Review of the Guardianship Act 1987

Question Paper 5

Seniors Rights Service

Medical and Dental Treatment and Restrictive Practices

Question 2 Capacity to consent to medical and dental treatment

Question 2.1 Incapable of giving consent

1. **Is the definition of a person incapable of giving consent to the carrying out of medical and dental treatment in s 33(2) of the Guardianship Act 1987 (NSW) appropriate? If not, what should the definition be?**

   The principles of capacity are that capacity is decision specific and that a person should be assumed to have capacity to make a decision unless proven otherwise. Capacity can be partial, temporary or fluctuating.

   We support the current definition of determining whether a person is able to consent to medical and dental treatment as set out in s33(2) of the Guardianship Act 1987 as it is a decision specific test.

   We would support that the definition of capacity in the Attorney General Tool Kit NSW and the principles for assessment of capacity be incorporated in the legislation.

   Definition of capacity
   A person has capacity to make a decision if they:
   - *Understand the facts involved;*
   - *Understand the main choices;*
   - *Weigh up the consequences of the choices;*
   - *Understand how the consequences affect them;*
   - *Communicate their decision*

   Capacity Assessment Principals
   - *Always presume a person has capacity;*
   - *Capacity is decision-specific*
   - *Don't assume a person lacks capacity based on appearances*
   - *Assess the person's decision making ability not the decision they make;*
   - *Respect a person's privacy*
   - *Substitute decision making is a last resort.*

2. **Should the definition used to determine if someone is capable to consenting to medical or dental treatment align with the definitions of capacity and incapacity found elsewhere in the Guardianship Act 1987 (NSW)? If so, how could we achieve this?**

   As capacity to make a decision is decision specific it would be difficult to have one definition of capacity which aligned with all facets of decision making under the Guardianship Act. For example, the ability to make a lifestyle decision about where to live and a decision about the management of finances are separate areas of decision making which require separate tests for capacity.

   We refer above to our recommendation that there could be a general definition of capacity which focuses on a decision specific test and principles for assessment as set out in the Attorney General Tool Kit NSW. These definitions would guide assessors determining capacity but should not replace the legal decision specific tests for capacity. It is important the older person is given as much scope to be autonomous and make their own decisions for as long as they are able to.

<u>Question 3 Types of medical and dental treatment</u>

Question 3.1 : Withholding or stopping life sustaining treatment

1. **Should Part 5 of the Guardianship Act 1987 (NSW) state who, if anyone, can consent to withholding or stopping life sustaining treatment for someone without decision- making capacity?**

   Case law of the Guardianship Division of NCAT NSW, as stated, provides authority that Guardians with appropriate Health Care function can withdraw life sustaining treatment where there is medical evidence to show that this treatment would be futile and inconsistent with good medical practice.

   We submit that there should be similar clarification as to when a person responsible as defined under the Guardianship Act has the authority to withdraw life sustaining treatment, in circumstances where there is medical evidence to show that this treatment would be futile and inconsistent with good medical practice.

2. **If so, who should be able to consent and in what circumstances?**

   We refer to out comments in 3.1 (1) above.

Question 3.2 Removing and using human tissue

1. **Should Part 5 of the Guardianship Act 1987 (NSW) state who, if anyone, can consent to the removal and use of human tissue for a person who lacks decision-making capacity?**

SRS does not receive requests for advice in relation to this area of the enquiry and makes no comment.

2. **If so, who should be able to consent and in what circumstances?**

   We refer to our comments in Question 3.2 (1) above.

Question 3.3 Treatment by a registered health practitioner

Should the definition of medical and dental treatment in Part 5 of the Guardianship Act 1987 (NSW) include treatment by a registered health practitioner?

We support the definition of medical and dental treatment being extended to treatment by a registered health practitioner so that the consent of a person responsible is required for treatment of a person lacking capacity by these practitioners.

Question 3.4 Types of treatment covered by Part 5

1. **Are there any other types of treatment excluded from Part 5 of the Guardianship Act 1987 (NSW) (or whose inclusion is uncertain) that should be included?**

   SRS makes no further comment. The treatments covered by Part 5 of the Guardianship Act 1987 include minor treatment, major treatment and special treatment and appear to cover most treatments.

2. **Should any types of treatment included in Part 5 of the Guardianship Act 1987 (NSW) be excluded?**

   We refer to our comments in Question 3.4(1).

