guidelines aim to help all staff in residential aged care facilities meet their responsibilities while caring for residents with challenging behaviours to ensure the residents live their lives with dignity and within a secure place of residence. This includes the maintenance of a resident’s skills where possible, ensuring access to community life and activities, encouraging and fostering relationships with family and friends, the protection of the person’s privacy and maximising the person’s level of independence on a day to day basis.

These principles must also be applied to carers, families and friends. Following entry to a residential care facility, the carer’s role may change in some way but it is vital that the carer’s role is respected and that ongoing involvement and partnership is actively encouraged and supported.

The Guidelines for working with people with challenging behaviours in residential aged care facilities aim to:

- improve the quality of care for residents living within residential care settings
- improve orientation and training of staff working in residential care facilities
- inform responsive development of policy and protocols
- increase the capacity of the residential aged care sector to provide appropriate assessment and care for older people with challenging behaviour.

In this document, ‘people with challenging behaviour’ refers to people whose behaviour causes stress or distress to the person with the behaviour or any number of other people interacting with them including other residents, care staff, family and friends. Challenging behaviours are associated with a decline in their cognitive capacity, generally due to dementia and/or psychiatric conditions such as schizophrenia, bipolar affective disorder, anxiety disorders and agitated depressive states.

While the document discusses the issues surrounding older people living in the residential care environment, it is acknowledged that this is not an exclusive group and that younger people are also residents in these environments. The differences between these groups should be considered when applying the information contained within this document.

The information provided in this document can assist residential aged care providers to provide optimal care for older residents who have challenging behaviours. It will inform the development of local policies, protocols and practices regarding issues of restraint, medication use and management of challenging behaviour and improve staff skills in caring for older people within these environments. It will contribute to safer environments, which optimally reflect the views of older people and their families and friends.
and best interests of the residents, their ‘persons responsible’ and the community at large.

References to additional tools, guidelines, resources and supplementary and supportive material have been included in this document. It is anticipated that these references will lead to discussion and the development and implementation of policies and practices that enhance the quality of life of older people residing in residential aged care facilities within NSW.

The inclusion of information about medications is provided with the explicit understanding that whilst medications are prescribed and reviewed by medical practitioners, information about them may be beneficial to the overall knowledge of all residential care staff.
2.1 Challenging behaviours in RACFs

As noted in the NSW Health report on the Management and accommodation of older people with severely and persistently challenging behaviours (refer to page 26 Guidelines – supporting policy documents) challenging behaviour is considered one of the most difficult issues facing residential care providers in NSW. Residents may exhibit challenging behaviour in the residential care setting for a number of reasons. This behaviour is common in dementia but may also be related to a range of other medical and psychiatric conditions such as schizophrenia, bipolar affective disorder, anxiety disorders and agitated depressive states. People with dementia may also have pre-existing mental disorders which may further complicate their management. When challenging behaviour occurs, it can be distressing not only to the person affected but also to carers, family and friends, residential care staff and other residents.

There are a number of complex and interactive presentations which may occur, which may have a combination of behavioural and psychological components and may include psychotic features such as hallucinations. Other issues which may impact on or influence challenging behaviour in the residential care setting include delirium, depression and dementia. With complex presentations, at times, it may be necessary for RACFs to seek the expertise and assistance from specialist mental health services for older people (SMHSOP), specialist aged care and/or dementia services.

Caring for people with challenging behaviour requires a holistic and individualised approach. Many challenging behaviours can be prevented by providing effective person-centred care which accommodates individual differences and requires a thorough understanding of the resident including their cultural, linguistic and religious background, their sense of identity and life experiences. This understanding is imperative to inform the effective assessment, treatment and delivery of appropriate interventions that are tailored to a person’s specific needs. Such care is respectful of individuality and aims to promote dignity and quality of life through maximizing independence and providing opportunities for pleasure and enjoyment.

The first step in the management of behavioural and psychological symptoms involves the careful assessment and appropriate response to any physical, biological, psychosocial, cultural or environmental triggers, or other perpetuating factors including pain.

A range of interventions may be used to prevent challenging behaviours as well as respond to them (refer to Section 3). Prior to a discussion of these interventions, it is important to outline the responsibilities of RACFs in the management of challenging behaviours, explore the factors influencing challenging behaviours in residential aged care facilities and discuss how to undertake an assessment process that aims to identify causal factors.

2.2 Responsibilities of RACFs

RACFs must provide services according to the requirements of the law. It is important that residents are not exposed to unlawful acts (such as ‘assault’ and ‘battery’) and are safe within the place of residence. Residences need to be equipped, operated and maintained in accordance with current occupational health and safety practices to minimise the risk of accident or injury to residents and carers and to allow them access to staff as required.

RACFs should be able to provide the services that each resident needs. Occasionally, these needs will exceed the capacity of the environment to safely and appropriately care for the person concerned. If a residential aged care facility cannot provide the services needed by a person, it should not accept that person as a resident. If needs increase significantly following entry to the residence, the most appropriate supports, interventions, resources and options should be sought.

Staff of RACFs must regularly review the circumstances of each resident to ensure any relevant adjustments are made to their individual care plan and regularly review their practices, policies and protocols to ensure they reflect the views and expectations of the community and society as a whole.
2.3 Factors influencing challenging behaviour in RACFs

Delirium, depression and dementia may additionally affect the presentation of challenging behaviour. They may occur in isolation, in a combination of two or all three or with concomitant physical or psychological illnesses.

An understanding of delirium, depression and dementia is therefore necessary to accurately assess, diagnose, treat and understand the subsequent impact on the behaviours of older residents in residential aged care facilities.

The following points outline the key characteristics of these conditions.

2.3.1 Delirium

Delirium is a state of fluctuating organic mental confusion characterised by an acute change in the state of consciousness, attention and cognition.

- Delirium is often abrupt in onset but can develop gradually.
- Delirium may be missed or misdiagnosed.
- The most common cause of delirium is physical or medical problems including infection, constipation, general discomfort, dehydration and medication.
- Older people in residential care environments are particularly at risk of developing delirium.
- Management involves specifically treating each contributing factor, maintaining body fluid balance (homeostasis), minimising complications and controlling all symptoms.
- Delirium is a potentially life threatening condition.

2.3.2 Depression

Depression is an abnormal emotional state characterised by exaggerated feelings of sadness, worthlessness and hopelessness, which are out of proportion with reality. It creates a sustained impairment in physical, social and psychological functioning.

- Depression is a treatable illness.
- Depression in the residential care environment is under-diagnosed and even when diagnosed, often goes untreated or under treated.
- Depression in the elderly requires thorough assessment to confirm the diagnosis or to differentiate it from an irreversible dementia or reversible delirium.
- Depression may also present in combination with delirium and/or dementia.
- Good practice in the residential aged care setting should include asking questions about people’s mood eg “do you feel sad or depressed? If so, how often?”
- There are a number of easy to use tools to assess residents with suspected depression in the residential care sector (refer to Assessment tools page 25).
- These tools do not diagnose depression and do not replace a comprehensive clinical assessment. However, they are useful for screening purposes and may thus assist with identifying older people who require a more detailed assessment.

2.3.3 Dementia

Dementia is a syndrome characterised by changes in thinking, behaviour and ability to perform tasks of daily living. It is caused by one or a combination of conditions that affect the brain. Most of these conditions are irreversible. Dementia can affect memory, attention, thinking, perception, judgement, language, emotions, behaviour and/or physical function.

