H&H Care SA Pty Ltd	**Form26. Dementia Distress and Behaviour Support** **Australian Government Support at Home Program**	
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Policy and procedure 26

H&H Care SA Pty Ltd | Support at Home services

This policy guides respectful daily support for people living with dementia, early recognition of distress and illness, and safe responses to behaviour that may cause harm. Individual understanding, supported choices and practical prevention are central to care.

Document control	Details
Policy number	HH SAH DEMENTIA 026
Version and status	1.0 — Draft for Director and Clinical Lead RN approval
Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le Clinical Lead RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Review due	12 months after approval or earlier following change or incident
Applies to	Workers, nurses, coordinators and approved personnel supporting clients with dementia or distress

1 Purpose and scope

Promote comfort, independence, participation and safety at home. Distress and changed behaviour may communicate pain, fear, confusion, unmet needs or environmental stress. Workers must describe what they observe and seek the cause rather than label a person as difficult or assume dementia explains every change.

This policy supports services delivered by H&H on behalf of The Fig Trees and other approved arrangements. Confirm the written service scope, clinical oversight, contacts and authorised care plan. This policy is not a diagnosis, medicine order or authority to use restraint.

2 Responsibilities

The Director ensures resources, workforce competence and safeguarding systems. The Clinical Lead RN coordinates assessment, clinical escalation, plan review and specialist advice. The coordinator arranges consistent workers and reliable handover. Workers follow the plan, support choice, report changes and record actual care and outcomes.

The Fig Trees and H&H agree responsibility for care coordination, clinical review and incident notifications. The Fig Trees retains its registered provider obligations; H&H remains responsible for the safety and quality of its work. No worker waits for funding or manager approval before calling 000 when needed.

3 Rights consent and decision making

Do not infer lack of decision-making ability from a dementia diagnosis, language, age or disagreement. Support the particular decision at the best time, using plain language, interpreters, visual cues and familiar supports. Verify any substitute decision maker's legal authority and its scope; being next of kin does not by itself establish authority. Seek RN advice if consent is uncertain or decisions conflict.

Assessment and understanding the person

4 Initial and ongoing assessment

With consent, obtain the client's history, strengths, routines, values, cultural identity, preferred language, interests and communication style. Ask the person and chosen supporters what helps them feel safe and what makes care difficult. Record what the client can do independently and the assistance they prefer.

The RN reviews dementia history and relevant clinical information, pain, medicines, sensory needs, mobility, falls, sleep, nutrition, hydration, continence and mental health. Workers report observations without diagnosing causes. Refer new or suspected cognitive changes to the GP; do not diagnose dementia from a screening score.

- Identify hearing aids, glasses, dentures, communication aids and how to maintain access to them.
- Record usual attention, alertness, orientation, speech, function, walking and sleep so a change is recognisable.
- Assess home safety, getting lost, cooking, medicines, financial vulnerability and carer strain with the person, balancing safety and chosen independence.
- Identify trauma, personal care preferences and cultural or gender needs without requiring unnecessary disclosure.

5 Explore the meaning of distress

When behaviour changes, first consider immediate health needs and safety. Check for pain or injury, breathlessness, constipation, urinary retention, infection symptoms, thirst, hunger, fatigue, temperature, medicine changes and sensory difficulties. A qualified clinician assesses possible illness and treatment; workers do not assume an infection or start medicines.

Consider how the task, tone, timing, unfamiliar worker, noise, crowding, lighting, loss of privacy, boredom or fear may contribute. Ask whether the person is trying to go somewhere meaningful, protect themselves or communicate a need. Record patterns and successful responses as well as events causing concern.

6 Sudden change and possible delirium

A change over hours or days, fluctuating attention, unusual drowsiness, withdrawal or new confusion needs urgent medical assessment. A quiet or sleepy person may be seriously unwell. Do not wait to complete behaviour charts or attribute the change to dementia.

Use Policy 12. Call 000 for sudden confusion with severe or rapidly worsening symptoms, reduced consciousness, stroke signs, major injury, breathing difficulty or immediate danger. For a sudden unexplained change without these features, contact the RN and arrange urgent medical assessment without delay; use emergency services if timely safe assessment cannot be secured. Record onset, last known baseline, symptoms, medicines and recent events.

