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Consultation on the Draft Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2020

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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide feedback on the Draft Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2020.

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

ACEM appreciates the effort that has been made in this draft amendment to address the current lack of legislative framework around the use of restrictive practices in patients who require this for their or others' safety in the context of illness, injury or intoxication. ACEM supports many of the provisions of the draft bill, including the use of restrictive practice as a practice of last resort for the minimum necessary time, the necessity of audit and review for all cases of restrictive practice, and the need to ensure strong safeguards for patients. However, ACEM does wish to raise a number of areas where the draft bill could be enhanced in order to minimise confusion, enhance practical application and improve the standard of care where restrictive practices are required.

The framing of this response will start with review of the four questions provided by South Australia (SA) Health for consideration, before reviewing a number of other considerations relevant to the Draft bill's wording and implementation.

Question 1. Is it appropriate/necessary for health practitioners to use restrictive practices to assess and treat patients who are exhibiting challenging behaviours, do not have decision making capacity, and who are presenting a risk to themselves and others?

The ED is well-recognised as a setting in which violence is more likely to occur. A survey of ACEM members found that 88% had been threatened by a patient in the past year and 43% had been physically assaulted in the past year.[1] As a result, ACEM acknowledges that restrictive practices (including sedation or physical restraint) may be needed to manage agitated or violent patients who pose a risk to themselves, staff or other patients, and when all other de-escalation techniques have been unsuccessful.[2] Evidence also suggests that patients who are intoxicated with alcohol or other drugs are less likely to respond to verbal forms of de-escalation and are more likely to require sedation compared to patients with a principal diagnosis of mental illness.[3] [4]

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[1] Australasian College for Emergency Medicine. (2016). ACEM Workforce Sustainability Survey Report, November 2016. Melbourne: ACEM

[2] Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, Emergency Medicine Australasia

[3] Yap, C.L., Taylor, D. Kong, D.C.M., Knott, J.C., Taylor, S., Graudins, A., Keijzers, G., Kulawickrama, S., Thom, O., Lawton, L., Furyk, J., Finucci, D., Holdgate, A., Watkins, G., Jordan, P. (2019) Management of behavioural emergencies: a prospective observational study in Australian emergency department. J Pharm & Prac, 49 (4): 341-348.

[4] Braitberg, G., Gerdtz, M., Harding, S., Pincus, S., Thompson, M. and Knott, J. (2018) Behavioural assessment unit improves outcomes for patients with complex psychosocial needs, Emergency Medicine Australasia, 30:353-358.

At times, restrictive practices are the only option available to health practitioners to allow the safe assessment and appropriate treatment of patients suffering from acute behavioural disturbance in the setting of injury, illness or intoxication. As such, whilst restrictive practices are to be minimised and their use closely reviewed, they do unfortunately remain a necessary option in the management of these patients.

Question 2. Is the timeframe for the use of restrictive practices (up to a maximum of 24 hours for adults, and 12 hours for those who are under 18 years) appropriate?

ACEM supports the intent of the draft bill to ensure that restrictive practices, when used, are used for the minimum length of time possible. As interventions imposed on a patient without their consent, restrictive practices must be used only as measures of last resort, be as least restrictive as necessary, and be in place for the minimum time required.

ACEM understands the intent of the 24 hour and 12 hour timeframes is to minimise duration of restraint. However, the practical application of these timeframes in many circumstances will pose challenges and reviewing these timeframes (or at least standardising them to be 24 hours across all ages) may help this somewhat, without detracting from the intent, which is clearly expressed within Division 4. 14K (6). Challenges that may be encountered under the current draft timeframes include:

- Restrictive practice orders under the act expiring out of hours, including overnight, especially given most of these orders will be placed in the community or EDs and presentations with acute behavioural disturbance and trauma are greater out of hours.
- A large subset of children potentially affected by the draft bill (adolescents primarily) presenting with the same toxicological causes for acute behavioural disturbance as adults – which often take over 12 hours to resolve. In the case of these children, they would require two orders for standard care – triggering automatic review for each of these children.
- Management of patients requiring ongoing restrictive practices orders under this draft bill for greater than 24 hours. Patients presenting with delirium commonly take greater than 24 hours to recover. Under the proposed changes, there is no clear pathway forward for this group if restrictive practices are required past 24 hours and this needs to be clearly spelled out.

Question 3. Are the proposed safeguards in the Bill appropriate/necessary to protect patients and monitor the use of restrictive practices?

ACEM strongly supports the need for robust governance, review and safeguards with respect to the use of restrictive practices in order to ensure protection for patients, transparency and the early identification of practice that may require review.

ACEM notes the ongoing significant concerns voiced in South Australia by the Chief Psychiatrist, Dr John Brayley, about recording and reporting on episodes of restrictive practice under the current arrangements, and strongly encourages SA Health to ensure processes are put in place to allow automated, rapid reporting of episodes of restraint. The current Safety Learning System (SLS) platform has severe limitations in its general function and is simply not fit for purpose to record episodes of restrictive practice in an efficient or effective manner.

Section 14P of the draft amendments outline a requirement to ensure adequate recording and maintenance of records relating to instances of restrictive practices, including financial penalties on individuals for failing to record or maintain these records. Whilst ACEM understands the need for strong incentives to maximise compliance with elements of the act enabling oversight and providing safeguards, we have concerns over the proposed punitive approach directed at individuals rather than organisations in targeting compliance. Ultimately, organisations and health services bear a responsibility to provide the environment, education and systems to enable recording of restrictive practices in their facilities and play a core role in the maintenance of standards in implementation and record keeping. As such, ACEM believes that penalties for non-compliance should be primarily directed at organisations (such as Health Networks, Services or Hospitals) rather than individuals.