- The two most common conditions causing dementia are Alzheimer's disease and vascular dementia.
- Other conditions causing dementia include Lewy body disease, frontal lobe syndrome and alcohol-related brain damage.
- Dementia affects each person in a unique way.
- Many older people in the residential aged care environment will have dementia, with or without other co-occurring physical and/or psychological illnesses.
- Delirium and/or depression may also be present in someone with dementia.
- Behavioural disturbance and psychiatric symptoms may accompany dementia but may also occur with other psychiatric disorders.
- Memory loss is commonly a feature of dementia but is not always present.
- Thorough assessment should determine the type of dementia and the subsequent treatment approaches necessary.

Dementia, depression or delirium may occur individually or in combination in older people living in residential care. The following table highlights the similarities and differences in the features that characterise these three processes.
2.4 Differentiating between delirium, depression and dementia

Differentiating between delirium, depression and dementia (the three D’s) requires skilled assessment. The differences and similarities are outlined in the following table.

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>Delirium</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thoughts</strong></td>
<td>■ Repetitiveness of thought</td>
<td>■ Bizarre and vivid</td>
<td>■ Often slowed</td>
</tr>
<tr>
<td></td>
<td>■ Reduced interests</td>
<td>■ Frightening thoughts and ideas</td>
<td>■ May be preoccupied by sadness and hopelessness</td>
</tr>
<tr>
<td></td>
<td>■ Difficulty making logical connections</td>
<td>■ Often paranoid</td>
<td>■ Negative thoughts about self</td>
</tr>
<tr>
<td></td>
<td>■ Slow processing of thoughts</td>
<td></td>
<td>■ Reduced interest</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td>■ Often a disturbed 24 hour clock mechanism (later in the disease process)</td>
<td>■ Confusion disturbs sleep – may have a reverse sleep-wake cycle</td>
<td>■ Early morning waking or intermittent sleep patterns (in atypical cases the person may sleep too much)</td>
</tr>
<tr>
<td></td>
<td>■ Nocturnal confusion</td>
<td>■ Vivid and disturbing nightmares</td>
<td></td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Increasingly impaired sense of time and place</td>
<td>■ Fluctuating impairment of sense of time, place and person</td>
<td>■ Usually normal</td>
</tr>
<tr>
<td><strong>Onset</strong></td>
<td>■ Usually gradual, over several years</td>
<td>■ Acute or sub acute (hours/days)</td>
<td>■ Usually over days or weeks</td>
</tr>
<tr>
<td></td>
<td>■ Insidious in nature</td>
<td></td>
<td>■ May coincide with life changes</td>
</tr>
<tr>
<td><strong>Memory and cognition</strong></td>
<td>■ Impaired recent memory</td>
<td>■ Immediate memory is impaired</td>
<td>■ Recent memory sometimes impaired</td>
</tr>
<tr>
<td></td>
<td>■ As disease progresses, long term memory also affected</td>
<td>■ Attention and concentration is impaired</td>
<td>■ Long term memory generally intact</td>
</tr>
<tr>
<td></td>
<td>■ Other cognitive deficits such as in word finding, judgement and abstract thinking</td>
<td></td>
<td>■ Patchy memory loss</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Months/years and progressive degeneration</td>
<td>■ Usually brief - hours to days</td>
<td>At least two weeks – but can be several months to years</td>
</tr>
<tr>
<td><strong>Course throughout a day</strong></td>
<td>■ May be variable depending on type of dementia</td>
<td>■ Fluctuates – usually worse at night in the dark</td>
<td>Commonly worse in the morning with improvement as the day continues</td>
</tr>
<tr>
<td><strong>Alertness</strong></td>
<td>Usually normal</td>
<td>■ Fluctuates – lethargic or hyper vigilant</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>May be able to conceal or compensate for deficits (early)</td>
<td>■ May occur as a consequence of a drug interaction/reaction, physical disease, psychological issue or environmental changes</td>
<td>■ Often masked</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>■ May or may not have past history</td>
</tr>
</tbody>
</table>
2.5 Responding to challenging behaviours

When a resident exhibits challenging behaviours, responding appropriately and skilfully to these behaviours is imperative. The management and appropriate interventions of these behaviours will initially require an assessment process to identify triggers that may contribute to these behaviours. The following table summarises the necessary steps to undertake when responding to challenging behaviours. These steps will be most productive when undertaken in environments that acknowledge the influence of the organisational culture, the resident's cultural, linguistic and religious backgrounds, past life experiences, family supports, staff skills and provision of safe environment and care practices on these responses.

There are a number of resources that have been produced to assist staff when assessing and working with challenging behaviours. These are contained on page 25, Education and training packages.

![Figure 1. Assessment and response to challenging behaviours](image)
3.1 **Overview**

All interventions must be based on individual presentation and rigorous and individualised assessment. It is not possible to offer prescriptions for interventions; rather, each person’s background, needs and circumstances must be comprehensively assessed within the context of the emotional and physical environment in which the behaviour is occurring. The more thoroughly the individual is assessed for causes of the behaviour, the more likely it is that any interventions, psychosocial and/or pharmacological, will be well focussed rather than trial and error. (See appendix 6 and 7.)

When psychosocial interventions are used, the consistent documentation of actions taken, the reasons why they were taken and how they work will be required. In some instances, a combination of pharmacological and psychosocial interventions will be the desired choice to achieve an optimal quality of life for the resident. The issue of restraint as a form of intervention will be discussed in Section 4. In general, this document endorses, as preferred practice, the minimal use of restraint as the last resort.

All interventions should be based on an approach which:
- assesses the problem behaviours comprehensively
- implements strategies to alleviate/address factors underlying the behaviour
- evaluates outcomes
- prevents recurrence
- focuses on quality improvement.

3.2 **Understanding behavioural interventions in the residential aged care setting**

The following table aims to provide an overview of some of the pharmacological and psychosocial interventions which may be implemented for a resident displaying specific behaviours. Remember, however, that there is no single “recipe book” approach to complex behaviour. All behaviour should be assessed thoroughly to determine potential causes. An individualised care plan that details appropriate responses and caring strategies should also be developed that aims to address causes and contributing factors.

It is also important to note that an individualised approach to care is paramount in the assessment of behaviour and implementation of appropriate interventions. Person-centred care facilitates an increased understanding of the cultural, linguistic and religious factors and life experiences of the person which should then be considered in the assessment and care of the resident. Interventions should vary depending on these factors, in addition to the person’s current circumstances and types of unmet needs.

Before implementing any of the following interventions:
- conduct comprehensive physical assessment
- investigate the cause
- assess for delirium
- investigate and treat pain
- remain calm
- respond to feelings
- reassure the resident
- ensure appropriate staff training.
### 3.2.1 Understanding behaviours and interventions in the residential aged care setting

The information contained within this table is provided as a guide and is not meant to act as a substitute for personalised assessment and personalised clinical judgement.

This table does not include all specified side effects or relevant information regarding medications. Prescribers must ensure that they are acquainted with all up to date information in relation to side effects, interactions and recommended use of medications before they are administered to residents. It is important to note that research trends and knowledge on side effects are still developing.

Where dementia with Lewy bodies is suspected, typical antipsychotics should never be used, nor should they be used for residents with Parkinson's disease.

