Duty of care, restraint & restrictive practices

Blaise Lyons and Melanie Shea
Legal Branch – Ministry of Health

NSW GOVERNMENT | Health

Duty of Care & Restraint

- What does ‘duty of care’ mean?
- Principles of restraint and duty of care
- Do you need consent to restrain a patient?
- Who can give consent?
- Suggested ways forward
- Reviews and other developments

What does ‘duty of care’ mean?

Duty of care is a concept that comes from **negligence**.

To prove a negligence claim, a patient, or their family must prove that:

1. The healthcare provider or LHD **owed** them a duty of care; and
2. The healthcare provider or LHD **breached** their duty of care; and
3. The patient suffered an **injury** as a result of that breach.

The duty owed is a duty to take ‘reasonable care’ to avoid causing harm.

What is ‘reasonable care’?

- What is ‘reasonable’ will depend on the specific facts and circumstances
- A court will consider what a reasonable, competent, RN would do in response to a specific risk.
- ‘ Reasonableness’ - will depend on the likelihood of the risk eventuating, the magnitude of risk, and the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities.

You may be negligent if you do not take precautions against a risk of harm if the risk was **foreseeable, not insignificant, and a reasonable person would have taken precautions**

NSW GOVERNMENT | Health

Civil Liability Act 2002 (NSW)

- **5O Standard of care for professionals**

1. A person practising a profession (***a professional***) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
2. However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
3. The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
4. Peer professional opinion does not have to be universally accepted to be considered widely accepted.

This provision provides a defence to some negligence claims if a practitioner can establish that their peers would view their actions as competent professional practice.

Can you owe a duty of care to restrain a patient?

- **In general, the law protects a person's right NOT to be restrained.** The law protects an individual's right to decide what happens to their own body. Inappropriate use of restraint may be assault, battery, false imprisonment or negligence.

- However, a Hospital has a **duty of care** to reduce or eliminate foreseeable risks of harm to its patients, staff and visitors. At times restraint may be necessary to ensure the safety of the patient, visitors and staff.

Balancing care and safety when using restraints

RISKS

- Patients have a right to receive the least restrictive type of care possible.
- Restrictive interventions are known to pose risks to older people, including falls, serious injury, increased hospitalisation and death
- Restraint can be traumatic and de-humanising to patients.
- International obligations – *UN Convention on the Rights of Persons with Disabilities* and *UN Convention against Torture*

PRINCIPLES

- Restraint should only be used when less restrictive alternative options have been considered and trialed.
- Restraint should generally only be used for a brief period until the risk has subsided and safety can be maintained.
- The nature of the restraint should be proportional to the risk (for example, the patient's behavior).
- Restraint must be used in accordance with professionally accepted standards
- Patient must be regularly reviewed and monitored.
- Should be local policies, procedures and training
- Must have lawful excuse and/ or appropriate consent

Case Studies

Importance of local policies, procedures and monitoring patients:

- **Victorian Coronial Inquest (Robertson):** A tie rug was used to restrain Mr Robertson on the commode, he was left for 20 minutes and then found dead after he had slipped and the tie rug had caught around his neck. Cause of death asphyxiation.
- The Coroner had before him **policies** for the restraint of residents in the nursing home and statements regarding **training** on those policies, how they were communicated to staff.
- Even though the Coroner did not find that anyone contributed to the death, the case highlights the importance of **regularly monitoring** patients who are subject to restraint.

Case studies

Restraint has to be justified and proportionate

- Fair Work Commission case – Victorian case where a Disability Instructor claimed her termination was ‘harsh, unjust or unfair’.
- Patient had left a therapy room and Ms Joseph followed her, wrapped her arm around her shoulders and neck. Witnessed by other staff.
- Ms Joseph argued that she had offered a ‘helping touch’ to ‘guide her back’ to the therapy room.
- Care home disagreed and said Ms Joseph was inappropriately restraining the patient. Off the back of this incident, and the fact Ms Joseph was still in probationary period, the care home terminated Ms Joseph.
- Termination upheld by Fair Work Commission.

Do you need consent to restrain a patient?

- Whether you need consent and who can give consent depends on the capacity of the person and on purpose of the treatment or intervention.

