# 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](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/chemical-restraint.pdf)
* [Mechanical Restraint](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/mechanical-restraint.pdf)
* [Physical Restraint](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/physical-restraint.pdf)
* [Restricting Access](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/restricting-access.pdf)

For the use of **containment and/or seclusion** (and other restrictive practices used in conjunction) please contact the [Office of the Public Guardian](https://www.publicguardian.qld.gov.au/restrictive-practices) for further information.

Please ensure before submitting this application you have used the [Short Term Approval Eligibility Calculator](file:///C%3A/Users/rzdavies/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/O8DDICTW/Short%20Term%20Approval%20Eligibility%20Calculator) 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’](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/short-term-approval-guide-for-service-providers.pdf) fact sheet for further information.

## 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 Service 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 (on page 15).

## Part A.1 – Adult Information

## This part must be completed.

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 (*if relevant*):

Last name:

Gender (*female, male, indeterminate, intersex, unspecified, non-binary*):

Date of birth (*date of birth cannot by under 18 years of age*):

NDIS Participant Number:

Primary intellectual or cognitive disability:

Residential address:

Town/Suburb:

State:

Postcode:

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 15) 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

## This section must be completed.

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:

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*):

What is 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, complete ‘Entity B’ section below, no – if no, 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:

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, list the support provided in next question):

What is 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 attach an additional page at time of application submission.

## Part C – Background Information

## This section must be completed.

Is this the first time you have applied for a short term approval for this adult? (*yes, no*):

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

Has a previous application/s been submitted to the Queensland Civil and Administrative Tribunal (QCAT) regarding restrictive practice matters for this adult? (*no, yes – if yes, please provide brief details of all previous applications (including the date of lodgment*):

Is the adult on any Forensic or Involuntary Treatment Orders? (no, yes – if yes, confirm the order/s in next question):

Please indicate the order/s (*Forensic Order, Forensic Order Disability, Community Treatment Order, Involuntary Treatment Order*):

Is there a QCAT appointed Guardian for a restrictive practice matter (general or respite) for the adult? (*no – if no, move to ‘Is there an informal Decision Maker?’, yes – if yes, complete the following questions and move to ‘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 – if no, *move to ‘Is there a Guardian appointed for other matters (e.g. healthcare or day to day care?)’,* yes – *if yes, complete the following questions and move to ‘Is there a Guardian appointed for other matters (e.g. healthcare or day to day care?)’:*

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, if no - *move to ‘Part D.1 – Restrictive Practices Information’*, yes – *if yes, complete the following questions):*

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 practices(s) are you requesting approval to use? (*Chemical Restraint (as required), Chemical Restraint (fixed dose), Mechanical Restraint, Physical Restraint, Restricting Access*):

For each restrictive practice noted above, provide a detailed description of the behaviour of harm. Note, if requesting the use of physical and/or mechanical restraint 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.

Detail the immediate and serious risk of harm the adult’s behaviour will cause to the adult or others if approval is not given. Note, 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 that 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 – if no, move to ‘Part D.2 – Restrictive Practices Information - Medication’, yes – if yes, please complete the following):*

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

Name:

Profession:

Contact Number:

Date consulted:

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted:

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted:

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted:

Specialist Opinion:

Name:

Profession:

Contact Number:

Date consulted:

Specialist Opinion:

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

## Part D.2 – Restrictive Practices Information – Medication

This section must be completed.

### Instructions

1. Complete one section only.
2. Complete **Section A** if requesting [mechanical restraint](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/mechanical-restraint.pdf), [physical restraint](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/physical-restraint.pdf) or [restricting access](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/restricting-access.pdf).
3. Complete **Section B** if requesting [chemical restraint](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/chemical-restraint.pdf) (in combination with other restrictive practices)

### Section A: Mechanical Restraint, Physical Restraint or Restricting Access

Is the adult currently taking any prescribed medication? (*yes – if yes, complete below information, no – if no, move to ‘Part D.3 – Restrictive Practice Information – Entity Views’):*

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Medication Name:

Dosage:

Treating Doctor Name:

Date of last full medication review:

Medication reviewed by (T*reating Medical Professional, Pharmacist)*:

Date of last full medical assessment - for example a Comprehensive Health Assessment Program (CHAP):

Date of next full medical assessment - including medication review:

### Section B: Chemical Restraint (in combination with other restrictive practices)

If requesting chemical restraint, the adult’s treating doctor must have been consulted.

Treating Doctor Name:

Mobile number:

Daytime phone number:

Email:

Date of consultation:

Date of last full medication review:

Medication reviewed by (T*reating Medical Professional, Pharmacist)*:

Date of next full medical assessment - including medication review:

Provide a full list of medication the adult is currently taking:

The primary purpose of each medication must be clearly identifiable. It is recommended you attach a signed copy of the departmental [Clarification of Purpose of Medication form](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/clarification-of-purpose-of-medication-form.pdf) or the NDIS Quality and Safeguards Commission’s [Medication Purpose form](https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers/medication-purpose) as evidence at time of application submission.

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

Medication Name:

Dosage:

## Part D.3 – Restrictive Practices Information – Entity Views

This section must be completed.

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:

The following question is voluntary.

Please provide any additional information relevant to your application:

## Part E – Attachment Checklist

This section must be completed.

Below is a list of supporting documentation to be attached at the time of application submission.

Confirm by answering ‘yes’ or ‘no’ if attached:

* QCAT Heath Professional Report (*yes, no*):
* Mechanical Restraint Procedure - if requesting approval (*yes, no*):
* Physical Restraint Procedure - if requesting approval (*yes, no*):
* Behaviour Recording Sheets (*yes, no*):
* Incident Reports (*yes, no*):
* Comprehensive Health Assessment Program (CHAP) document - if relevant (*yes, no*):
* Departmental [Clarification of Purpose of Medication form](https://www.dcssds.qld.gov.au/resources/dcsyw/disability/service-providers/centre-excellence/clarification-of-purpose-of-medication-form.pdf) - if requesting chemical restraint approval OR NDIS Quality and Safeguards Commission’s [Medication Purpose form](https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers/medication-purpose) - if requesting chemical restraint approval (*yes, no*):
* Other – for example Positive Behaviour Support Plan, medical and/or allied health reports (*yes, no*):

## Part F – Privacy Notice and Declaration

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 competed:

## Part G – Next Steps

This section must be completed.

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](https://www.dcssds.qld.gov.au/our-work/disability-services/positive-behaviour-support-restrictive-practices/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](https://www.dcssds.qld.gov.au/our-work/disability-services/positive-behaviour-support-restrictive-practices/contact-information)’ page.