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<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Psycho-social intervention</th>
<th>Medication group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGGRESSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May be related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>Potential strategies include:</td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td>■ Distraction</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>■ Diversion</td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>■ Staff training in managing and approaching residents</td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td>■ Peaceful environment</td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>■ Music</td>
<td></td>
</tr>
<tr>
<td>Excessive stimuli</td>
<td>■ Exercise</td>
<td></td>
</tr>
<tr>
<td>Change of environment</td>
<td>■ Avoidance of identified triggers</td>
<td></td>
</tr>
<tr>
<td>Poor communication techniques</td>
<td>■ Appropriate levels of light</td>
<td></td>
</tr>
<tr>
<td>Loss of control</td>
<td>■ Reassurance with familiar objects</td>
<td></td>
</tr>
<tr>
<td>Drug reaction</td>
<td>■ Family support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Noise and crowd reduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Assessment of family, social, psychological and occupational history</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Socialisation</td>
<td></td>
</tr>
</tbody>
</table>

**Atypical antipsychotics**

- Diminished risk of developing tardive dyskinesia and extrapyramidal symptoms compared to typicals
- May have increased risks of raised blood sugar levels, postural hypotension, sedation,
- May have significant weight gain
- Clinicians take note of current debate linking atypical antipsychotics and increased risks of cerebrovascular adverse events in patients with dementia

**Anti-dementia drugs**

- Need to be aware of authority conditions for use
- Seek advice on use and eligibility in dementia associated with Parkinson's disease or Lewy body dementia

**Typical antipsychotics**

- Often associated with side effects at anything but low doses

**Benzodiazepines**

- Short term or PRN* use
- Can worsen disinhibition
- Can increase risk of falls
- Can increase risk of severe agitation with rapid withdrawal after long term use

**Analgesics**

- Should be considered if possibility of pain

**Antidepressants**

- Evidence suggests they may be effective in the presence of dementia where there is an absence of identifiable depression

**Mood stabilisers**

- Require monitoring for potential toxicity
- To be used only when first line treatment has proven unsatisfactory

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1 Behavioural and psychological symptoms of dementia (BPFD), International association (IAP) educational package www.ipa-online.org
<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Psycho-social intervention</th>
<th>Medication group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGITATION</strong></td>
<td>Potential strategies include:</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Is a multidimensional and complex phenomenon</td>
<td>- Modification of the environment</td>
<td>- PRN *or short term use</td>
</tr>
<tr>
<td>May be related to:</td>
<td>- Provision of lounge chairs and sofas for companionship</td>
<td>- Regular use can lead to tolerance, addiction, depression and cognitive impairment</td>
</tr>
<tr>
<td>- Anxiety</td>
<td>- Reassurance</td>
<td>Atypical antipsychotics</td>
</tr>
<tr>
<td>- Pain</td>
<td>- Stimulation</td>
<td>- Diminished risk of developing tardive dyskinesia and extrapyramidal symptoms compared to typicals</td>
</tr>
<tr>
<td>- Discomfort</td>
<td>- Regular exercise</td>
<td>- May have increased risks of raised blood sugar levels, postural hypotension, sedation,</td>
</tr>
<tr>
<td>- Constipation/Incontinence</td>
<td>- Signposting - cues</td>
<td>- May have significant weight gain</td>
</tr>
<tr>
<td>- Grief</td>
<td>- Asking the person if there is anything wrong</td>
<td>- Clinicians take note of current debate linking atypical antipsychotics and increased risks of cerebrovascular adverse events in patients with dementia.</td>
</tr>
<tr>
<td>- Change of environment</td>
<td>- Distraction</td>
<td><strong>Typical antipsychotics</strong></td>
</tr>
<tr>
<td>- Inappropriate medication regimes</td>
<td>- Contact and closeness, where appropriate</td>
<td>Mood stabilisers</td>
</tr>
<tr>
<td>- Restraint</td>
<td>- Reducing crowding</td>
<td>Antidepressants</td>
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<td>- Evidence suggests they may be effective in the presence of dementia where there is an absence of identifiable depression</td>
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<td><strong>Benzodiazepines</strong></td>
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<td></td>
<td></td>
<td>- Short term or PRN* only</td>
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<td></td>
<td></td>
<td>- Regular use can lead to tolerance, addiction, depression and cognitive impairment</td>
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<table>
<thead>
<tr>
<th><strong>ANXIETY</strong></th>
<th>Potential strategies include:</th>
<th>Antidepressants</th>
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<tbody>
<tr>
<td>May be related to:</td>
<td>- Distraction</td>
<td>- Evidence suggests they may be effective in the presence of dementia where there is an absence of identifiable depression</td>
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<tr>
<td>- Interpersonal symptoms</td>
<td>- Diverion</td>
<td><strong>Benzodiazepines</strong></td>
</tr>
<tr>
<td>- Change of environment</td>
<td>- Support - social interaction</td>
<td>- Short term or PRN* only</td>
</tr>
<tr>
<td>- Grief</td>
<td>- Exercise</td>
<td>- Regular use can lead to tolerance, addiction, depression and cognitive impairment</td>
</tr>
<tr>
<td>- Pain</td>
<td>- Asking the person what is worrying him/her</td>
<td><strong>Antipsychotics</strong></td>
</tr>
<tr>
<td>- Isolation</td>
<td>- Reassurance - familiar objects</td>
<td>- If psychosis is also present</td>
</tr>
<tr>
<td>- Excess stimuli</td>
<td>- Counselling/cognitive behaviour therapy</td>
<td><strong>Antidepressants</strong></td>
</tr>
<tr>
<td></td>
<td>- Reducing excessive stimuli</td>
<td>- Monitor for increased agitation and confusion</td>
</tr>
<tr>
<td></td>
<td>- Increased involvement and collaboration with family and friends</td>
<td>- Monitor for hyponatraemia (low blood sodium level)</td>
</tr>
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<td></td>
<td></td>
<td>- Adequate dose, for adequate time</td>
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<tr>
<td></td>
<td></td>
<td>- Tricyclics may be associated with range of side effects such as hypotension, sedation, urinary retention, constipation, dry mouth, visual problems.</td>
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<thead>
<tr>
<th><strong>DEPRESSION</strong></th>
<th>Potential strategies include:</th>
<th>Antidepressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive syndromes may be related to:</td>
<td>- Counselling</td>
<td>- Monitor for increased agitation and confusion</td>
</tr>
<tr>
<td>- Grief/bereavement</td>
<td>- Emotional support</td>
<td>- Monitor for hyponatraemia (low blood sodium level)</td>
</tr>
<tr>
<td>- Change in environment</td>
<td>- Companionship eg visitors schemes</td>
<td>- Adequate dose, for adequate time</td>
</tr>
<tr>
<td>- Coping skills</td>
<td>- Engagement in activities</td>
<td>- Tricyclics may be associated with range of side effects such as hypotension, sedation, urinary retention, constipation, dry mouth, visual problems.</td>
</tr>
<tr>
<td>- Loss of familiar environment</td>
<td>- Cognitive behavioural therapy</td>
<td><strong>Antipsychotics</strong></td>
</tr>
<tr>
<td>- Loss of role</td>
<td>- Observation</td>
<td>- If psychosis is also present</td>
</tr>
<tr>
<td>- Change in self image</td>
<td>- Increased involvement and collaboration with family and friends</td>
<td><strong>Mood stabilisers</strong></td>
</tr>
<tr>
<td>- Family history</td>
<td>- Socialisation</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>- Poor coping</td>
<td>- Exercise</td>
<td>- Evidence suggests they may be effective in the presence of dementia where there is an absence of identifiable depression</td>
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<tr>
<td>- Recent losses</td>
<td>- Pleasant events schedule</td>
<td><strong>Benzodiazepines</strong></td>
</tr>
<tr>
<td>- Disease processes</td>
<td></td>
<td>- Short term or PRN* only</td>
</tr>
<tr>
<td>- Past history of depression</td>
<td></td>
<td>- Regular use can lead to tolerance, addiction, depression and cognitive impairment</td>
</tr>
</tbody>
</table>
### PSYCHOTIC SYMPTOMS