<u>Question 4. Consent to Medical and Dental Treatment</u>

Question 4.1 Special Treatment

1. **Is the definition of special treatment appropriate? Should anything be added? Should anything be taken out?**

   Special Treatment – consent of NCAT

   SRS does not receive calls in relation to the categories of special treatment. SRS notes that it is appropriate the Tribunal consent to special treatment as special

treatments are categories of treatment which are more invasive and guardians should only be able to provide consent with the prior consent of the Tribunal.

2. **Who should be able to consent to special treatment and in what circumstances?**

   We refer to our comments in Question 4.1 (1) above.

3. **How should a patient's objection be taken into account?**

   We refer to our comments in Question 4.1 (1) above.

4. **In what circumstances could special treatment be carried out without consent?**

   We refer to our comments in Question 4.1 (1) above.

Question 4.2 Major Treatment

1. **Is the definition of major treatment appropriate? Should anything be added? Should anything be taken out?**

   The definition of major treatment would appear to be appropriate.

2. **Who should be able to consent to major treatment and in what circumstances?**

   The Tribunal or a person responsible should be able to consent to major treatment.

   Major Treatment – consent of person responsible

   We refer to the current law which also enables a person responsible to override a persons' objection in relation to major treatment where the person has no understanding of treatment and the treatment will cause only reasonably tolerable or transitory distress to the person.

   We recommend that this law be examined closely to determine if Tribunal consent should be required to major treatment in all circumstances where the person objects , as some of the major treatments appear to have significant impact on persons health. The person responsible should in these circumstances be able to demonstrate to the Tribunal the procedure is in the older person's best interests.

3. **How should a patient's objection be taken into account?**

   We refer to our comments in Question 4.2 (2) above.

4. **In what circumstances could major treatment be carried out without consent?**

   We agree with the current legal position that major treatment may be carried out without the older person's consent where urgent treatment is needed to save the person's life, prevent serious damage to the patient's health or to prevent the patient from suffering or continuing to suffer significant pain and distress.

Question 4.3 Minor Treatment

1. **Is the definition of minor treatment appropriate? Should anything be added? Should anything be taken out?**

   We support the current definition of minor treatment.

2. **Who should be able to consent to minor treatment and in what circumstances?**

   The Tribunal or person responsible should be able to consent to minor treatment as currently required.

3. **How should a patient's objection be taken into account?**

   Minor Treatment – Consent of person responsible

   In this instance, as the treatment is minor treatment, we agree with current law that the patient's objection may be overridden by the person responsible where:

   - the Tribunal's consent is obtained and the person responsible is satisfied the procedure is manifestly in the patient's best interest, OR

   - where the person has no understanding of treatment and the treatment will cause only reasonably tolerable or transitory distress to the person.

4. **In what circumstances could minor treatment be carried out without consent?**

   We agree with the current legal position that minor treatment may be carried out without the older person's consent where urgent treatment is needed to save the person's life, prevent serious damage to the patient's health or to prevent the patient from suffering or continuing to suffer significant pain and distress.

   We also agree where there is no person responsible, or cannot be contacted or unwilling to make a decision, that doctor can treat where necessary, where the treatment promotes the patient's health and well being and patient does not object to treatment.

Question 4.4: Treatment that is not medical or dental treatment

Does the Guardianship Act NSW (1987) deal with treatments that fall outside of the Part 5 regime adequately and clearly?

Treatments that fall outside the Part 5 regime should still require the consent of the person responsible as a protection for the older person, such as alternative health therapies. This could be specified in the legislation.

Questions 4.5 Categories of Treatment as a Whole

1. **Does the legislation make clear what consent requirements apply in any particular circumstance? If not, how could it be clearer?**

   SRS is of the view that the current categories are reasonably clear.

2. **Do you have any other comments about the treatment categories and associated consent regime in Part 5?**

   SRS refers to its response in Question 4.5(1) above.

Question 4.6 Person Responsible

1. **Is the "Person responsible" hierarchy appropriate or clear? If not, what changes should be made?**

   One observation is that where there hierarchy falls to a close friend or relative of the older person this person may be difficult to determine. An older person may have several close friends or relatives. We note the observation the Tribunal has not issued any further guideline on who can be a close friend or relative of the person though it is able to do so.

   Where there are disputes arising as to who is the person responsible in the hierarchy or disputes arise amongst several persons responsible about the care in an older person's interests an application can be made for a guardianship order.

   For this reason SRS educate older people on planning ahead and making a guardianship appointments so that there is no dispute as to who is the person responsible for making medical and dental treatment decisions when the older person loses mental capacity to make those decisions for themselves.