- In general, a competent adult has the right to consent to, or refuse any treatment including restraint.

- In an **emergency situation** where restraint is necessary to provide immediate treatment to save a person's life or prevent serious injury to their health consent is not required.

No civil (or criminal) liability for acts in self defence

- Section 52, CLA and s418, Crimes Act:

  A person does not incur a liability / is not criminally responsible for an offence arising from any conduct of the person carried out in self-defence, but only if the person believes the conduct was necessary:

  (a) to defend himself or herself or another person, or

  (b) to prevent or terminate the unlawful deprivation of his or her liberty or the liberty of another person, or

  (c) to protect property from unlawful taking, destruction, damage or interference, or

  (d) to prevent criminal trespass to any land or premises or to remove a person committing any such criminal trespass,

  and the conduct is a reasonable response in the circumstances as he or she perceives them.

- CLA: the conduct to which the person was responding to must have been unlawful, or would have been unlawful if the other person carrying out the conduct to which the person responds had not been suffering from a mental illness at the time of the conduct.

Defences for security staff employed by Health Services

- There are also specific protections from personal liability for employed security staff in the Mental Health Act, the Mental Health (Forensic Provisions) Act and the Health Services Act.
- If a security officer is assisting a health care professional to exercise a function conferred on them by one of these Acts they cannot be personally liable for any injury or damage.
- This is why NSW Health policies state that security staff should only be restraining patients and others under the direction of a health care professional. It is partially for the legal protection of the security officer.

What about involuntary mental health patients?

- The Mental Health Act requires that patients be provided with the best possible care in the least restrictive environment. In the use of restraint, staff must be satisfied that the intervention is reasonable and accepted as safe, competent professional practice.
- No consent is needed in order to provide (mental health) treatment to involuntary patients. An authorised medical officer of a mental health facility may give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an **involuntary** patient.
- S190(2) states that nothing in the Mental Health Act prevents an authorised medical officer from taking any action that the officer thinks fit to protect a patient or person detained in a mental health facility, or any other person in a mental health facility, from serious physical harm.

Do you need substitute consent?

- When a patient lacks capacity and it is not an emergency, health practitioners are required under law to seek substitute consent from either:

  - **Person responsible –** if the restraint is an adjunct to medical treatment; or

  - **An NCAT appointed guardian** with a restrictive practices function, if the purpose of the restraint of intervention is to address behavior, rather than treat a medical condition.

NCAT – New Restrictive Practices and Guardianship Factsheet

- When NCAT appoints a guardian for a person, it chooses what decision making functions that guardian will have, including whether the guardian should make 'restrictive practice' decisions.
- A restrictive practice is regarded NCAT as being any practice or intervention that has the effect of restricting the rights or freedom of movement of the person and this includes the use of chemical restraint.
- Chemical restraint is defined to be *'where medication is used for the primary purpose of influencing a person's behavior and not for the treatment of a diagnosed mental disorder, physical illness or physical condition.'*
- Restrictive practice decisions will be made when the person's behaviour involves physical or other risks to themselves or others or where intervention is needed to reduce or remove these risks.
- **Restrictive practices are not considered to be a form of medical treatment under the *Guardianship Act 1987.***

NSW GOVERNMENT | Health

Case Studies

Only an appointed guardian with a specific function can consent to restrictive practices

- **HZC [2019] NSWCATGD 8 :** In April 2019, 12 month review of a guardianship order. HZC has a genetic condition and is severely intellectually disabled and lives in supported accommodation operated by an NDIS provider. HZC's parents were reappointed as joint guardians – GD reviewed their functions.
- The guardians were given a number of functions, including to give or withhold consent as to whether the following restrictive practices should be used to influence HZC's behaviour:
  - Chemical Restraint
  - Environmental Restraint
  - Mechanical Restraint and
  - Seclusion
- The conditions placed on exercising this function include that such practices would only be consented to:
  - As a last resort to prevent HZC harming herself or others and
  - In accordance with a behaviour support plan which has been developed by a behavior support practitioner after having conducted a functional behavioural assessment upon HZC and which is reviewed regularly.