**Psychotic Symptoms include:**
- Delusions
- Hallucinations
- Paranoid ideation

**May be related to:**
- Misinterpretation of the environment
- Drug toxicity/interactions
- Visual or hearing impairment
- Physical illness

**Potential strategies include:**
- Emotional support
- Avoiding fatigue – induce rest periods
- Personalise environment/belongings
- Clear communication
- Always keeping an open mind
- Reducing stimulation and external stimuli e.g., TV, radio
- Listening to their concerns and offer reassurance; however do not reinforce the delusions/paranoid ideations. This needs to be applied with respect for and sensitivity to the individuality of each situation.
- Investigating if there is any reality to what the person is saying

**Atypical antipsychotics**
- Use only very low doses when symptoms are associated with Parkinson's disease or Lewy body dementia
- Clinicians take note of current debate linking atypical antipsychotics and increased risks of cerebrovascular adverse events in patients with dementia

**Typical antipsychotics**
- Note more adverse side effect profile
- Do not use when symptoms are associated with Parkinson's disease or Lewy body dementia

### SLEEP DISTURBANCES

Include sleep – wake cycle problems

**May be related to:**
- Pain/joint stiffness
- Poor mattress comfort
- Nocturia
- Noise

**Potential strategies include:**
- Investigate the night-time environment, including practices of night-staff disrupting residents’ sleep
- Creation of a sleeping environment
- Night lights
- Warm milk
- Relaxation music
- Caffeine restrictions
- Limit daytime sleeping
- Increase daytime exercise

**Antidepressants**
- Consider if sleep disturbance is attributed to depression

**Antipsychotics**
- If psychotic in nature

**Benzodiazepines**
- PRN or short term only
- Regular use can lead to tolerance, addiction, depression and cognitive impairment

**Anti-dementia drugs**
- Need to be aware of authority conditions for use
- Seek advice on use and eligibility in dementia associated with Parkinson's disease or Lewy body dementia

### WANDERING

**May be related to:**
- Pacing associated with agitation
- Restlessness associated with pain, anxiety frustration
- Effect of medication
- Stress
- Boredom
- Fear/loneliness
- Isolation
- Depression

**Potential strategies include:**
- Asking the person what they are looking for or where they want to go
- Identification
- Use of alarms and monitors
- Creating safe wandering opportunities
- Walking programs
- Exercise
- Safe return programs
- Diversions/distractions
- Reminiscence therapy
- Participating in household activities

**Medications should only be used to treat the cause of the wandering (if known).**

Extreme caution in prescribing practice is warranted to minimise the impact of medication on the mobility of the resident.
4.1 Minimising the use of restraint in RACFs

RACFs should promote individual care, dignity and the protection of residents from foreseeable harm and should minimise the person’s vulnerability to inappropriate practices. This should occur in restraint free environments wherever possible. The use of restraints should only be used as a last resort to prevent harm to the individual resident or to other residents and staff and to optimise the resident’s health status.

Residents maintain better health, the ability to walk safely and a greater ability to attend to activities of daily living when not restrained. It is well documented that there are worse health outcomes for the resident who is restrained. Rather than protecting residents from harm, the inappropriate use of restraints may leave residents more vulnerable to poor mobility and the ill effects of this immobility. (Refer to page 27 for supportive reading.)

Care staff in RACFs must not restrict a resident’s freedom of movement unless there is a severe threat to the individual’s safety and/or the safety of others. Such restrictions must be provided with care, compassion and consideration and be the least restrictive form of restraint available.

Care staff in RACFs must be trained to be proficient in the safe, appropriate, minimal and least restrictive use of restraint in caring for residents displaying difficult behaviours.

Any objection by the person, verbally or through their behaviour, means the guardian or person responsible can no longer consent to the use of the restraint without the necessary authority from the Guardianship Tribunal.

An application to the Guardianship Tribunal should be made to request the authorisation necessary to consent to the use of the restraint, or to give a guardian authority to consent to the continued use of the restraint.

4.2 What constitutes restraint?

Restraint is anything that limits an individual’s voluntary response or movement. It most commonly involves physical or chemical restraint but may also include psychological and environmental restraint or aversive treatments or practices.

- **Physical restraint** – the intentional restriction of a person’s voluntary movement or behaviour by the use of a device or physical force for behavioural purposes. This includes the use of lap belts, table tops, posy restraints, wrist restraints, bedrails, water chairs and deep chairs.

- **Chemical restraint** – the intentional use of medication to control a person’s behaviour when no medically identified condition is being treated and where the treatment is not necessary for the condition or amounts to over-treatment for the condition. Chemical restraint includes the use of medication when the behaviour to be affected by the medication does not appear to have a medical cause and part of the intended pharmacological effect of the drug is to sedate the person for convenience or for disciplinary purposes.

Although the pursuit of restraint-free environments should guide practice, there may be occasions where restraint is unavoidable in response to specific situations. When determining whether to restrain, the potential risks of the resident not being restrained must be outweighed by the potential risks of the resident being restrained. The use of restraint should always be viewed as a temporary solution and implemented only in the least restrictive form at the end of pursuing all other options. The use of restraint is guided by legal principles which is further expanded in 4.3 over page. The use of restraint outside these limited situations, or without the appropriate approval, is most likely to be unlawful.
### 4.3 Situations and processes for the use of restraint in RACFs in NSW