2. **Does the hierarchy operate effectively? If not, how could its operation be improved?**

   We refer to our comments in 4.6 (1) and importance of an older person making a guardianship appointment.

Question 4.7 Factors that should be considered before consent

Are the factors a decision-maker must consider before consenting to treatment appropriate? If not, what could be added or removed?

The factors a decision-maker must consider before consenting to treatment as set out in section 40 the Guardianship Act 1987 are appropriate.

Question 4.8 Requirement that consent be given in writing?

Is the requirement that consent requests and consents must be in writing appropriate? If not, what arrangements should be in place?

SRS is of the view that the current practices are adequate and if consents are taken verbally these consents should be recorded by medical practitioners in their medical notes.

Question 4.9 Supported decision-making for medical and dental treatment decisions.

1. **Should NSW have formal supported decision-making scheme for medical and dental treatment decisions?**

   SRS would support a formal and informal supported decision making model which could operate for older people who have capacity to understand the nature and effect of medical treatments with supports. Suitable open ended questions could be asked by the medical professional to the older person, with the support person, to determine if the older person had capacity to understand the treatment. Caution should be exercised that any informal support person does not seek to override or unduly influence the older person. After the medical professional has spoken to the older person with a support person the professional should speak to the older person on their own to gauge their understanding. We refer to our previous submissions in relation to supported decision making models in Question Paper 2 and how these might work for the benefit of the older person.

2. **If so, what should the features of such a scheme be?**

   SRS refers to it's response in Question 4.9 (1) above.

Question 4.10 Consent for sterilization

1. **Who if anyone should have the power to consent to sterilize a person?**

   SRS does not give advice in relation to this area and makes no comment.

2. **In what ways, if any could the Guardianship Act 1987 (NSW) better uphold the right of people without decision-making capacity to participate in a decision about sterilization?**

   SRS refers to it's response in Question 4.10 (1) above.

Question 4.11 Pre- conditions for consent to sterilization

What matters should the NSW Civil and Administrative Tribunal be satisfied of before making a decision about sterilization?

SRS does not give advice in relation to this area and makes no comment.

Question 4.12 Matters that should not be taken into account in sterilization decisions

1. **Is there anything the NSW Civil and Administrative Tribunal should not take into account when deciding about sterilization?**

   SRS does not give advice in relation to this area and makes no comment.

2. **Should these be stated expressly in the Guardianship Act 1987 (NSW)?**

   SRS refers to it's response in Question 4.12 (1) above.

Question 4.13 Legislative recognition of advance care directives

1. **Should the legislation specifically recognize advance care directives?**

   An advance care directive is a record of the older person's wishes about treatment that they would like to have or not have in the event of life – threatening illness or injury. An advance care directive must be made whilst an older person has capacity and be voluntary, give clear and specific details about the treatments an older person would accept or refuse and be current and extend to the circumstances at hand (NSW Sydney Local Area Health Advance Care Directive).

We support the recognition in legislation of advance care directives to make it clear that these documents are enforceable in NSW and binding on medical practitioners once made known to them by their patients.

2. **If so, is the Guardianship Act 1987 (NSW) the appropriate place to recognize advance care directives?**

   SRS submits that the Guardianship Act 1987 (NSW) or similar legislation would be an appropriate place to recognize advance care directives. SRS recommends advance care directives are attached to a guardianship appointment form so that the guardian is aware of the existence of the directive and can communicate the older person's wishes to the medical practitioner. An appropriate directive form could be included as part of the regulations. We refer to the Central and Eastern Sydney Area Health Service Advance Care Directive as a sample form for consideration.

Question 4.14 Who can make an advance care directive

Who should be able to make an advance care directive?

An advance care directive should be able to be made by a capable adult who understands what and advance care directive is, the consequences of making one, and the nature and effect of the treatments they are refusing as set out in the advance care directive. An older person's doctor would witness their signature as the doctor can certify the older person had the capacity to understand the effect of the treatments they were accepting or refusing.

Question 4.15 Form of an advance care directive

What form should an advance care directive take?

An advance care directive should set out the treatments that an older person wishes to receive or not receive in a particular set of circumstances, and their signature should be witnessed, preferably by their medical practitioner who can explain to them the nature and effect of the treatments they are agreeing to receive or not receive.

An appropriate directive form could be included as part of the regulations to introduced legislation. We refer to the Central and Eastern Sydney Area Health Service Advance Care Directive as a sample form for consideration.

