Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Wednesday, September 2, 2026
Crockett AB Room
2:45pm-3:45pm

3c. The High-Risk PAS Client: Dementia, Behaviors, Falls, Elopement, Boundaries, and Staff Safety

Presented by:

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The High-Risk PAS Client: Dementia, Behaviors, Falls, Elopement, Boundaries, and Staff Safety

Rosalind J. Nelson-Gamblin | September 2, 2026

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These are still PAS clients. They are not low-risk clients.

The client profile changed faster than the traditional PAS operating model.

- Bathing assistance + fear, resistance, or striking
- Mobility assistance + unsafe attempts to stand
- Meal preparation + stove, swallowing, or wandering risk
- Routine visit + new bruising, confusion, or family conflict

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What you should be able to do after this session

Recognize

Behavior changes and safety risks that require follow-up.

Escalate

Use a clear pathway for urgent and non-urgent concerns.

Stay in scope

Protect clients, staff, and the agency without drifting into clinical judgment.

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Today's path

01 — The changing PAS client

02 — Recognize the risk signal

03 — Know the PAS boundary

04 — Escalate, document, reassess

05 — Separate change from ANE incidents

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The numbers are already at the PAS front door

Current national indicators show why PAS agencies are encountering more cognitive and safety complexity.

7.4M

Americans age 65+ living with Alzheimer's in 2026

6 in 10

People with dementia who will wander at least once

14M+

Older adults who report falling each year

Sources: Alzheimer's Association (2026); CDC (2026)

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Autism, mental health, and substance use are part of today's PAS profile

449,631

Estimated Texas adults living with autism in CDC's 2017 model

26.7%

Autistic 8-year-olds meeting a proposed profound-autism definition in a multi-site cohort

46.3M

U.S. adults had a substance use disorder in 2024

61.5M

U.S. adults with any mental illness in 2024

Sources: CDC adult ASD model; CDC profound-autism study; SAMHSA 2024 NSDUH

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Mental health diagnoses, neurodivergence, and substance use change planning - not PAS scope

A diagnosis is context. The attendant still works from observable facts and an authorized individualized service plan.

- Do not assume a diagnosis predicts behavior or dangerousness
- Identify functional effects, known triggers, communication needs, and crisis contacts
- Train for change from baseline - not diagnostic interpretation
- Escalate suicidal statements, immediate threats, severe new symptoms, or inability to remain safe
- Make every report lead to a clear, actionable next step

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Personal Assistance Services is not a medical model

Attendant	Supervisor	Administrator
Observe and report; do not diagnose or treat.	May qualify without a nursing license.	Is not presumed to be a clinician.

A PAS-only HCSSA is not required to maintain an RN as a supervising nurse or on-call clinician.

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Boundaries begin at assessment and admission

- Explain what PAS is - and is not
- Establish clear understanding
- Identify the tasks the agency agrees to provide
- Explain report, escalation, and emergency expectations
- Include the client and family or responsible party, as appropriate
- Document questions, risks, and agreed boundaries

Do not make the attendant negotiate PAS scope at the bedside.

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The ISP turns known risk into defined action

Service	Supervision
What will be done, where, how often, and for how long?	What oversight, contacts, and reporting expectations apply?
Foreseeable risk	**Backup**
What specific response is expected if the risk occurs?	Who is activated when ordinary service cannot continue safely?

Planning is part of prevention.

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The behavior-support plan must be agreed, written, and trained

- Agree: client or responsible party and agency; involve authorized professionals as appropriate
- Incorporate: place the plan in or attach it to the ISP
- Define: triggers, prevention, communication, safe responses, prohibited actions, and escalation
- Train: every employee or contractor assigned to the client before providing care
- Verify: document access, understanding, and task-specific competency
- Update: revise the plan and retrain when patterns or authorized supports change

Attendants follow the plan. They do not diagnose, improvise treatment, or use unapproved restrictions.

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A usable behavior-support and safety plan answers 8 questions

1. What does the behavior look like—objectively?
2. What is the person's usual baseline?
3. What triggers, settings, demands, communication barriers, or sensory conditions may precede it?
4. What preventive approaches and preferred supports work?
5. What should staff do, step by step?
6. What must staff never do?
7. What requires a supervisor, 988, 911, or another planned contact?
8. What must be documented, reviewed, and retrained?