<table>
<thead>
<tr>
<th>Situations warranting consideration of restraint</th>
<th>Explanatory notes</th>
<th>Guidelines for service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent situation</strong></td>
<td>To discharge the duty of care in these instances it may be necessary to protect the person from harming themselves or from harming others.</td>
<td>In this situation, staff can restrain without consent to prevent an immediate crisis. However, this would not necessarily justify the ongoing use of restraint once a crisis has resolved. In this situation, forms of “least restrictive” restraint that do not cause the person harm, agitation or distress and do not reduce the person’s dignity or increase their risk of falling, may be justified for this short term emergency use. To discharge the duty of care owed to a resident in these instances such physical restraint must be developed and recorded using the good practice principles identified in this document.</td>
</tr>
<tr>
<td><strong>An adjunct to medical treatment</strong></td>
<td>Consent for medical treatment can be provided by the ‘person responsible’ provided the person/resident is not objecting.</td>
<td>Seek consent of ‘person responsible to the medical treatment’ and the associated restraint required, if the patient is not objecting. If the patient is objecting to the medical treatment or the restraint, an application must be made to the Guardianship Tribunal for consent. Must be regularly reviewed. This restraint cannot be maintained beyond the requirement to support medical treatment.</td>
</tr>
<tr>
<td><strong>Appropriate management under duty of care</strong></td>
<td>To discharge the duty of care in these instances it may be necessary to protect the person from harming themselves or from harming others.</td>
<td>A guardian does not need to be appointed to consent to this type of restraint. To discharge the duty of care owed to residents in these instances, such physical restraint must be developed and recorded using the good practice principles identified in this document. Staff must review the person regularly. This includes the need to ensure the person restrained is toileted regularly and skin integrity is maintained and that all needs are met. (See Guideline for the documentation of restraint Appendix 3)</td>
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*Situations warranting consideration of restraint* refers to specific scenarios where the use of restraint may be necessary. *Explanatory notes* provide guidance on how to approach these situations, emphasizing the importance of using restraint as a last resort. *Guidelines for service providers* outline the procedural steps and considerations necessary for the ethical and justifiable use of restraint in residential aged care facilities (RACFs). The document underscores the importance of developing restraint plans and documenting these processes, ensuring they align with the principles of care and dignity.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Physical restraint as a management strategy</td>
<td>Physical restraint that is <strong>neither</strong> an adjunct to medical or dental treatment nor acceptable within the above mentioned urgent situations requires the approval of a guardian empowered by the Guardianship Tribunal to give such approval.</td>
<td>A guardian needs to be appointed by the Guardianship Tribunal with authority to make decisions about restraint. A behaviour management plan must be developed as part of the person's individual care plan and submitted to the Guardianship Tribunal prior to the hearing to determine the need for a guardian to authorise the use of restraint. If appointed, a private guardian or the Public Guardian may require further information from service providers before consenting to the use of physical restraint (see Appendix 4).</td>
</tr>
<tr>
<td>Psychotropic medication used as restraint</td>
<td>Medication to control a person's behaviour is considered to be restraint if the medication is not being used for someone who has a psychotic condition or other conditions for which treatment with psychotropic medication is indicated; or the dosage levels, or combinations, or numbers or duration of the medication is outside the accepted mode of treatment.</td>
<td>Medication to control a person's behaviour is regulated by Part 5 of the Guardianship Act 1987. In these circumstances, an application for consent must be made to the Guardianship Tribunal.</td>
</tr>
</tbody>
</table>
SECTION 5

Good practice principles in the management of challenging behaviours in RACFs

What is good practice?

Good practice is an evolving concept that contributes to the delivery of quality care in residential aged care facilities. Good practice is not static and involves the ongoing evaluation of current practices and the development of new initiatives. The following good practice principles have been derived from current practices and resources, (refer to Resources for the development of policy and practice, page 25).

5.1 Good practice principles for assessing and caring for people with challenging behaviours in RACFs

Good practice in the assessment and care of people with challenging behaviours incorporates:

- Emphasis on the uniqueness and individuality of the resident.
- A philosophy that supports person centred care.
- Individualised and comprehensive assessment including medical, psychiatric, social, cultural, linguistic, religious and environmental factors, history of life experiences and interests/hobbies.
- The implementation of management strategies which are responsive to individual differences and needs and carried out with dignity and respect.
- Employment of staff with mental health experience.
- Flexibility and creativity in approach.
- A workplace culture that is underpinned by education and training.
- Consistency in approach.
- Identifying why and to whom the behaviour is a problem.
- Exploration and acknowledgement of the causalities of the behaviour.
- Appropriate design and use of a ‘dementia-friendly’ physical and social environment. (Refer to reference Adapting the ward for people with dementia).
- Emphasis on and use of psychosocial interventions that are individualised and responsive to different needs.
- Interventions (both pharmacological and non-pharmacological) being evaluated and evidence of benefit or detriment documented clearly and accurately.
- The use of approaches which aim to prevent recurrence and focus on quality improvement.
- Acknowledgement and documentation of the ‘person responsible’ as the person who will be a decision-maker for the resident deemed not capable to make medical decisions.
- Use of interpreters for people with low English language proficiency.

5.2 Using medications in positive ways

The appropriate use of any medication can treat disease and/or control symptoms and subsequently improve health or comfort of older people living in the residential care environment. As the normal ageing process impacts significantly on the metabolism of medication, the older person is more vulnerable to adverse effects of medication.
5.3 **Good practice principles for the use of medications in general in RACFs**

The following points outline good practice for the use of medication in RACFs.

- A medical practitioner who has assessed the resident must prescribe medications.
- Medication administration must be adhered to and reflected in the development of local medication management policy.
- A resident can only be treated if a valid consent has been obtained. If the person is unable to provide this consent, then substitute consent must be sought from the person responsible.
- Information on the rights of residents in residential aged care facilities regarding medication must be provided to them and their families and/or the person responsible for the resident by brochures or any other suitable means.
- When using pharmacological interventions, the aim is to settle distress, without affecting clarity of consciousness or compromising quality of life.
- It is important to be aware that the inappropriate administration of medication can harm a resident and polypharmacy may increase the risk of medication side effects for older people.
- **Start low and go slow** with increased vigilance for any side effect.
- Dosages of medication will generally be lower in elderly patients with dementia than those used in younger patients and in older non-demented people. The elderly are a heterogeneous group requiring an individualised approach to dosage.
- All medication should initially be considered as a trial for a specified period to see if it helps to clearly identify problems. It should then be reviewed by the medical practitioner to determine the duration and efficacy of the use of medication. If the medication is found not to be effective, it should then be altered or ceased.

5.4 **Medication advisory committee (MAC)**

The Australian Pharmaceutical Advisory Council (APAC) recommends in the document *Guidelines for medication management in residential aged care facilities (2002)*, that residential aged care facilities should establish or have direct access to and utilise the services of a Medication Advisory Committee (MAC) to facilitate the quality use of medicines, including psychotropic medication.

It is suggested that each residential aged care facility should establish or have access to a MAC. Membership should include at least a medical practitioner, an accredited pharmacist, a nursing representative and a resident or their relative/carer.

The setting up of committees in this way is commended and ensures that good practice guidelines are maintained for the use of psychotropics and other medications in the residential aged care setting.

5.5 **The use of psychotropic medication**

Psychotropic medication refers to a group of drugs that have an effect upon an individual’s mental state. These include antipsychotics, ‘anti-dementia’ medication, antidepressants and sedatives, hypnotics, anti anxiety drugs and anti mania medication. Other medications not designed as psychotropics, including anticonvulsants, narcotics, anti-histamines and beta-blockers, may at times be used for their psychotropic properties.

The older person is, in general, more susceptible to side effects from psychotropic medication and may manifest adverse and at times atypical or not previously described effects.
5.6 Good practice principles for the administration of psychotropic medication in RACFs

The following points underpin good practice in the administration of psychotropic medication in RACFs:

- If psychotropic medications are required, then the lowest dose of medication necessary to achieve therapeutic effect should be used.
- Note when using antidepressants, medications must be used in doses that are agreed to be therapeutic and dosage may need to be increased if improvement has not occurred.
- The behaviour of the resident whilst on medication must be documented to assist GP review.
- Standard practice must include regular reviews by the resident’s General Practitioner. (The term ‘GP review’ means examining the therapy, confirming that it is still appropriate and optimal).
- Frequent review early in the course of therapy may be required. Timing of subsequent reviews should be determined by the clinical circumstances. In most cases, this will be no longer than six weeks.