Question 4.16 Matters an advance care directive can cover

What matters should an advance care directive be able to cover?

An advance care directive can cover

- The medical treatment a person does or does not want to receive in certain circumstances;
- Specify who their guardian or person responsible is for medical and dental decision making
- Specify their values (what is important to them if they are ill? What they would find acceptable if their quality of life was impaired to a certain level?)

This information could help the medical professional decide on appropriate treatment consistent with the older person's wishes when they had capacity to the circumstances at hand.

Question 4.17 When an advance care directive should be invalid

In what circumstances should an advance care directive be invalid?

An advance care directive should be followed to respect a person's wishes as to treatment when they had capacity. There would be certain exceptions if it could be shown the person did not have capacity to make the directive, or it was made because of inducement or coercion, or if at the time it was made the person did not understand the consequences of making the decision, or relied on incorrect assumptions. This is why it is important that the directive be witnessed by the person's medical practitioner to ensure that these influences are not present and that the person sees the practitioner on their own.

Question 4.18 : Part 5 offences

1. **Are the various offences of treating without authorization and the maximum penalties that apply appropriate and effective?**

   The penalties would appear to be appropriate. There should be more serious penalties for a person conducting special treatment or clinical trials without consent of Tribunal as is the case with the current law.

2. **Is there a need for any other offences relating to medical and dental treatment?**

   SRS makes no further comment.

<u>Question 5 Clinical Trials</u>

Question 5.1 Definition of Clinical Trial

How should the Guardianship Act 1987 (NSW) define clinical trial?

SRS does not give advice in relation to this area and makes no comment.

Question 5.2 Categories of Medical Research

1. **Should there be more than one category of medical research?**

   SRS does not give advice in relation to this area and makes no comment.

2. **If so, what should those categories be and what consent regimes should apply to each?**

   SRS does not give advice in relation to this area and makes no comment.

Question 5.3 Who can consent to clinical trial participation

1. **Who should be able to approve a clinical trial?**

   SRS does not give advice in relation to this area and makes no comment.

2. **Who should be able to consent to a patient's participation in a clinical trial if the patient lacks decision-making capacity?**

   SRS refers to it's response in Question 5.3 (1) above.

3. **How can the law promote the patient's autonomy in the decision-making process?**

   SRS refers to it's response in Question 5.3 (2) above.

Question 5.4 Considering the views and objections of patients

1. **If the patient cannot consent, should the decision maker be required to consider the views of the patient?**

   SRS does not give advice in relation to this area and makes no comment.

2. **What should happen if a patient objects to participating in a clinical trial? Should substitute consent be able to override a patient's objection? If so, in what circumstances?**

   SRS does not give advice in relation to this area and makes no comment.

Question 5.5 Preconditions for consent

What preconditions should be met before a decision maker can consent to participation?

SRS does not give advice in relation to this area and makes no comment.

Question 5.6 Requirements after consent

What should researchers be required to do after consent is obtained?

SRS does not give advice in relation to this area and makes no comment.

Question 5.7 Waiver of clinical trial consent requirements

Are there any circumstances in which the individual consent requirements of clinical trials should be waived?

SRS does not give advice in relation to this area and makes no comment.

Question 5.8 Other Issues

Do you have any other comments about the consent requirements for clinical trials?

SRS does not give advice in relation to this area and makes no comment.

Question 6 The relationship between the Guardianship Act and mental health legislation

Question 6.1 Relationship between Guardianship Act and Mental Health Act

1. **Is there a clear relationship between the Guardianship Act 1987 (NSW) and the Mental Health Act 2007 (NSW)?**

   Where a person is admitted to a mental health facility and is under an order of the Mental Health Review Tribunal it is submitted that these orders take precedence over a guardianship order under the Guardianship Act 1987. We submit that the Mental Health Review Tribunal should be the decision maker for all medical decisions in circumstances were a person is detained in a mental health facility.

SRS would advise an older person in relation to guardianship orders under the Guardianship Act 1987(NSW). Whilst we get some mental health enquiries we often refer these clients to the Mental Health Advocacy Service at Legal Aid.

2. **What areas if any are unclear or inconsistent?**

   We refer to our comments in Question 6.1 (1) above.

   We note that if it is currently unclear whether a voluntary patient in a mental health facility can discharge themselves if they are under a guardianship order with the Public Guardian for medical and dental function, then this needs to be clarified. The guardianship legislation needs to state whether the medical and dental function includes mental health treatment on an involuntary basis.

