Annexure 2. Reform Perspectives 7 November 2025

This opinion was provided by Melanie Scott as part of Aged Care Justice's Education Project on Restrictive Practices.

The Project was called *Reducing Serious Incidences of Restrictive Practices in Aged Care Settings through Legal Education and Access to Legal Services* and the education materials can be found here.

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Restrictive Practice Reform in Aged Care by Melanie Scott

In caregiving settings, the concept of "restraint" has undergone a profound transformation.

Historically dating back to the 19th and early 20th centuries, restraint was seen as an appropriate response to disruptive behaviour in education and caregiving settings, being used to manage people's behaviour. Rooted in control, these practices were designed to enforce compliance, often without consideration of underlying triggers that may be causing their responses

However, over the last few decades the use of restraint has been informed by human rights, psychology, and accepted best practice. Reflecting a change in the way society views such controlling and impersonal treatment. Policies around restraint have evolved significantly. Legislative changes and professional standards now emphasize restraint as a last resort, employed only when a person's behaviour poses an immediate threat to themselves or others.

In today's aged care community, a conscious shift towards a more empathic and humanistic approach is gradually gaining momentum, highlighting the important role of trauma awareness, resident centred care, de-prescribing (chemical restraint medications) and reduction of restraint use. Whilst advocacy groups continue to push for reforms, we are awaiting the implementation of the new Aged Care Act and strengthened Aged Care Quality Standards (ASQSC). The purpose of which is to ensure people receiving aged care services receive high-quality person-centred care that meets their needs, choices and preferences in a safe and equitable environment. Whilst providing a framework for care providers to improve the safety, effectiveness and quality of care provided, and continuously upholding the rights of older Australians.

For aged care staff and clinical educators, the evolution of restraint practices has led to a greater focus on skill-building and communication with a focus on empathy and respect, intentional practice and trusting relationships with those in their care. By learning de-

escalation techniques and gaining a deeper understanding of trauma and response triggers, staff will be more adept at responding to responsive/challenging situations without resorting to restraint.

In todays aged care community, the focus must continue to be on reducing the incidence of restraint/restrictive practice and ensuring it is only ever used as a last resort not a first line response. To fulfill provider requirements, on each review and re-authorisation for restraint/restrictive practice, nursing staff and GPs must ensure and document that all non – pharmacological strategies have been tried and failed before resorting to restraint/restrictive practice.

Positive Behaviour Support (PBS), takes a holistic view of an individual's behaviour, seeing it as communication rather than something to be controlled. PBS focuses on enhancing quality of life and teaching new skills that can assist in reducing the likelihood of responsive behaviours. By understanding the person's needs, preferences, and triggers, staff can work towards creating environments that allow people to thrive with dignity and respect, whilst maintaining social connections and enablement.

The language healthcare providers use is very important, in conjunction with their approach to people living with dementia. As we remember, care is around "seeing the person", understanding their needs and preferences. A very important aspect is to know your person's story. Only too often a resident in an aged care facility may be asked to do something out of their routine or comfort zone and this may trigger what we call "responsive or changed behaviour", a much more compassionate term than challenging behaviour. As he/she is communicating to you through their response. E.g. If he/she had an afternoon shower routine at home, then as far as possible this needs to be maintained in their new living environment. Often residents are asked to shower outside of their routine time, and this may result in them communicating through responsive or changed behaviour that they feel uncomfortable. Sadly, due to a history of blame placing and possible lack of experience or training, often staff will record this scenario as "refused shower or refused personal care". But they did not refuse, this is an example of how an inappropriate approach from staff can be the actual trigger to a responsive episode.

So, we must always ask "what is their story?" and what are they trying to communicate. Experiential training and senior clinical oversight are necessary to ensure attitudes continue to improve and staff see their residents with compassion and understanding, not as a nuisance.

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The Royal Commission into Aged Care Quality and Safety identified that psychotropic medicines are being misused and overused. Inappropriate use of psychotropic medicines has been recognised as a safety and quality issue in aged care.

Using psychotropic medicines, such as antipsychotics and benzodiazepines, to calm, sedate, influence or control the behaviour of people who exhibit responsive or changed behaviours is a restrictive practice and is subject to regulatory oversight.

Healthcare practitioners and aged care providers require informed consent for the prescription and use of psychotropic medicines, including when used as a restrictive practice. It is now recognised that behaviour support planning and the implementation of behaviour support strategies reduce the use of restrictive practices.

My experience as a nurse:

As a student nurse I remember seeing 4 hospital patients placed on commodes in a 4 bedded area, with only a curtain blocking the view from the corridor, no curtains between the patients were drawn, no privacy provided, their dignity ignored. I still remember to this day how that experience triggered my desire to advocate for those who could not advocate for themselves – "a voice for the voiceless"

I have also been told by a resident's daughter how staff at her mother's nursing home woke her at 4am to shower her. Is there any wonder people show responsive or changed behaviour to such dreadful situations. I always ask how would I feel if that was my family member, and how would I react?

Now as a registered nurse with over 40 years' experience, I am still witnessing care to residents that ignores their dignity, choice, physical and psychological safety.

I have witnessed what I call "facility induced behaviour responses" – e.g.:

A gentleman, when at home always had an afternoon shower, especially in the winter as it was too cold in the morning. He then goes to live in an aged care facility and is showered at 6am. This is not his usual routine, it is cold, and his wish is to stay in bed. Staff members keep trying to get him to have a shower until he becomes verbally and physically agitated. They then document this agitation as "refusal of personal care" and ask the RN to give him some medication.

This is a simple example of how staff approach or staff behaviour can trigger a response by not knowing the person's story or following his normal routine.

So, what can families and friends do to advocate for their loved ones?

- Visit frequently.
- Build relationships with staff, open communication.
- Encourage activities inside the home and trips out into the community to help your loved one feel socially connected.
- Ensure your loved one is involved in all decisions regarding their health, social care and care planning as they choose.
- Be involved in care planning (where appropriate).
- Ask questions if you have a concern.

- If you or your loved ones have concerns, address them with the most appropriate person-know the chain of command.
- Ensure you and your loved one understand the “Charter of Aged Care Rights”.
- Seek external help if required e.g.: advocacy support, Allied Health - targeted physiotherapy.
- If your loved one is receiving restrictive practice – be it physical, environmental or chemical, ask questions and understand the facilities obligations and ongoing plan.
- If chemical restraint - ask the staff and GP which nonpharmacological strategies have been tried before resorting to chemical restrictive practice. This must be reviewed every 6 months.
- For any resident receiving restrictive practice (RP), a Behaviour Support Plan (BSP) is required outlining the need for the RP, intentions, the goal of its use, effectiveness at review and strategies for eventual reduction, (de-prescribing for chemical RP) and cessation.
- Ensure regular medication reviews are completed, at least annually with a pharmacist, in addition to when medications are changed and on hospital discharge.
- If you witness negative changes to your loved one’s behaviour when medications are changed or increased/decreased, discuss concerns with GP.

The aged care community is going through many long overdue changes, and with this comes uncertainty about the future.

Including people entering aged care facilities with much more complex needs, changes to policy and legislation, workforce issues, access to assistive technology, a reduced confidence in the aged care sector, changes to the means tested contributions to care, potential for premature admission to aged care facilities due to home care co-payment change. To name but a few areas.

With this in mind, we cannot afford to take our eye off the ball or lose focus.

The focus must always be on “the safety and quality of care provided to the people we are caring for, ensuring they have a voice and decision-making power over where, when and how they receive care services”.