Daily care and prevention of distress

7 Communicate calmly

Approach from the front, introduce yourself and use the person's preferred name. Speak slowly in short sentences, offer one step at a time and allow time to respond. Use respectful adult language and simple choices. Check understanding without testing memory or repeatedly correcting the person.

Acknowledge emotion and offer reassurance. Avoid arguing about beliefs or insisting on your account of events. For hallucinations or suspiciousness, respond to the fear, check for environmental causes and report new or distressing symptoms for clinical assessment. Do not reinforce frightening beliefs or ridicule the person.

8 Support familiar and meaningful routines

Offer familiar activities, music, gentle movement and social contact that the person enjoys. Balance activity and rest. Keep useful objects visible and routines predictable, while allowing choice and changes in preference. Explain worker changes and provide a handover about what helps.

Support meals, drinks, toileting, oral care and prescribed aids according to the plan. Notice signs of discomfort when the person cannot describe pain; use an approved observational pain tool only with training and RN interpretation. Monitor sleep and daytime activity without imposing sedation as a routine solution.

9 Personal care and refusal

Explain before touching and obtain permission. Maintain warmth, privacy and modesty; offer the preferred worker, time, location and method. Break tasks into smaller steps and encourage the person to do what they can.

If the person becomes distressed, pause, step back and offer another approach or time. Do not force washing, dressing, feeding or medication. Report refusal of essential care promptly, including the immediate health risk and alternatives tried. Arrange clinical review and a safe follow-up plan rather than repeatedly pressuring the person.

10 Walking and community access

Support purposeful walking, safe routes and meaningful destinations. Identify getting-lost risks with the client and agree check-ins, accompaniment and emergency information. Any tracking or monitoring technology needs a specific privacy, consent and risk assessment; it must not replace human support or create unreviewed restrictions.

Do not automatically lock exits, remove mobility aids or prevent access to belongings because a client has dementia. Seek a supported, proportionate safety plan and review any restriction through section 14. Escalate driving safety concerns through the RN and treating clinician; workers do not decide fitness to drive.

Responding to distress and immediate risk

11 During an episode

Stay calm, lower your voice, reduce noise and give space. Use one familiar person to communicate where possible. Stop the triggering task and offer a quieter area, comfort, toileting, a drink if safe, or a preferred activity. Explain each action and avoid sudden touch or a crowd around the person.

Keep a safe exit, remove immediate hazards only if safe, and move other people away where possible. Do not corner, chase, threaten, punish or physically overpower the person. If a worker must withdraw for immediate safety, call help and arrange a safe response; do not silently abandon an unsafe client.

Situation	Action
Distress without immediate danger	Pause care, reduce stimulation and address likely unmet needs. Follow the individual plan and report new, repeated or unresolved distress to the RN.
Threats, violence or an immediate serious risk	Move to safety, call 000 where emergency assistance is needed, and follow dispatcher advice. Alert the coordinator when safe. Do not attempt an untrained restraint.
Person missing or whereabouts unexpectedly unknown	Start the agreed immediate response, check safe nearby locations without delaying police, and contact police promptly. Call 000 for immediate danger; no 24-hour waiting period applies.
New confusion, marked drowsiness or other deterioration	Arrange urgent clinical assessment under section 6 and Policy 12. Do not treat the episode solely as behaviour.

12 Missing person response

Notify the coordinator and agreed contact, provide last seen time and place, clothing, recent photograph if lawfully available, mobility, likely destinations and urgent medical risks. Coordinate safe searching with police. Keep someone contactable at the home where possible and avoid losing oversight of other clients. When found, assess health, provide reassurance, arrange medical review as required and complete incident follow up.

13 After the episode

Check the person and others for injury, pain and emotional distress. Provide reassurance and privacy. Record what happened, actions and outcome; notify the RN and coordinator. Offer workers and supporters a debrief without blame or labelling. Review the cause, staffing and care approach before repeating the task. Use incident and open disclosure processes when indicated.