- Factors to be considered by a GP in a review should include:
  - the natural history of the underlying disorder
  - previous history of response to and effects of reduction in medication
  - any long term side effects of the medication
  - assessment of staff reporting on resident’s behaviour whilst on medication
  - intercurrent health problems
  - environmental circumstances
  - effects of any behavioural interventions.
- Accurate documentation and ongoing record keeping need to be provided for the medical practitioner for review.
- The frequency and severity of behaviour must be well documented prior to commencing pharmacotherapy. Behaviour should be described rather than labelled.
- Care plans for residents manifesting complex, severely and persistently challenging behaviours should be developed with involvement of mental health professionals, preferably from a local old age psychiatry service.
Understand the guidelines for consent

A resident in a RACFs cannot be treated without their consent. Practitioners are required to respect the person's decisions provided the resident is capable of making that decision. If a person is unable to give informed consent then substitute consent applies (The Guardianship Act 1987). The Act states that a person cannot give valid consent if they:

- Cannot understand the general nature of the treatment; or
- Cannot communicate whether or not they consent to the treatment.

Staff, therefore, must have a clear understanding of the capacity of their clients and an additional understanding of who would consent if the resident were unable to because of diminished competency and capacity. Information about who would be the decision maker in this event should be documented in the resident's file on admission. (Refer to Appendix 1 to identify who is a resident's 'person responsible'.)

Further information regarding consent and capacity is contained within the following texts:
- Who can consent www.gt.nsw.gov.au
- Who can decide? The six step capacity assessment process Dr Peteris Darzins; Dr William Molloy; Dr David Strang.

Assess appropriateness of restraint

Key questions to be asked are:

- Is the restraint considered necessary and beneficial to the person?
- Does the level of risk and the reasons for the prevention of injury outweigh the effects of the restraint?
- Are there any objections to the restraint from the person or any interested person?
- Is its use considered to be non-contentious?
- Does the use of this restraint withstand ethical scrutiny? (Refer to Glossary ‘Duty of care’.)

Have alternatives to restraint been fully pursued by:

- Skilled and comprehensive resident assessment, including discussion with the resident’s family and friends to better understand the meaning of the behaviour and the life experience of the resident.
- Skilling of staff in the recognition of medical, physical or psychiatric problems.
- Up skilling of staff in alternatives to restraints.
- Exclusion or appropriate treatment of physical causes eg delirium, pain.
- Incorporating changes to create a safe, familiar, accepting and secure environment.
- Providing activities of choice.
- Reassuring anxious residents.
- Using pharmacological approaches only if they complement other approaches and to promote health and well-being.

Remember any restraint used must:

- Be the least restrictive form of restraint available for the shortest duration necessary.
- Be removed when the resident's condition improves or it becomes feasible to use a less restrictive alternative or form of restraint for the resident.
- Be adequately recorded in the resident’s file.
- Include arrangements for toileting, feeding and hydrating the person while restrained.
- Be removed for 15 minutes every hour.
- Be regularly planned and reviewed by the medical practitioner (at least monthly).
- Be monitored by nursing staff hourly with the observations recorded in a format that is clearly understood by all staff. (Refer to suggested proforma, Appendix 3 and 4.)
Who is the ‘person responsible’?

A ‘person responsible’ is not necessarily the patient’s next of kin. A ‘person responsible’ is either:

- a guardian (including an enduring guardian) who has the function of consenting to medical, dental and health care treatments

or, if there is no guardian:

- the most recent spouse or de facto spouse with whom the person has a close, continuing relationship. ‘De facto spouse’ includes same sex partners

or, if there is no spouse or de facto spouse:

- an unpaid carer who is now providing support to the person or provided this support before the person entered residential care

or, if there is no carer:

- a relative or friend who has a close personal relationship with the person.

If a person identified as being a ‘person responsible’ declines in writing to exercise the function of ‘person responsible’ or a medical practitioner or other qualified person certifies in writing that the person identified as ‘person responsible’ is not capable of carrying out those functions, then the person next in the hierarchy is the ‘person responsible’.

The ‘person responsible’ for someone who cannot consent for themselves has a right and a responsibility to know and understand:

- the proposed treatment
- the risks and alternatives
- that they can say ‘yes’ or ‘no’ to the proposed treatment
- that they can seek a second opinion.

The practitioner has a responsibility to give them this information and seek their consent to the treatment before treating the person.

The above information has been provided by the NSW Guardianship Tribunal www.gt.nsw.gov.au
APPENDIX 2

Preparation of a behaviour management plan to the Guardianship Tribunal/Office of the Public Guardian

A behaviour management plan to the Guardianship Tribunal or the Office of the Public Guardian should contain information regarding:

- The environmental factors which could contribute to or cause the behaviour.
- The possible health or medical factors which could contribute to or cause the behaviour.
- The possible communication needs of the person which may be contributing to the behaviour.
- Whether less restrictive alternatives for managing the behaviour have been considered and ruled out as not appropriate.

The resident care plan or behaviour intervention plan would also consider:

- the safety and comfort of the person under guardianship
- the specific needs of the person and her/his circumstances
- involving the resident, others important in the person’s life and the Public Guardian where appointed
- mechanisms to measure, monitor and review the effectiveness of the proposed interventions
- training for staff in the use of the restraint
- the person’s access to activities and services during the use of the restraint.

The behaviour intervention plan must be in writing and should be developed and reviewed by a suitably qualified professional. Once appointed, the Office of the Public Guardian, would also need to consider the information listed above and may request additional information (see Appendix 4).

The above information has been provided by the Office of the Public Guardian www.lawlink.nsw.gov.au/opg.
Guideline for the documentation of restraint

*It is suggested that this information be recorded hourly.

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Details</th>
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<tbody>
<tr>
<td>Time on</td>
<td>In hourly periods</td>
</tr>
<tr>
<td>Time off</td>
<td>15 minutes release periods</td>
</tr>
<tr>
<td>Type of restraint</td>
<td>Describe the restraint being used and where placed on body</td>
</tr>
</tbody>
</table>

**Record activity or action undertaken at time of hourly check**

Are you:
- Checking restraint? [ ] Yes [ ] No
- Removing restraint? [ ] Yes [ ] No
- Mobilising resident? [ ] Yes [ ] No
- Undertaking personal care? [ ] Yes [ ] No
- Examining the resident? [ ] Yes [ ] No

**Condition of restrained resident**

General comment on emotional and physical well being of resident

**Is restraint still required?**

[ ] Yes – Why?
[ ] No – State when removed

**Has use of restraint been reviewed by professional proposing the restraint?**

[ ] Yes [ ] No

**Review dates**

**Those involved in the review**

**Specific comment of restrained part of body**

Specific observations of pulse, temperature, colour, pain, sensation (tingling, numbness)

**Condition of skin**

- In restrained part as well as other key pressure points of body
- Any signs of redness or broken skin?

**Name, Signature and Designation**

To be signed on each occasion of observation

This proforma suggests the minimum information that should be recorded. The residential aged care facility should add other information as applicable to its particular environment.