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A fall is both an event/incident and a pattern

3M Older-adult emergency room visits from falls each year

1M Fall-related hospitalizations each year

- Follow the emergency and post-fall plan
- Report what was observed and what the client said
- Do not diagnose injury or decide the fall is insignificant
- Repeated falls or near-falls trigger agency review

Source: CDC Facts About Falls, Jan. 27, 2026

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Wandering requires a plan before the door opens

- Identify exit-seeking, getting lost, and prior episodes
- Define the attendant's expected response
- List immediate contacts and backup
- Set emergency-response triggers
- Reassess after every episode or meaningful near-miss

A missing client is not the moment to invent the search plan.

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Home safety includes firearms - without policing ownership

- Unsecured or newly accessible firearm
- Cognitive impairment plus handling or searching for a weapon
- New paranoia, agitation, threats, or escalating conflict
- Family member or visitor displaying a weapon threateningly
- Any request that the attendant move, unload, hide, or secure it

Risk = access + behavior + circumstances. Presence alone is NOT a reportable incident.

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Scenario: the pistol beside the chair

SCENARIO

Mr. Smith has dementia and is usually calm during visits. Today when the attendant arrived, Mr. Smith says "strangers enter at night." He appears increasingly agitated and keeps repeating that he "needs to protect his home." Each time, he points to a handgun beside his recliner in the living room.

What should the attendant do?

A. Pick it up and secure it

B. Unload it before continuing care

C. Tell him he cannot own a gun

D. Protect safety and report/escalate under policy

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The attendant is not the safety intervention

Recognition training must never become an expectation to remain in danger and solve it.

- Leave or create distance when immediate safety requires it
- Call 911 or emergency response when indicated
- Notify the agency as soon as safely possible
- Do not force care, physically confront, or handle weapons by default
- Agency leadership decides whether the assignment can safely continue

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When alcohol, cannabis, or other drugs are present in the home

- Focus on observable safety conditions; not labels, legality, or moral judgments.
- Plan for smoking exposure, impairment, unsafe visitors, sharps, unsecured substances, weapons, overdose, and interference with care.
- Staff do not purchase, transport, hide, search for, confiscate, or dispose of substances.
- If service cannot continue safely: create distance, notify the agency, and follow the emergency plan.
- Suspected overdose or immediate danger: call 911.
- Behavioral or substance-use crisis without immediate danger: use 988 or another identified resource according to the plan.

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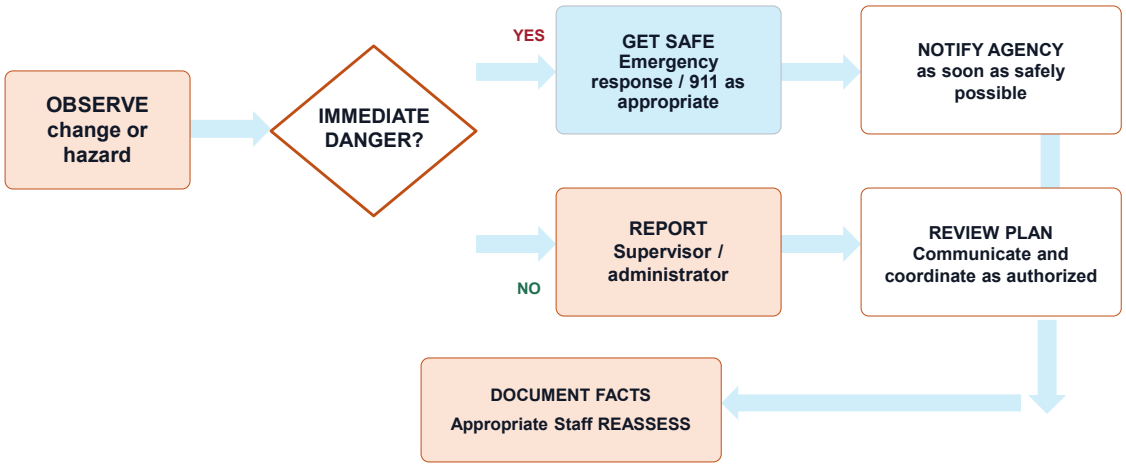
A practical PAS escalation pathway



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Document facts that the supervisor or another person can act on

Avoid labels and conclusions

- × Client was crazy and aggressive.
- × She cannot live alone anymore.
- × He had a bad fall but seemed fine.

Use facts and actions

- ✓ Client struck toward the attendant twice during bathing assistance and stated, 'Leave me alone.' Behavior was new from prior visits. Supervisor notified at 9:15 a.m.
- ✓ Client opened the front door three times and could not state her address. Supervisor notified.
- ✓ Client was found seated on the floor beside the bed and stated he fell while standing. Emergency and agency notifications completed per policy.