Where medical staff or other health practitioners fail to maintain adequate records, institutions should adopt system change and an educational approach to address knowledge deficits leading to inadequate record keeping. Where individual practitioners exhibit ongoing failure to adequately record instances of restrictive practices despite repeated education, current performance management and professional regulatory body review processes (through AHPRA) already exist.

Section 14Q of the Amendment bill outlines the triggers and requirements relating to reviewing the use of restrictive practices. ACEM supports regular Ministerial review of the use of restrictive practices. It is noted that the triggers for review are set quite low (>2 occasions of restrictive practice within a 7 day period) which, as described above in the response to Question 2, may result in a large number of mandated reviews. In this context, ACEM strongly believes that appropriate resources must be provided to support the regular review process to allow maximal benefit to be obtained from this in identifying areas for service development and improvement.

Question 4. Is it appropriate/necessary to require that health practitioners seek consent from responsible persons, or substitute-decision makers, or a guardian, before providing treatment to conditions arising from these situations?

ACEM supports the earliest possible involvement of patients, or where that is not possible, responsible persons, guardians or substitute decision makers on the patient's behalf, in decisions around patient care.

Where practical, efforts must be made to involve these people prior to the initiation of treatment and management, including restrictive practice. However, in many, if not most, of the occasions requiring restraint to facilitate safety, assessment and care, there is not an opportunity to obtain consent from relevant parties prior to initiating restraint. In these cases, ACEM supports the involvement of substitute decision makers, guardians or other responsible persons at the earliest practical time. This contact should include an explanation of the restrictive practice that has occurred and the reasons behind its use as well as provision of the written information as described in the draft amendments to the act.

Other Elements Requiring Consideration in relation to the draft Bill

Handover

Patients who require restrictive practices under the Amended Consent act are likely to transfer between areas of facilities and between different health teams (for example out of the ED to the care of an inpatient team on an inpatient ward).

The current draft Bill as it stands does not provide any guidance as to the requirements relating to transfer of responsibility for enacting and for ongoing review of any restrictive practices where patients move between services, or when health practitioners change shifts.

In order to prevent confusion in the application of the amendments, ACEM strongly recommends that explicit arrangements regarding transfer of care and responsibility for review of restrictive practice arrangements are incorporated into the bill.

Scope of treatment allowed under the Amendments to the Consent Act

Section 14L and 14M outline the scope of medical treatment that may be delivered under the act.

Importantly, patients will present who will have urgent medical and surgical needs that may not be directly related to the cause for their incapacity to consent under the act or be responsible for the requirement for restrictive practices, but require urgent attention in the context of a patient unable to provide consent. In these cases, where substitute decision makers, guardians or other responsible persons cannot be contacted, patients presumably fall under section 14M – allowing emergency treatment to occur provided two medical practitioners agree there is a medical emergency and the rest of the requirements of the act apply.

In the interests of clarity, it may be worth acknowledging this in 14L (1)(b)(i) and provide reference to 14M and section 13 of the Consent act.

Training and Implementation

The implementation of the proposed amendments to the Consent act will result in a change of practice for medical, nursing, paramedic and other health staff, as well as requiring significant work to be undertaken in developing easy to use resources, automated reporting arrangements, and defined audit and review schedules.

Whilst Local Health Networks and individual health services will be responsible for developing site specific policy and implementation, it will be important for clear central guidance around education and implementation requirements. Elements that will need to be considered include:

- Appropriate training for sufficient health staff to allow them to function as authorised persons – both in the community, as well as EDs and inpatient wards. It will be essential to ensure staff at all stages of patient care can act as authorised persons if required (facilitating transfer of responsibility for restrictive practices orders with patient movement)
- Appropriate training for any staff who may be called for under 14K(8) to assist in the use of restrictive practices. This will need to include private security personnel who are involved in Code Black response, as well as SAPOL as necessary.

Clarity of role designation

ACEM notes the somewhat interchangeable use of the two terms "medical practitioners" and "health practitioners" throughout the FAQ document, as well as the Draft Bill itself.

ACEM understands and supports the need for a range of health practitioners, including Paramedics, Nurses and Nurse Practitioners to be able to be authorised persons under the act, however, contrary to the FAQ document sees no need to expand the definition of "medical practitioner" to include these professionals, who are clearly already encompassed within the general "health practitioner" group.

Amendments to the Advanced Care Directives Act 2013

ACEM notes and supports the proposed amendments to the *Advanced Health Care Directives Act 2013* which will help provide greater clarity in regard to the application of both Acts in concert.

Amendments to the Mental Health Act 2009

ACEM notes and supports the proposed changes to the *Mental Health Act 2009* which will provide greater clarity around the provision of treatment to patients under sections 24, 28, 31 and 56 of the Mental Health Act.

Thank you for the opportunity to provide feedback on the draft Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2020.

There is much to be welcomed within this bill, but also improvements that can be made and an imperative to ensure that its implementation occurs in a way that provides certainty, safety and transparency for patients, staff and families alike.

If ACEM may be of any further assistance, provide any further information in support of this response or in support of further development of the Draft Bill, please do not hesitate to contact ACEM via policy@acem.org.au

Yours sincerely,

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