Behaviour planning medicines and restrictive practices

14 Individual behaviour support plan

For recurring distress or risk of harm, the RN coordinates a written plan with the client, chosen supporters, GP and relevant specialists. Seek Dementia Support Australia or other specialist input when needed. State the observable concern, possible causes, baseline, early signs, prevention, agreed responses, stop points, emergency contacts and review criteria.

Use practical strategies that improve comfort, participation and quality of life. Set measurable outcomes such as less distress during showering, fewer interrupted meals or safer supported walks. Record what works and what worsens distress. A plan does not by itself provide legal authority for a restrictive practice.

15 Medicines and chemical restraint safeguards

Only administer medicines under valid orders and Policy 20. A prescriber must establish the indication and review treatment. Workers must not request or use sedation for convenience, punishment, routine sleep, staff shortages or to make personal care easier. A medicine's purpose and use, not its name alone, determine whether it may constitute chemical restraint.

For any PRN medicine, require the indication, dose, interval, maximum, assessment criteria, monitoring and escalation instructions. Record alternatives attempted, why the medicine was given, effect and adverse effects. Escalate excessive sedation, new falls, swallowing problems or other deterioration. Do not change or stop prescribed psychotropics independently; obtain a prompt prescriber review.

16 Restrictive practices

Potential restrictions include holding a person, belts or equipment limiting movement, preventing access or exit, seclusion and medicines used to influence behaviour. Purpose, effect and circumstances require assessment. Family requests, a prescription, a signed consent form or a care plan alone must not be treated as sufficient authority.

H&H workers must not introduce a planned restrictive practice under this policy. Before any proposed restriction, the Director and RN must obtain appropriate clinical and legal advice, clarify the current aged care and South Australian requirements with The Fig Trees, confirm lawful authority and consent, and approve a specific documented pathway with monitoring, review and reduction arrangements. If the lawful pathway cannot be established, do not implement it; arrange safer alternatives and escalate risk.

Residential aged care restrictive practice requirements must not be assumed to apply unchanged to Support at Home. NDIS authorisations must not be assumed to authorise aged care practice. Confirm the actual service and legal framework. These distinctions do not reduce duties to uphold rights, avoid harm and respond to incidents.

This policy does not authorise emergency restraint. In an immediate danger, call 000 and take only lawful, necessary and proportionate protective action within training and competence. Any restriction or suspected unauthorised use requires immediate safety review, documentation and escalation under Policy 9. Report concerns involving family or carers under Policy 11; do not ignore restrictions observed at home.

Records coordination and service review

17 Record and hand over

Write objective, respectful notes: the client's own words where relevant, what was seen and heard, timing, duration, environment, care task, health changes, actions and response. Avoid labels such as manipulative, non-compliant or aggressive without describing the actual actions.

Use an antecedent, behaviour and consequence record to explore patterns. Consequence means what happened afterwards, including worker responses; it does not mean punishment. A possible trigger is a hypothesis for review, not a proven cause. Link case notes, medication records and incident reports without inconsistent duplication.

Handover changes in health, effective communication, early warning signs, strategies to avoid, essential care omitted, outstanding referrals and who is following up. Keep plans accessible only to authorised people. Share with supporters and clinicians according to consent, privacy law and lawful safety exceptions.

18 Referral and continuity

The RN refers to the GP for new or persistent symptoms, pain, medicine review, cognition or mood concerns. Coordinate allied health, memory services, geriatric or mental health assessment and dementia specialists as appropriate. Do not delay emergency care while awaiting a routine referral.

Dementia Support Australia provides specialist behaviour support advice on 1800 699 799, 24 hours a day. Dementia Australia's National Dementia Helpline is 1800 100 500, 24 hours a day. These services do not replace emergency response.

Discuss carer strain, sleep disruption and respite or other support with consent. Escalate unsafe care gaps and possible abuse. At transitions, obtain updated clinical information and explain any changed plan before workers resume care. If service needs exceed H&H capacity, coordinate a safe review and transition rather than an unplanned withdrawal.

19 Training and quality review

Before allocation, verify worker induction in dementia communication, supported decisions, distress prevention, delirium, safeguarding, emergency response and this policy. Provide client-specific coaching and assess practical ability to recognise a change and follow the plan. Reassess after incidents, changed needs or identified gaps.