3. **How could any lack of clarity or inconsistency be resolved?**

   We refer to our comments in Question 6.1 (1) and (2) above.

Question 6.2 Relationship between Guardianship Act 1987 (NSW) and the Forensic Provisions Act

1. **Is there a clear relationship between the Guardianship Act 1987 (NSW) and the Forensic Provisions Act?**

   SRS does not give advice in relation to this area and makes no comment.

2. **What areas if any are unclear or inconsistent?**

   SRS refers to our comments in Question 6.2 (1) above.

3. **How could any lack of clarity or inconsistency be resolved?**

   SRS refers to our comments in Question 6.2 (1) above.

Question 6.3 Whether mental health laws should always prevail

1. **Is it appropriate that mental health laws prevail over guardianship laws in every situation?**

   Mental Health Review Tribunal is a specialist Tribunal to deal with the mental health of its patients. SRS understands that the Tribunal is set up with different objectives to balance the needs of the person, to protect the safety of the person, and the general community.

The Guardianship Division of NCAT deals with a high volume of older people with cognitive impairments as well as people with intellectual disability and is a Tribunal seeking to focus on best interests and welfare of the older person and make substitute decision making orders as a last resort.

The Tribunals had 2 different philosophies and should be considered separately.

For the reasons noted above, if the person is admitted for mental health care in a hospital the decisions of the Mental Health Review Tribunal should prevail.

2. **If not, in which areas should this priority be changed?**

We refer to our comments in section 6.3 (1) above.

Question 7 Restrictive Practices

Question 7.1 Problems with the regulation of restrictive practices

What are the problems with the regulation of restrictive practices in NSW and what problems are likely to arise in future regulation?

SRS provides advice in relation to restrictive practices in private aged care facilities currently regulated by the Aged Care Act (Cth).

Restrictive Practices – NSW Health Guidelines for Aged Care

SRS sets out below information developed from the Department of Health publication ***How to support a restraint free environment in residential aged care*** (www.health.gov.au). SRS endorses the adoption of guidelines which encourage restraint free practices in aged care in accordance with these guidelines.

Most aged care homes support a restraint-free environment. This means no words, devises or actions will interfere with a resident's ability to make a decision or restrict their free movement. The use of any form of restraint confronts a resident's rights and dignity, and in some cases, may subject the resident to an increased risk of self-harm.

To ensure a resident has their individual needs identified and addressed is a priority of care. A restraint-free approach means that staff, management and resident representatives work together to identify these individual needs and to devise a care plan with preservation of the human rights of residents, especially when responding to challenging behaviours which the resident may be exhibiting. Prevention is the key to restraint-free environment and critical to this success is a partnership approach with the residents' representative.

Management of aged care homes do not support any action or the use of any device that does not have the consent of a resident or their representative. They will not use:

- *Physical mechanisms such as bed rails or lap-belts*
- *Medications including psychotrophic drugs*
- *Aversive treatment practices, punishment or yelling*
- *Locked doors where this is not necessary*

Under the Charter of Care Recipients' Rights and Responsibilities- Residential Care (Aged Care Act 1997, Schedule 1 User Rights Principles 2014) 1.g) states that a resident has the right " to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction". Also 1. u) states "to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights".

<u>When a decision may need to be made about restraint use</u>

The decision to use a form of restraint is not taken lightly and is only used as a measure of last resort. Resident Representatives need to be empowered to feel comfortable when discussing the potential for restraint when talking to staff, and need to involve the resident if appropriate.

The representative may ask the care staff these questions:

- *Why has the decision been made to use restraint?*
- *What are the alternatives to using restraint?*
- *Is the restraint chosen the least restrictive form of restraint for this person?*
- *How will the restraint be monitored?*
- *For how long will restraint be used?*

A decision about the least restrictive form of restraint possible may, as a last resort only, be necessary in situations where a resident is doing something that may result in them:

- *Harming themselves or others, or*
- *Experiencing a loss of dignity, or*
- *Causing damage to property, or*
- *Disrupting or severely embarrassing other residents.*

Prevention of these behaviours will always be a priority, and learning what may trigger any of these will have an ongoing focus of staff's attention. The decision to use restraint is a clinical decision.