Describe. Quote. Compare to baseline. Record actions and times.

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Not every reportable change is a reportable incident

Report to the agency supervisor/ administrator

- New confusion or resistance
- Fall, near-fall, or unsafe mobility
- Wandering or exit-seeking
- Accessible firearm plus changed behavior
- Needs that no longer fit the ISP

Evaluate ANE / self-neglect duties

- Facts suggesting abuse, neglect, or exploitation
- Alleged actor and relationship to the client
- Possible self-neglect
- Current HHSC versus DFPS reporting
- Required timeframes and investigation steps

Internal escalation and external incident reporting can both be required - but they are not the same decision.

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Route the ANE report by the facts and alleged actor

Agency-related perpetrator

Employee, volunteer, contractor, or other provider-related person: use the current HHSC self-reporting process.

Outside perpetrator

Family member, friend, neighbor, or another non-agency person: report under the current DFPS process for protective services.

Self-neglect

Report under the current DFPS process when the facts create cause to believe self-neglect is present.

Immediate means within 24 hours for HCSSA reporting - follow current policy and guidance.

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Private-pay scenario: one attendant, two clients

SCENARIO

Mrs. Green has dementia and a wandering history. Her sister cannot safely transfer without help. One attendant is serving both under their separate private-pay ISPs. Mrs. Green walks out while her sister is in the bathroom awaiting transfer assistance.

What should the attendant do?

A. Leave the sister and follow Mrs. Green

B. Stay and allow Mrs. Green to leave

C. Decide which client is at greater risk

D. Use the pre-established two-client response and immediately escalate

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Each client keeps an individual plan - the agency plans the interaction

Client A

Wandering risk, expected response, emergency trigger.

Client B

Can this person ever be left alone, and under what conditions?

Shared staffing

What if both clients need hands-on help at the same time?

Backup

Supervisor, family, 911, or other identified support - in what order?

The plans should not force the attendant to invent the safety plan during the emergency.

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If the plan is missing, escalate fast - do not improvise

Protect both clients as circumstances allow

Activate emergency response when indicated

Contact the supervisor immediately

Activate identified family or backup support

Document the event and the absence of a workable plan

Reassess staffing and both ISPs before the next shift

The attendant should not have to choose which client matters more.

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Patterns trigger agency reassessment

- Repeated wandering, missing-person events, or exit-seeking
- Repeated falls, near-falls, or unsafe transfers
- Escalating aggression, threats, or unsafe firearm access
- Two-client conflicts the current staffing cannot safely resolve
- Family requests outside PAS scope or the agreed plan
- Needs consistently exceeding what the agency agreed and can safely provide

The agency reassesses service, supervision, staffing, coordination, and whether it can safely continue the arrangement.

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Refusal is a client's right; and sometimes a reassessment signal

- Pause
- Respect refusal
- Offer authorized choices
- Check immediate safety
- Report
- Document
- Agency reviews the pattern

The agency reassesses service, supervision, staffing, coordination, and whether it can safely continue the arrangement.

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Texas workplace-violence threshold: W-2 RNs

Chapter 331 applies to a PAS-only HCSSAs when

- The agency employs at least two registered nurses
- Current HHSC guidance treats 'employed' as a formal employment relationship with a W-2 from that agency

Contractor distinction under current guidance

- One W-2 RN with one 1099 RN: the two-person threshold is not met by those individuals alone
- Two 1099 RNs and no W-2 RNs: the threshold is not met

A statutory program threshold is not a permission slip to ignore violence risk below the threshold.

Verify current HHSC guidance; contractor examples reflect the stated W-2 test.

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Build the system before the next high-risk call

- Review admission language on PAS and license boundaries
- Add risk-specific directions and backup contacts to ISPs
- Train attendants on facts, urgency, safety, and reporting
- Audit documentation for labels and unsupported conclusions
- Update ANE/self-neglect reporting instructions
- Check the two-W-2-RN workplace-violence threshold

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Keep the attendant in the right lane

01 — **Set expectations at admission.**

02 — **Individualize the plan.**

03 — **Recognize change.**

04 — **Report and escalate.**

05 — **Document facts.**

06 — **Reassess patterns.**

The goal is not to make PAS staff clinicians in practice. The goal is to make them observant, prepared, and confident about what happens next.

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Questions and discussion

What high-risk situation is your agency trying to plan for now?

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Thank you for your Attendance

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