Dementia Support Australia

Translating Risk Reduction Strategies

What is the risk reduction strategy ?	How the strategy presents in hospital settings	How the strategy presents in residential aged care settings	Considerations
One-to-one staff for close observation	One-to-one staff observation involves assigning a staff member to a patient for close monitoring. While often used to manage higher risk behaviours, it can also provide social support and help redirect people with dementia who struggle to recognise safe objects or spaces. In hospital settings, where clinical areas may present added risks, these strategies are especially important.	In care homes, long term ongoing one-to-one staffing should be reduced through wraparound behaviour support and better environmental design. However, one-to-one support may still be needed during periods of higher risk behaviours or changing care needs.	**Define:** Understand the specific role of the one-to-one staff member and the particular risks they may be supporting in different settings. **Frequency:** Assess how often the one-to-one staff member engages in intervention to manage risks effectively. They may just be sitting at the bedside for observation only. **Context:** Determine the specific situations in which the one-to-one staff member needs to intervene, if at all, and how the care setting would respond to this situation.
Code Black events (there may be other similar names)	A Code Black is a call for urgent assistance, with procedures varying by hospital. Responses may include; senior staff support, verbal de-escalation, presence of security, physical assistance, or additional medication. Some doctors adopt a 'low threshold' approach, calling Code Black early when there is potential for escalation due to past behaviour, staff concerns, patient vulnerability, or perceived risk. If escalation of behaviour does not occur, the call may be cancelled.	Care homes may use duress systems to request staff assistance, and emergency services can be called if needed. Unlike hospitals, these are rarely referred to as Code Blacks and occur less often due to different risk-reduction strategies and better environments.	**Define:** What occurs when a Code Black is called for this individual? Assessing the effectiveness of the response and the outcomes of previous Code Black events can inform the development of appropriate strategies in the receiving care setting. **Frequency:** How often has a Code Black been called for the individual? Are Code Black calls usually cancelled or stood down due to successful de-escalation through verbal communication and behaviour support strategies? How long has it been since the last Code Black was called and what strategies have been put into place to mitigate? **Context:** What specific action or behaviour prompted the Code Black call? The receiving care setting may consider how they would respond to similar situations or if it is likely to occur in a different environment.
PRN intramuscular or subcutaneous antipsychotics	PRN (as needed) intramuscular or subcutaneous antipsychotics are more common in hospitals, where close monitoring enables rapid response to adverse reactions. Psychotropics are used only when non-pharmacological strategies fail, when a mental health condition is diagnosed or suspected, or when behaviours pose significant harm or severely reduce quality of life. They are a last resort, guided by a comprehensive individual assessment.	Care homes can administer PRN (as needed) antipsychotic medications, but this is a key consideration for new admissions if prescribed. Aged care providers are required to minimise unnecessary chemical restraint restrictive practice, including the inappropriate use of psychotropic medications.	**Clarify:** Were oral options trialled and what was the response? The person may have declined the oral option, or they may have not been effective. **Frequency:** How often has the person required the medication? This information will be important for placement conversations, particularly if they have been prescribed this medication as a 'just in case' due to the lower risk appetite in a hospital setting. **Context:** What specific action or behaviour preceded the use of antipsychotics? The receiving care setting may consider how they would respond to similar situations or if it is likely to occur in a different environment.
Care approaches and consent	Awareness of behaviour support plans is growing in hospitals, though practices vary by ward. Care may require more than two staff, with security sometimes assisting.	Using physical force, such as holding a person's hands or body, may be a Physical Restrictive Practice. Behaviour Support Plans help ensure individual rights are considered and the least restrictive, most appropriate strategies are used.	**Clarify:** During care approaches, what is the role of the staff? Are they preventing the person from standing up, moving, or protecting others from potential physical aggression? **Frequency:** Is physical restraint required for all approaches? **Context:** What strategies have been trialled? Is it possible to re-approach instead of utilising restraint to assist with care approaches, or are there particular staff who are more successful in care with less restrictive approaches?

Define/clarify:
Who should be involved in managing that risk?

Frequency :
How often do staff need to engage/intervene?

Context :
Specific situations requiring intervention

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