Legal Requirements for consent to use restraint:

- *A family member must have a relevant guardianship order or Enduring Power of Attorney to have the legal capacity to consent to the use of restraint*
- *Consent may need to be obtained from the Guardianship Board/NCAT , particularly if the ongoing use of restraint is contemplated*
- *Service providers should obtain legal advice in cases where there is any doubt about the use of restraint.*

Common Misunderstandings about the use of restraint

- *Restraints decrease falls and prevent injury- false. Evidence of injury or death through strangulation or asphyxia resulting from the use of restraint is a real concern.*
- *Restraints are for the good of the resident- false. Evidence has shown that immobilization through restraint can result in chronic constipation, incontinence, pressure wounds, loss of bone and muscle mass, walking difficulties, increased feelings of panic and fear, boredom and loss of dignity.*
- *Restraints make care-giving more efficient- false. Evidence shows that although they might be a short-term solution they actual create greater dependence, have a dehumanizing effect, and restrict creativity and individualized treatment.*

Question 7.2 Restrictive Practices Regulation in NSW

1. **Should NSW pass legislation that explicitly deals with the use of restrictive practices?**

   SRS supports that the Tribunal have jurisdiction to make a guardianship order giving a guardian a restrictive practice function where this is deemed appropriate, and where the guardian has exhausted all other avenues for behavior management. We refer to our comments and Department of Health Guidelines in Question 7.1 above.

2. **If so, should that legislation sit with the Guardianship Act or somewhere else?**

   SRS suggests restrictive practice legislation should be implemented to govern aged care providers and that such legislation should be passed by the Commonwealth as the Commonwealth funds aged care homes and the Aged Care Act (Cth) regulates these providers. We refer to our comments and Department of Health Guidelines in 7.1 above.

3. **What other forms of regulation or control could be used to deal with the use of restrictive practices?**

   SRS refers to its comments in Question 7.1 and 7.2 above.

Question 7.3 Who should be regulated

Who should any NSW regulation of the use of restrictive practices apply to?

SRS suggests restrictive practice legislation be implemented to govern aged care providers and that such legislation might be more suitably passed by the Commonwealth as the Commonwealth funds aged care homes and the Aged Care Act (Cth) regulates these providers.

Question 7.4 Defining restrictive practices

How should restrictive practices be defined?

We refer to our comments in Question 7.1 above.

Question 7.5 When restrictive practices should be permitted

In what circumstances, if any, should restrictive practices be permitted?

We refer to our comments in Question 7.1 above.

Question 7.6 Consent and authorization mechanisms

1. **Who should be able to consent to the use of restrictive practices?**

   SRS recommends that the NCAT be the authority with the ability to provide a guardian with a restrictive practice function as a last resort, after having heard all the evidence in relation to possible treatment of the person, to prevent harm.

2. **What factors should a decision maker have to consider before authorizing a restrictive practice?**

   We refer to our comments in section 7.1. We also refer to the considerations listed in this paper such as:
   - Whether it is in the person's best interest;
   - Whether the person's behavior will cause serious harm to themselves or others;
   - Whether the restrictive practice will benefit the person;

- Whether it is the least restrictive option and a last resort;
- If last resort and involves seclusion, whether supplied adequate food, bedding and clothing and toilet access;
- Whether there is a behavior support plan that includes a restrictive practice;
- Nature and degree of any significant risk associated with the restrictive practice;
- Whether the person will be safeguarded from abuse, exploitation and neglect.

3. **What should be the mechanism for authorization of restrictive practices in urgent situations?**

   SRS observes that the ability of the NCAT to make a short order in urgent situations until a full hearing can be heard would appear to be adequate precaution.

4. **What changes if any should be made to NSW's consent and authorization mechanisms for the use of restrictive practices?**

   We observe that restrictive practice decisions for persons lacking capacity should be made only with NCAT consent under restrictive practice order. We also refer to our comments in Question 7.1 and recommend inclusion of guidelines for aged care homes in the Aged Care Act.

Question 7.7 Safeguards for the use of restrictive practices

What safeguards should be in place to ensure the appropriate use of restrictive practices in NSW?

We refer to the need to monitor and implement best practice guidelines in regards to aged care staff monitoring and recording a resident's condition and behavior, and taking action if the restraint does not modify the behavior as recommended.

Question 7.8 Requirements about the use of behavior support plans

1. **Should the law include specific requirements about the use of behavior support plans?**

   We refer to our comments in 7.8(2) below as to the specific requirements of behavior support plans.

2. **If so, what should those requirements be?**

The support plans should document which acute health specialists have assessed the individual resident, the type and reasons for the restraint, how long to be used, monitoring of residents and ensuring their human rights and care needs are being supported