Queensland Government

Department of Child Safety, Seniors and Disability Services

Short Term Approval Application for the use of Restrictive Practices

For use by service providers who require a short term approval for the use of restrictive practices in Queensland.

Who can complete this application?

An NDIS service provider or state-funded service provider who require a short term approval for the use of one or more of the following restrictive practices:

- Chemical Restraint
- Mechanical Restraint
- Physical Restraint
- Restricting Access

For the use of **containment and/or seclusion** (and other restrictive practices used in conjunction) please contact the Office of the Public Guardian for further information.

Please ensure before submitting this application you have used the Short Term Approval Eligibility Calculator to verify you meet the minimum requirements to apply. Information for aged care providers and forensic disability clients are included.

How to complete this application?

- This application can only be completed by an NDIS service provider or state-funded service provider who require a short term approval for the use of restrictive practices. This does not include the use of containment and/or seclusion.
- You will need to attach supporting documentation to this application.
- Delays in processing your application will occur if you have provided insufficient information or the application is not completed correctly.
- To help you complete this application, visit our 'Short Term Approval: A Guide for Service Providers' fact sheet for further information.

All sections marked with ◢ MUST be completed or your application can not be processed.

How will you use my information?

The Department is collecting information to assess an application for the use of restrictive practices by a relevant service provider under the *Disability Services Act 2006* (Qld).

Your information will be managed in accordance with the principles of the *Information Privacy Act 2009* (Qld) and the Positive Behaviour Support and Restrictive Practice Privacy Notice and Declaration (see page 11).

◢ Part A.1 – Adult Information

The following questions relate to the adult who has impaired capacity for making decisions about the use of the restrictive practice(s) being sought.

A Queensland Civil and Administrative Tribunal (QCAT) Health professional report or any other report that makes a declaration regarding the adult's decision-making capacity about restrictive practices must be provided. To avoid unnecessary delays, this documentation must be attached at time of application submission.

Legal Name

Title	First name	Middle name	Last name

No middle name/Unknown (please tick) ☐

Gender: ☐ Female ☐ Male ☐ Indeterminate ☐ Intersex ☐ Unspecified ☐ Non-Binary

Date of birth (DD/MM/YYYY): _____ *Date of birth cannot be under 18 years of age.*

NDIS Participant Number: _____

Primary intellectual or cognitive disability:

Residential address:

Town/ Suburb | State | Postcode

☐ *Adult's residential address is the same as their postal address.*

Postal address (if different from residential address):

Town/ Suburb | State | Postcode

Part A.2 – Voluntary Adult Information

Answering the following questions is voluntary. Answers provided will not be used in considering your short term approval application. Please refer to the 'Privacy Notice and Declaration' (on page 11) for further details on how your information is used.

Is the adult of Aboriginal or Torres Strait Islander origins?

☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – both ☐ Not disclosed

Does the adult identify as South Sea Islander? ☐ Yes ☐ No ☐ Not disclosed

Is the adult from a culturally or linguistically diverse background? ☐ Yes ☐ No ☑ Not disclosed

What is the adult's preferred language(s):

Are there any other considerations relevant to this application (e.g. cultural, communication, disability (blind/deaf)? If so, please provide further information:

Part B – Service Provider Information

The following questions relate to entities who provide NDIS or state disability work to the adult.

Residential Aged Care Providers are not eligible to proceed with this application. Information about the use of restrictive practices in aged care including education and regulatory requirements can be found on the Aged Care Quality and Safety Commission website.

Entity A

Service Provider name:

Provider number:

Contact person:

Position:

Mobile number:

Daytime phone number:

Email:

Residential address:

Town/ Suburb | State | Postcode

☐ *Residential address is the same as postal address.*

Postal address (if different from residential address):

Town/ Suburb | State | Postcode

Is the service provider a registered NDIS provider? ☐ Yes ☐ No

Is the organisation a state-funded service provider? ☐ Yes ☐ No

Please select the support provided:

☐ Supported Independent Living
☐ Supported Independent Living – Respite
☐ Community Access Services
☐ Community Day Services
☐ Other – *If other, provide a brief description of the support provided:*

Are there other (known) service providers involved in providing support to the adult?