The RN reviews a new distress plan within four weeks of implementation, or sooner if risk or response requires it; thereafter at the agreed clinical interval and after every significant change. This is an H&H review standard. Seek the client's experience and compare outcomes with their goals.

At least quarterly the Clinical Lead reviews a sample of plans, episodes, missed care, PRN use, restrictions, injuries and referrals. The Director tracks actions to completion under Policy 18. Increased sedation or reduced activity must not be counted as successful behaviour support without considering harm and quality of life.

Person profile and behaviour support plan

DEMENTIA F01 | Complete with the client and relevant supporters and clinicians. Attach clinical orders separately. This form does not authorise restrictive practices.

Client identifiers: _____

Preferred name language culture and communication: _____

What matters to me interests roles routines and strengths: _____

Consent support and verified decision-making authority if relevant: _____

Baseline cognition attention function sleep and usual presentation: _____

Health pain sensory mobility nutrition and medicine factors: _____

How I show comfort discomfort fear or a need for help: _____

Known preferences triggers and approaches to avoid: _____

Observable concern frequency duration and impact: _____

Possible unmet needs and clinical assessment findings: _____

My goals and agreed measures of comfort participation and safety: _____

Prevention meaningful activity and environmental strategies: _____

Early signs and worker actions: _____

During distress agreed calming responses and when to pause care: _____

Immediate danger sudden change and emergency response: _____

Missing person and community safety plan if relevant: _____

Essential care refusal or interruption response and backup: _____

Clinical contacts after hours and person accepting follow up: _____

Medicine order reference and monitoring if applicable: _____

Any proposed or observed restriction escalated to whom and when: _____

Referrals worker briefing and competency needs: _____

Client participation and agreed information sharing: _____

Plan author and clinician role signature date: _____

Client or authorised decision maker involvement: _____

H&H RN approval and Fig Trees coordination reference: _____

Review date outcome measures and earlier review triggers: _____

Distress observation record and approval

DEMENTIA F02 | One episode per record. Record facts and the person's perspective; add pages as needed.

Client identifiers: _____ Worker name role: _____

Date start time duration location and others present: _____

Usual baseline and any sudden change or health concern: _____

Before the event task environment words and possible unmet needs: _____

During the event exact actions words intensity and risks: _____

Response steps reassurance alternatives and safety actions: _____

Afterwards client response comfort injuries and care completed or omitted: _____

PRN medicine record reference effect and adverse effects if applicable: _____

Any restriction observed or used details duration and immediate escalation: _____

RN emergency or other contact time advice and follow up accepted by: _____

Possible explanation for clinical review not assumed cause: _____

Client and supporter feedback plan changes and review date: _____

Incident report reference and worker signature date: _____

20 Related policies and references

Read with Policies 1 to 25, especially rights and supported decisions, consent, assessment, care plans, incidents and SIRS, safeguarding, deterioration, medication, nursing governance and WHS. Clinical and legal sources checked 24 October 2026. Some Commission resources retain historical legislation; use the current Act and Rules and verify applicability before any restrictive practice decision.

- Aged Care Act 2024 and Aged Care Rules 2025; applicable strengthened Quality Standards. Commission guidance on delivery of funded aged care services. https://www.agedcarequality.gov.au/strengthened-quality-standards/care-and-services/delivery-funded-aged-care-services
- Commission restrictive practice resources and SIRS guidance. https://www.agedcarequality.gov.au/providers/clinical-governance/restrictive-practices-provider-resources
- Dementia Australia — Agitation and aggression; National Dementia Helpline. https://www.dementia.org.au/living-dementia/mood-and-behaviour-changes/agitation-and-aggression | https://www.dementia.org.au/get-support/national-dementia-helpline
- Healthdirect — Delirium. https://www.healthdirect.gov.au/conditions/brain-diseases/delirium
- Dementia Support Australia. https://www.dementia.com.au/
- South Australia Police — Report missing persons. https://www.police.sa.gov.au/your-safety/report-missing-persons

21 Approval and implementation

Before use approve the policy, confirm Fig Trees responsibilities, enter local contacts, review client plans, brief workers, verify competence and ensure incident escalation and backup arrangements are operational.

Director: _____ Clinical Lead RN: _____

Effective date: _____ Next review: _____