This proforma has been formulated as part of the development of this document.
Proforma for the documentation of restraint

*It is suggested that this information be recorded hourly

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<td></td>
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<tr>
<td>Condition of restrained resident</td>
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<td>□ Yes □ No</td>
</tr>
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This proforma suggests the minimum information that should be recorded. The residential aged care facility should add other information as applicable to its particular environment.
APPENDIX 5

How the Public Guardian determines consent to the use of restraint on an elderly person in a RACF

The Public Guardian views the use of restraint as an infringement on the personal liberty of a person and should only be used as a measure of last resort for the purpose of promoting and maintaining the person’s health and well-being. The Public Guardian endorses, and will strongly promote, the concept of restraint free environments and will work with relevant agencies and authorities to achieve this.

The Public Guardian supports the use of positive, non-restrictive procedures to assist a person with a disability. This may include:

- Altering the person’s physical environment.
- Changing the mix of residents in a bedroom.
- Avoiding activities or situations which provoke anxiety in the person.
- Providing meaningful activities for the person.
- Providing appropriate support to enable ‘safe wandering’.

The Public Guardian has an expectation that service providers caring for elderly people will act in accordance with the general principles of the *NSW Guardianship Act 1987*. Prior to an application for consent to the use of a restraint, service providers will have ruled out all less restrictive alternatives and will have carefully considered all possible causes of the behaviour and made changes accordingly. If this behaviour occurs regularly, a written planned response is required and will only be considered if it is designed to protect the person or others from physical harm, the actions are appropriately recorded and the proposal is time – limited and will be reviewed.

The Public Guardian considers that the benefit of the restraint must clearly outweigh the possible negative effect on the person and the risk involved if restraint is not used. The Public Guardian will only consider consent to the use of a restraint where there is clear evidence that the level of risk and potential harm outweighs the person’s right to remain unrestrained.

In considering an application for consent to the use of a restraint the Public Guardian will seek the views of the person, where possible, as well as the views of family members and significant others.

Any plan for the restriction of a person’s movement and liberty must be based on a specific assessment by a specialist clinician in aged care. The assessment should examine the underlying cause of the behaviour and rule out any possible medical or external causes for the behaviour that can be addressed through other means. This assessment should lead to the development and implementation of a care plan that minimises the need for the use of the restraint and is regularly reviewed by key people involved in the person’s care and treatment.

The Public Guardian will not consent to the use of a restraint when it is proposed because the service context involves a lack of appropriate resources and untrained staff. In these circumstances, the purpose of the proposed restraint would be seen to be attempting to address a service deficiency rather than meeting the individual needs of the resident.

The above information has been provided by the Office of the Public Guardian www.lawlink.nsw.gov.au/opg
### APPENDIX 6

**Behaviour monitoring log**

This proforma has been developed by the Illawarra Dementia Support Team, SESIAHS Port Kembla Hospital (a NSW project for the Australian Government Psychogeriatric Care Unit Program)

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<td>When did it happen? (date/time)</td>
<td>What behaviour was observed? (be specific)</td>
<td>Where did the behaviour occur?</td>
<td>Who else was present?</td>
<td>What else was happening?</td>
<td>How did people respond to the behaviour?</td>
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</table>
This proforma has been developed by the Illawarra Dementia Support Team, SESIAHS Port Kembla Hospital
(a NSW Project for the Australian Government Psychogeriatric Care Unit Program)

Date _____________________________________________________ Time of problem behaviour ______________________am/pm

Client Name and Location_______________________________________________________________________________________

Name and Title of staff _________________________________________________________________________________________

Where it happened
☐ Toilet  ☐ Shower  ☐ Bedroom  ☐ Living room
☐ Kitchen  ☐ Dining room  ☐ Outdoors
☐ Other (please specify)

Possible triggers
☐ Noise  ☐ Smells  ☐ Temperature
☐ Activity  ☐ Quiet period
☐ Other (please specify)

Who was involved during the incident
(please specify names or numbers)

☐ Staff
☐ Family
☐ Visitors
☐ Residents
☐ Others

How did the person behave after
☐ Reserved  ☐ Unchanged  ☐ Unsettled  ☐ Happy
☐ Other (please specify)

How did other residents respond
☐ Not aware  ☐ Unchanged  ☐ Unsettled
☐ Other (please specify)

What happened before the incident
☐ Visit  ☐ Outing  ☐ Distressing news
☐ Other (please specify)

What happened during the incident
Description of incident:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What actions were taken by staff
☐ Medication  ☐ Removal to another area
☐ Validation  ☐ Reality orientation  ☐ Isolation
☐ Aromatherapy  ☐ Music
☐ Other (please specify)

What overall effect did the action taken have
☐ Worked  ☐ Did not work  ☐ Worked short time

Further comments
________________________________________________________________________
________________________________________________________________________
Resources for the development of policy and practice

Assessment tools

Note scales are mainly of use in assessing outcome and epidemiological studies. No scale ascertains the cause of behaviour and determines appropriate response to this behaviour. These scales are to be considered as aids, not diagnostic instruments.

Abbey pain scale
Abbey, J.; DeBellis A; Piller, N.; Esterman, A.; Giels, L.; Parker, D. and Lowcay, B. For measurement of pain in people with dementia who cannot verbalise.

The Mini Mental Status Examination (MMSE)

Standardised Mini Mental State Examination (SMMSE)

Cohen-Mansfield Agitation Inventory

Rowland Universal Dementia Assessment Scale (RUDAS)
A multicultural Mini-Mental State Examination, Liverpool Aged Care Service, South Western Sydney Area Health, Tel. 9828 6200 Storey JE, Rowland JT, Conforti DA and Dickson HG. The Rowland Universal Dementia Assessment Scale (RUDAS): A multicultural assessment scale International Psychogeriatrics 2004;16 (1):13–31

The Geriatric Depression Scale


The Cornell Scale for Depression in dementia

The RAGE scale

The General Practice Assessment of Cognition or GPCOG

Education and training packages/material


Suicide prevention for older people NSW Health - Early intervention, assessment and referral options for staff working with older people who may be at risk of suicide. Training Manual NSW Department of Health. Available through the Elderly Suicide Prevention Worker in each Area Health Service.

The TECH approach
Kratiuk – Wall, S., Quirke, S., Heal, C., and Shanley, C. A resource kit for caring for people with challenging behaviours in a residential care setting, Centre for Education and Research www.cera.usyd.edu.au
Poole’s algorithm
A kit which provides an algorithm for nursing management of disturbed behaviour in older people in acute care.
Julia Poole, Department of Aged Care and Rehabilitation Medicine, Royal North Shore Hospital Tel. (02) 9926 8705

Cultural diversity and dementia
Wall, S. Shanley, C. Russell, K. A planned approach to residential care for people with dementia who come from a non English speaking background, The Centre for Education and Research www.cera.usyd.edu.au

International Psychogeriatric Association (IPA) website modules 1–7 www.ipa-online.org

The Dementia Educator
A quarterly publication – free to professional members of Alzheimer’s Australia (NSW) or people who can subscribe to it separately. For information contact Alzheimer’s Australia – NSW Tel. (02) 9805 0100

Challenge depression – a manual to help staff identify and reduce depression in aged care facilities
Richard Fleming, The Hammond Care Group, Judd Avenue, Hammondville NSW 2170 Tel. (02) 9825 5090

Mental health first aid manual

Guidelines - supporting policy documents

Consensus guidelines for assessment and management of depression in the elderly – Faculty of Psychiatry of Old Age, NSW Branch RANZP
NSW Health, Copies available from Better Health Centre Tel. (02) 9816 0452 www.health.nsw.gov.au