☐ Yes – *If yes, provide additional details below.* ☐ No – *If no, please move to 'Part C – Background information'.*

Entity B

Service Provider name:

Provider number:

Contact person:

Position:

Mobile number:

Daytime phone number:

Email:

Residential address:

Town/ Suburb | State | Postcode

☐ *Residential address is the same as postal address.*

Postal address (if different from residential address):

Town/ Suburb | State | Postcode

Does the provider wish to be included in this application? ☐ Yes ☐ No

Is the service provider a registered NDIS provider? ☐ Yes ☐ No

Is the organisation a state-funded service provider? ☐ No ☐ Yes – *If yes, please select the support provided:*

☐ Supported Independent Living
☐ Supported Independent Living – Respite
☐ Community Access Services
☐ Community Day Services
☐ Other – *If other, provide a brief description of the support provided:*

☐ If there are more than two service entities involved in providing support to the adult, please tick this box and attach an additional page at time of application submission.

Part C – Background Information

Is this the first time you have applied for a short term approval for this adult?

☐ Yes ☐ No – *If no, please provide brief details below:*

Second or subsequent short term approvals will only be considered if there are exceptional circumstances.

Are you aware if any short term approvals have previously been given in relation to this adult?

☐ Yes ☐ No ☐ Unsure

Has a previous application(s) been submitted to the Queensland Civil and Administrative Tribunal (QCAT) regarding restrictive practice matters for this adult?

☐ Yes ☐ No ☐ Unsure

If you have answered yes to either of the above two questions, provide brief details below:

Is the adult on a Forensic Order or Treatment Authority?

☐ No ☐ Yes – *If yes, please select all that apply:*

☐ Forensic Order – Disability ☐ Forensic Order– Mental Health ☐ Treatment Authority

Is there a QCAT appointed Guardian for a restrictive practice matter (general or respite) for the adult?

☐ No ☐ Yes – *If yes, complete the following and move to question 'Is there an Informal Decision Maker?'*

☐ General or ☐ Respite

QCAT Appointed Guardian Name:

Mobile number:

Daytime phone number:

Email:

Residential address:

Town/ Suburb | State | Postcode

Have steps been taken to have a Guardian for a restrictive practice matter (general or respite) appointed by QCAT?

☐ No ☐ Yes – *If yes, what steps have been taken?*

Is there an Informal Decision Maker?

☐ No ☐ Yes – *If yes, please provide the following:*

Informal Decision Maker Name:

Relationship to adult:

Mobile number:

Daytime phone number:

Email:

Have you consulted with the informal decision maker regarding this application? ☐ Yes ☐ No

Is there a Guardian appointed for other matters (e.g. healthcare or day to day care)?

☐ No ☐ Yes – *If yes, please provide the following:*

Guardian Name:

Relationship to adult:

Mobile number:

Daytime phone number:

Email:

Part D.1 – Restrictive Practices Information

Carefully read and complete all questions in this part. You will need to attach supporting documentation as evidence when submitting this application. Delays in processing your application will occur if there is insufficient supporting documentation or the application is not completed correctly.

What restrictive practice(s) are you requesting approval to use?

☐ Chemical Restraint (Fixed Dose) ☐ Chemical Restraint (As Required)

☐ Mechanical Restraint ☐ Physical Restraint

☐ Restricting Access

Using the below table, provide a description for each restrictive practice selected above for which approval is being sought:

☐ If more than five restrictive practices are being sought for approval, please tick this box and attach an additional page at time of application submission.

Name of Medication/Technique/Object	Fixed/PRN (as required)	Dose/Maximum Duration

If requesting the use of physical, mechanical, chemical (PRN) restraint and/or restricting access, a procedure for each restrictive practice must be provided. To avoid unnecessary delays, this documentation must be attached at time of application submission.

For each restrictive practice selected above, provide a detailed description of the behaviour of harm:

Detail the immediate and serious risk of harm the adult's behaviour will cause to the adult or others if approval is not given:

Behaviour Recording Sheets and Incidents Reports must be provided. To avoid unnecessary delays, this documentation must be attached at time of application submission.

Outline how this restrictive practice(s) is the least restrictive way of ensuring safety of the adult and others:

Outline the alternative strategies (including risk management strategies) attempted to reduce the risk associated with the adult's behaviour:

Outline the positive impacts of each restrictive practice on the adult:

Outline the negative impacts of each restrictive practice on the adult:

Have any medical specialists and/or other allied health professionals been consulted regarding the adult's behaviour for the use of restrictive practices?

☐ No ☐ Yes – *If yes, please complete the following:*

If the adult is subject to a Forensic Order or Treatment Authority under the *Mental Health Act 2016* (Qld), the authorised psychiatrist must be listed.

