Can a Resident ever be confined in an area in their aged care facility?

Fact Sheet: Isolating an aged care resident as a form of seclusion.

In Australia, an aged care resident (**Resident**) generally has the right to move around their aged care facility freely, except where there may be a risk of harm to the Resident or others.

If, for the primary purpose of influencing a Resident's behaviour, they are left on their own in any area of their aged care facility where they cannot exit or it is implied that they cannot exit, it is known as seclusion. Seclusion is a 'restrictive practice' because its use restricts a person's rights or freedom of movement and can only be used as a last resort to prevent harm.

Restrictive practices are strictly regulated and aged care providers (**Providers**) are required to meet various obligations. This fact sheet applies to aged care services delivered under the *Aged Care Act 2024* (Cth) in a Victorian aged care facility (**Facility**).

This fact sheet will:

- Define seclusion;
- Explain the legal requirements that must be met by Providers to authorise and apply seclusion, including in emergency situations;
- Define informed consent; and,
- Explain what you can do if you are concerned about the misuse of seclusion.

What does seclusion look like?

Seclusion is a practice or intervention that is, or that involves, the solitary confinement of a Resident in a room or a physical space at any hour of the day or night where voluntary exit is prevented or not facilitated; or it is implied that voluntary exit is not permitted; in order to influence the care recipient's behaviour.

It may involve locking a Resident in their room or other part of the facility, directing a Resident to a specific area within the facility with the Resident believing they are not allowed to leave, or when Residents and staff all leave an area but the Resident is unable to leave and is left on their own.

David, age 88, aged care resident

At certain times of the day, David wishes to be left alone in his room. Staff have fitted David's door with a lock and provided David a key, at his request. Staff also have a key. David has been informed of the risks of having a locked door and strategies to reduce the risk have been discussed and agreed. Strategies include the door opening from the inside without a key and staff regularly checking on David by knocking on the door. David has no mobility issues.

This is *not* seclusion, as David has chosen to be alone yet can leave his room easily and by choice.

Angela, age 84, aged care resident.

Hadiza has dementia and issues with mobility. She requires assistance from staff to move around her aged care facility. She often yells out loudly and when staff attend to Hadiza they cannot understand her to meet her needs. Staff move Hadiza to a second common room, far from the main lounge area, and turn the TV on. Hadiza continues to yell out and cannot leave the area without assistance.

This *is* seclusion. Hadiza has been moved because she is noisy and she is alone and unable to leave.

What are the Provider's obligations in the use of seclusion?

The Provider must be satisfied that:

- Seclusion is only used as a last resort to prevent harm to the Resident or other persons, and after consideration of the likely impact on the Resident;
- Alternative strategies are considered and used to the extent possible, and documented in the Resident's Behaviour Support Plan;
- The seclusion is only used to the extent it is necessary and in proportion to the risk of harm to the Resident or other persons; is in the least restrictive form, and for the shortest time necessary to prevent harm;
- The seclusion complies with the Resident's Behaviour Support Plan (and other relevant care plans), the Aged Care Quality Standards, and is consistent with the Statement of Rights.
- Informed consent to the use of the restraint has been obtained, except in an emergency (see below).

The Provider must be satisfied that a health practitioner with day-to-day knowledge of the Resident has;

1. Assessed the Resident as posing a risk of harm to themselves or any other person; and
2. Assessed that the use of the seclusion is necessary.

The Provider must document the following in the Resident's Behaviour Support Plan:

- The Resident's behaviour and assessments relevant to the use of seclusion.
- The alternative strategies that have been considered or used, including a record of any consultations with the Resident or their substitute decision maker discussing such strategies.
- Details of the seclusion, including duration, frequency and intended outcome, and how it is to be monitored, including the escalation process.
- Any engagement with persons other than the health practitioner in relation to the use or assessment of the seclusion (for example, dementia support specialists).
- A record of the informed consent obtained by the Provider from the Resident or their substitute decision maker, for the use of the seclusion.

Responsibilities of the Provider while seclusion is being used:

- The use of the restraint is monitored, reviewed and documented in the Resident's Behaviour Support Plan.
- The Resident is monitored for signs of distress or harm, side effects, changes in mood or behaviour, including ability to engage in activities and to maintain independent function (to the extent possible).
- Consider if appropriate alternative strategies can be used, or changes to the environment could be made, for the restraint to be reduced or stopped.

How is seclusion used in an emergency?

Seclusion can be used in an emergency as necessary, such as in a dangerous event that is unanticipated and requires immediate action. It does not require informed consent.

The seclusion must be in the least restrictive form, for the shortest period possible, and documented. The Provider must inform the Restrictive Practices Substitute Decision Maker as soon as practicable after the event, and document the Resident's behaviour, the alternatives considered or used, why the restraint was necessary, and the care provided.

Who can consent to seclusion on behalf of a Resident?

- A decision to use seclusion requires informed consent by the individual receiving the restraint, or if they lack capacity, by a substitute decision maker.
- A Resident is presumed to have capacity to make their own decisions.
- Determining a person's capacity can be difficult, it may be appropriate to obtain an assessment by a suitably qualified medical practitioner.
- If a Resident does not have capacity to provide informed consent to the use of seclusion, consent must be obtained from a substitute decision maker.
- In Victoria, there is a hierarchy of persons who can be Restrictive Practices Substitute Decision Makers (**RPSDM**). See our Fact Sheet on the RPSDM Act here.

What is 'informed consent'?

A Resident or RPSDM must provide informed consent to the use of seclusion. This requires the Provider to explain the reason for the use of the seclusion, the risks and benefits, the timeframe and intended outcomes, and any alternative options. In addition, consent should be provided independently, free from duress, and involve the opportunity to review and ask questions.

Consent can be refused or withdrawn and is required each time seclusion is proposed.

Legal remedies for unlawful seclusion

- Unauthorised use of restraint may give rise to civil or criminal actions, and be considered assault or false imprisonment, in severe cases.
- A person may seek an injunction from the courts to prevent the restraint from happening or continuing.

What can you do if there is an inappropriate use of seclusion?

- Make a complaint to the Provider
- Make a complaint to the Aged Care Quality and Safety Commission (ACQSC).
- Contact ACJ if you are unsure of your rights for a free legal consultation.

Contact Aged Care Justice if you would like a free legal consultation:

Email: info@agedcarejustice.org.au

Phone: 0417 234 415

Website: **www.agedcarejustice.org.au**

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