Patient information and consent to medical treatment


Quality Dementia Care Position paper 2 Alzheimer’s Australia 2003
www.alzheimers.org.au

Determining whether to consent to the use of restraint on an elderly person in a care facility

Australian Society for Geriatric Medicine, Position statement on physical restraint use in the elderly Australian Journal on Ageing, Vol 15, No. 1, 1996

Commonwealth Department of Health and Aged Care Standards for aged care facilities, Government Printing Service, Canberra 1997

Restraint, use in acute and residential care facilities
Joanna Briggs Institute, 2002 Physical Best Practice, Vol 6 Issue 3, Blackwell Publishing, Asia Australia

The Guardianship Tribunal
Consent, Substitute Consent and Person Responsible www.gt.nsw.gov.au

Decision-making tool: Responding to issues of restraint in aged care
Australian Government Department of Health and Ageing, 2004

Who can decide? The six step capacity process
Darzins, P., Molloy, W., and Strang, D., Memory Australia Press, Adelaide 2000

Adapting the ward for people with dementia (2003)
NSW Health, Copies available from Better Health Centre Tel. (02) 9816 0452 www.health.nsw.gov.au

Behaviour guide ReBOC – Reducing behaviours of concern
National Dementia Behaviour Advisory Service Tel. 1300 366 448

The carer experience

Restraint, seclusion and transport guidelines for patients with behaviour disturbance
To be published by NSW Health www.health.nsw.gov.au

The management and accommodation of older people with severely and persistently challenging behaviour in NSW: Summary report
NSW Health www.health.nsw.gov.au
Supportive research

Dementia-Psychosocial approaches to challenging behaviour in dementia: a controlled trial

Academic Department for Old Age Psychiatry
A research and clinical unit located at the Prince of Wales Hospital in Randwick, NSW and affiliated with the Department of Medicine at the University of NSW. http://www.med.unsw.edu.au/adfoap/

Supportive reading


Williams, C.C. ‘Long-term care and the Human Spirit’ in Generations, Vol 14, No. 4, p.25

Young, K.F. and Vucic, R.A. ‘Turning a dream into reality; developing a restraint-free environment’ in Nursing Homes and Senior Citizen Care, Vol 39, No. 3–4, p.29, Sept–Oct 1990.

Fisher, R., Dalgleish, V. The Use of Psychotropic Medication in Hostels, Spring Hill, St Andrews Aged Care Clinical Services, 1996.

Towards a restraint free environment, Braun, J.V., Lipson, S., Health Professionals Press Inc, 1993

Horsfall, J., 2002. Mental Health Nursing: Shaping Practice, Sydney South West Area Mental Health Service, Nursing Division, 109–130. Further copies are available from Sydney South West Area Mental Health Service, Nursing Administration, PO Box 1, Rozelle, NSW 2039

Practical Psychiatry in the Long-Term Care Facility

Therapeutic Guidelines: Psychotropic, Version 5, 2003 Therapeutic Guidelines Limited, Ground Floor, 23–47 Villiers Street, North Melbourne, Victoria 3051, Australia

Capacity (Competency)
Is determined by whether an individual can understand the nature and effect of the decision they are making. The individual is considered to have decision-making capacity until evidence proves otherwise. A determination of capacity is a determination of the particular client’s capacity to make a particular decision at a particular time. It is possible that a client could be competent to make some, but not all decisions, or that their capacity to consent to treatment changes day to day.

Carer
A carer is a family member, parent, significant other, friend or neighbour who provides care on an unpaid basis. The person they support may have a chronic illness, disability, mental illness or may be frail. (Carers NSW – www.carersnsw.asn.au)

Care staff
In the context of this paper refers to paid staff (or volunteers) who provide care for older people in residential aged care facilities.

Challenging behaviour
A challenging behaviour is any behaviour which causes stress or distress to the person with the behaviour or any others interacting with them. In this document, it refers to people whose challenging behaviours are associated with a decline in their cognitive capacity, generally due to dementia including associations with other medical conditions.

Consent
Before medical or dental practitioners provide treatment, they have a professional and legal responsibility to seek and obtain consent to the proposed treatment from the person. To obtain a valid consent, practitioners must explain to the person:

- the general nature and effects of the proposed treatment
- the risks associated with the proposed treatment
- the general nature, effects and risks associated with alternative treatments, or no treatment.

Further, practitioners must appreciate that those persons:

- have a right to consent or withhold consent to the proposed treatment
- must indicate to the practitioner whether they consent to the proposed treatment before the treatment can be administered.

If practitioners believe a person is not capable of giving valid consent to a treatment, they have a legal responsibility, under the NSW Guardianship Act (1987), in most circumstances, to seek and obtain consent from a substitute decision maker.

Also refer to NSW Health Policy Directive on Consent PD 2005–406 titled ‘Consent to Medical Treatment– Patient Information’.

Duty of care
The duty of care owed to older people in a residential aged care facility will differ according to specific needs and circumstances. In order to adequately discharge their duty of care, staff and facilities should have regard to the following information.

Duty of care should withstand ethical scrutiny and should include the elements of:

- individualised needs assessment
- constant clinician review
- common sense
- supporting the pursuit and development of good practice
- primarily meeting the needs of the resident
- peer review
- provision of care in a dignified manner
- promotion of health and well-being.

Person responsible
Is a substitute consent provider for medical and dental treatment for a person 16 years and over who is unable, for some reason, to give valid consent for their own medical or dental treatment. (Refer to Appendix 1 ‘person responsible hierarchy’)
Residential Aged Care Facilities (RACFs)

Refers to the accommodation provided for older people in Commonwealth-funded low care (previously hostel) or high care (previously nursing home) environments. These facilities offer a care component and are funded and accredited by the Department of Health and Ageing.

The NSW Guardianship Tribunal

The Guardianship Tribunal is a legal tribunal, located in Sydney. The Tribunal conducts hearings throughout NSW. Its purpose is to keep paramount the interests and welfare of people with disabilities through facilitating decision making on their behalf.

The Guardianship Tribunal makes decisions in relation to the appointment of guardians and financial managers, or in relation to medical and dental consent, for people with disabilities who do not have the capacity to make their own decisions. The Tribunal may make a range of other orders as well.

Contact:
Toll free 1800 463928
Main switch (02) 9555 8500
Telephone typewriter (02) 9552 8534
www.gt.nsw.gov.au

The Office of the Public Guardian

The Office of the Public Guardian promotes the rights and interests of people with disabilities through the practice of guardianship, advocacy and education.

The Guardianship Tribunal appoints the NSW Public Guardian as guardian of last resort to make health and lifestyle decisions on behalf of a person under guardianship. Additionally, they provide information and support to private and enduring guardians and information on the role and function of guardians to the general community.

Contact:
Community Information Officer
Tel. (02) 9265 1443 or 1800 451 510

The Protective Commissioner

The Protective Commissioner is an independent public official legally appointed to protect and supervise the financial affairs and property of people unable to make financial decisions for themselves.

Contact:
Tel. (02) 9265 3131
Outside Sydney 1300 360 466
Fax. (02) 9265 3686
Telephone Typewriter 1800 882 889
www.pt.nsw.gov.au
Obsolete
Obsolete