Name:

Profession:

Contact Number:

Date consulted (DD/MM/YYYY):

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted (DD/MM/YYYY):

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted (DD/MM/YYYY):

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted (DD/MM/YYYY):

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted (DD/MM/YYYY):

Specialist Opinion:

☐ If more than five medical specialists and/or allied health professionals have been consulted, please tick this box and attach an additional page at time of application submission.

Part D.2 – Restrictive Practices Information – Medication

Provide a full list of prescribed medication the adult is currently taking. If the adult is not currently taking any prescribed medication, please select 'N/A':

☐ N/A

The primary purpose of each medication must be clearly identifiable. As evidence at time of application submission, it is recommended you attach a signed copy of the departmental Clarification of Purpose of Medication form or the NDIS Quality and Safeguards Commission's Medication Purpose form.

Medication Name | Dosage | Treating Doctor Name

Medication Purpose (if known):

Medication Name | Dosage | Treating Doctor Name

Medication Purpose (if known):

Medication Name | Dosage | Treating Doctor Name

Medication Purpose (if known):

Medication Name | Dosage | Treating Doctor Name

Medication Purpose (if known):

Medication Name | Dosage | Treating Doctor Name

Medication Purpose (if known):

☐ If more than five medications are to be listed, please tick this box and attach an additional page at time of application submission.

If requesting chemical restraint the adult's treating doctor must have been consulted. Please complete the below questions:

Treating Doctor Name:

Mobile number:

Daytime phone number:

Email:

Date of consultation (DD/MM/YYYY):

Date of last full medication review (DD/MM/YYYY):

Medication reviewed by: ☐ Treating Medical Professional ☐ Pharmacist

Date of last full medical assessment (e.g. a Comprehensive Health Assessment Program (CHAP)):

Date of next full medical assessment – including medication review:

Part D.3 – Restrictive Practices Information – Entity Views

Detail the adult's views about the use of the restrictive practice(s). If you have not consulted with the adult, explain why:

Detail all informal decision makers' views about the use of the restrictive practice(s). If you have not consulted with an informal decision maker, explain why:

Please provide any additional information relevant to your application:

Part E – Attachment Checklist

Supporting Documentation *(please tick if attached)*

- ☐ QCAT Heath Professional Report
- ☐ Chemical Restraint (PRN) Procedure (if requesting approval)
- ☐ Mechanical Restraint Procedure (if requesting approval)
- ☐ Physical Restraint Procedure (if requesting approval)
- ☐ Restricting Access Procedure (if requesting approval)
- ☐ Behaviour Recording Sheets
- ☐ Incident Reports
- ☐ Comprehensive Health Assessment Program (CHAP) document (if relevant)
- ☐ Departmental Clarification of Purpose of Medication form (if requesting chemical restraint approval) OR NDIS Quality and Safeguards Commission's Medication Purpose form (if requesting chemical restraint approval)
- ☐ Other (e.g. Positive Behaviour Support Plan, medical and/or allied health reports)

Part F – Privacy Notice and Declaration

All check boxes in this section must be completed to proceed with your Short Term Approval Application for the use of Restrictive Practices.

I declare that:

☐ I am the service provider contact person named in this application.

☐ The information provided by me for this application is, to the best of my knowledge, true and correct and I understand it is an offence to provide false or misleading information.

Please read the following privacy notice information carefully before indicating your consent and understanding:

- I consent that the information on this application is being collected to enable Disability, Seniors and Carers clinical staff to make informed decisions about the use of restrictive practices.
- I consent the collection is authorised by the *Disability Services Act 2006* (Qld) and information may be disclosed to statutory bodies and non-government service providers involved in this process.
- I consent that all personal information will be handled in accordance with the *Information Privacy Act 2009* (Qld).

☐ I understand the service provider's obligation to notify the department (via the Online Data Collection system) within **14 days** if a short term approval is given.

☐ I have read and understand the contents of this application and make all of the above declarations.

Name:

Position:

Service Provider:

Mobile number:

Daytime phone number:

Email:

Date this application was completed (DD/MM/YYYY):

Part G – Next Steps

Return your completed application and all relevant supporting documentation in a single submission to STA_Applications@qld.gov.au.

If you have not received a response to your application within two weeks of submission, please contact enquiries_RP@dsdsatsip.qld.gov.au or call 1800 902 006.

If you have provided insufficient information or the form is not completed correctly, the application will not be accepted and will be returned to you for completion.

For further information:

Please visit our 'Resources' page for fact sheets, frequently asked questions, and policies and procedures.

If you would like to speak to a member of our unit in your region, please visit our 'Contact Information' page.