Case Studies

- **HZC continued…**

<u>The GD has adopted the NDIS definitions of restrictive practices</u>

- In reviewing the Guardians' functions, GD undertook a review of the role of the GD in terms of restrictive practices more broadly.
- GD adopted the definition of the Commonwealth *NDIS Act* for restrictive practices. That is,

  'any practice or intervention that has the effect of restricting the rights or freedom of movement of the person with disability.'

- '*Regulated restrictive practices'* include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint (in this case, access to food).
- NDIS providers must comply with *NDIS (Restrictive Practices and Behaviour Support Rules).* GD adopted the definitions of the Restrictive Practices under those rules.
- Whilst the Commonwealth NDIS legislation is not binding on the GD, it was found it was in the best interests of people with whom restrictive practices are being used, if a consistent definition was applied.

Case studies

- **HZC continued**
- *Chemical Restraints* - GD found that the use of medications primarily to influence someone's behavior, rather than to treat, or enable treatment of a diagnosed medical condition, (including a mental disorder) requires the consent of a **guardian** with authority to decide about the use of restrictive practices if the person is unable to provide their own consent. The use of medications in these circumstances should not be categorised as only requiring 'consent to medical treatment' and therefore, a **person responsible** cannot give consent.

Implications of NCAT Ruling

- Whether or not a treatment is a restrictive practice will depend on the purpose and effect of the treatment. If the purpose is treatment of a medical condition or adjunct to that treatment, it will be medical treatment for the purposes of the *Guardianship Act* and the person responsible can consent.

- If a restrictive practice aims to address behavioural issues and minimise harm not associated with a medical condition, only an appointed guardian with a restrictive practices function can give consent.

Suggested way forward

- If there is any doubt that the purpose of an intervention is NOT to treat a medical condition, and it is possible for the family (or the LHD) to lodge an application with NCAT seeking appointment of a guardian with a restrictive practices function this should be done.

- Where this is not practical, or you are waiting for a decision from NCAT - treat the patient in accordance with standard professional practice, with their safety in mind and with the full knowledge and understanding of their person responsible.

Spotlight on restraint

Recent

- NCAT NSW – new factsheet on restrictive practices, June 2019
- Ombudsman's report- Abuse and neglect of vulnerable adults in NSW – the need for action, 2018
- Law Reform Commission's Review of the *Guardianship Act 1987*, 2018
- NSW Parliamentary Inquiry into Elder Abuse, 2016
- Parliamentary Inquiry into the implementation of the National Disability Insurance Scheme (NDIS) and provision of disability services, 2018

Ongoing/upcoming

- Royal Commission into Aged Care Quality and Safety 2018- 2021
- NSW Ageing and Disability Commissioner (from 1 July 2019)
- NDIS Quality and Safeguards Commission
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability 2019 - 2022

NSW GOVERNMENT | Health

Aged Care Royal Commission – consideration of restraint

- The hearings in Sydney in early May focused on the quality of care in residential aged care, with particular focus on people living with dementia.
- The Commission heard evidence of public and professional concern about the use of physical restraints and the overuse of psychotropic drugs (in particular, antipsychotics and benzodiazepines) in residential aged care to manage the behavior of people living with dementia.
- *Pharmaceutical interventions* and overprescribing were a key theme of the hearing – clinical evidence was that these should be used as a last resort and be time limited for specific indications. Pharmaceutical interventions should not be purely used for restraint or as a substitute for assessment of causes, staffing requirements or educational needs of staff.
- Also explored the adverse impacts of *physical restraints* – including attempts to escape from restraints, decreased mobility, deconditioning (falls risk).

Aged Care Royal Commission – consideration of restraint

Senior Counsel Assisting the Commissioner, Peter Gray QC:

"*Towards the more serious end of failings an approved provider may resort to restrictive practices, whether in response to real or perceived workload issues or the mistaken view that they need to manage challenging behaviours (associated with dementia).*"

"Restrictive practices are the antithesis of person centred relational care."

"The issue will be subject to further scrutiny as the Royal Commission continues."

Any questions….?

Contact details:

NSWH-LegalMail@health.nsw.gov.au

Blaise.lyons@health.nsw.gov.au

Melanie.Shea@health.nsw.gov.au

NSW GOVERNMENT | Health