Preventing Resident-to-Resident Aggression in Dementia

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Presentation Overview

- Dr. Caspi: Causes & triggers of resident-to-resident aggression (RRA) and strategies for prevention
- Dr. Bonifas: Research findings regarding best practice social work roles for addressing RRA
- Presenter and participant dialogue: Implications for practice
- Final questions and answers

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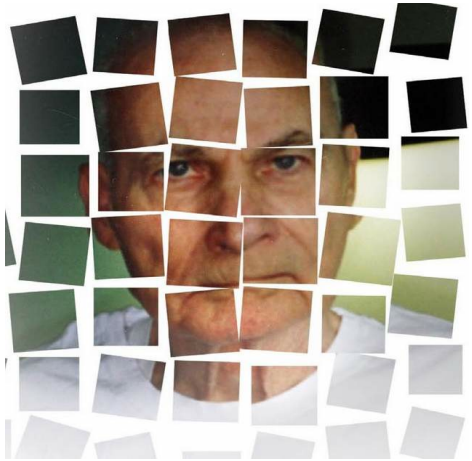


Dwayne E. Wall

Eilon Caspi
B.S.W. M.A. Ph.D.

Selected Quotations

- "*This is a matter of serious concern. It happens very often and will be fatal.*" – Resident

- "*Some of them really get afraid of him, and when I say get afraid…I mean get afraid…When they see him coming, they don't want to sit in the dining room…*" – CNA

- "*I am afraid that he will hurt someone when we don't see it…especially someone frail whom he can take down with one blow.*" – CNA

Guiding Principles

- Aggressive behaviors in persons with dementia are usually expressions of **unmet needs** (Whall & Kolanowski, 2004; Sifford, 2010)
- They usually have **meaning, purpose, and function**
- "The best way to handle aggressive behaviors is **to prevent them from occurring in the first place**" (Judy Berry, Lakeview Ranch)
- "The most important principle in treating the aggressive person is the effort to understand the **meaning of the sequence that led to** the aggressive behavior" (Cohen-Mansfield et al. 1996)
- **Situational triggers and early warning signs** can be identified in the majority of RRA episodes

Guiding Principles

- The **cumulative effects** of multiple factors – intersect with the resident's cognitive and other impairments – leading to RRA
- Interdisciplinary **assessment is critical** for identifying contributing factors, causes, and triggers – the basis for individualized intervention
- A **comprehensive, proactive, and well-coordinated** intervention must be applied consistently at multiple time points and levels to achieve a *sustainable* prevention effect
- **Commitment** by *everyone* at *all* levels of the organization and beyond…

Contributing Factors, Causes, & Triggers

Permission to use the picture was received from JDC-ESHEL (Photographer Moti Fishbain)

Contributing Factors, Causes, & Triggers

- **Resident's background factors**
  - Male
  - Birth order
  - Prior occupation
  - Pre-morbid personality
  - Aggression prior to admission
  - Poor quality of relationships
  - Depression
  - FTD; Vascular D; Early-onset AD; D Pugilistica; Korsakoff S
  - Mental illness (e.g. Schizophrenia); PTSD
  - Delusions and hallucinations
  - Substance abuse

Contributing Factors, Causes, & Triggers

- **Physiological/medical & functional factors**
  - Pain
  - Constipation
  - UTI
  - Incontinence
  - Memory loss
  - Visuospatial disorientation (Wayfinding difficulty)
  - Impaired ability to communicate
  - Hearing/vision loss

Contributing Factors, Causes, & Triggers

- **Situational causes and triggers**
  - Frustration
  - Boredom
  - Fatigue
  - Invasion of personal space
  - Seating arrangement
  - Intolerance of another's behavior
  - Repetitive speech
  - Competition for resources
  - Unwanted entry into bedroom
  - Conflicts b/w roommates
  - Racial/ethnic comments/slurs

Contributing Factors, Causes, & Triggers

- **Factors in the physical environment**

- Noise
- Crowdedness
- Lack of privacy
- Inadequate landmarks/signage
- Hallways (too narrow; “dead ends”)
- Inadequate lighting & glare
- Thermal discomfort (too cold / too hot)
- Indoor confinement
- TV
- Elevators

Contributing Factors, Causes, & Triggers

- **Staff and organizational factors**

- Low staff-resident ratio
- Burnout
- Lack of training
- Inappropriate approaches (“Elderspeak”)
- Inattentiveness to early warning signs & triggers
- Underreporting
- Poor quality of documentation/assessment
- Tense relationships
- Staff-resident language/cultural mismatch

Prevention and De-escalation Strategies

- **Strategies at regulatory/oversight, emergency, and law enforcement levels**

- **Procedures & strategies at organizational level**
- **Proactive measures**
- **Immediate strategies during episodes**
- **Post-episode strategies**

Strategies at the regulatory/oversight, Emergency, & Law Enforcement Levels

- Address RRA in regulations
- Increase state inspectors and Ombudsman's focus on RRA
- Address inadequate reimbursement (e.g. disincentive)
- Add RRA items to MDS 3.0 (Caspi, 2013)
- Require by law to inform residences on paroled offenders
- Increase involvement of Medicaid Fraud Control Units
- Improve Coroner/Medical Examiner's practices
- Improve collaboration b/w police & state survey agencies
- Train medical emergency staff & law enforcement personnel

Procedures & Strategies at Organization Level

- Employ the right people & support them!
- Train staff in communication techniques (Feil, 2012) and RRA recognition and prevention strategies (Teresi et al. 2013)
- Address RRA in Policies and Procedures
- Maintain adequate staff-resident ratio
- Recruit and train volunteers to strengthen supervision
- Promote empathy and compassion b/w residents
- Hold Resident & Family Council Meetings (at least monthly)
- Set realistic admission criteria
- Conduct pre-admission behavioral evaluation (home visits)
- Strengthen reporting policy & quality of documentation
- Improve roommate selection process (monitor existing assign.)

Proactive Measures

- Be constantly alert. Watch residents vigilantly!
- Be proactive! “Stop the vicious cycle of reactivity” (Zgola, 1999)
- Regularly move around the unit (avoid tendency to congregate)
- Remove or secure objects used as weapons
- Physical environment. Address described above and other triggers

- Observe & identify **early warning signs** (Caspi, 2012)

- Assess risk of imminent violence using **Brøset Violence Checklist** (Almvik & Woods, 1999; Almvik et al. 2007)

- Proactively identify & address unmet needs *before* they escalate…

Proactive Measures

- Assess physical discomfort/medical needs
  (e.g. **Discomfort Scale** – Hurley et al. 1992)
- Recognize & alleviate pain (**assessment tools** in LTC residents with dementia – Hadjistavropoulos et al. 2010)
- Be informed about previous altercations
- Work as a team!
- Enhance communication b/w staff and managers
- **Know the life history** of residents (**20 reasons**) (Caspi, 2014)
- Find out what makes him/her lose temper/become angry
- Build close trusting relationships with residents

Proactive Measures

- Structured/consistent daily routine (but be flexible)
- Engage residents in meaningful activities (critical!)
- Monitor content on TV and select soothing programs
- Ensure skilled managers actively present on evening shifts
- Train staff in non-violent self-protection techniques

- Install emergency call buttons & use hand-held radios
- Use assistive technology (e.g. Vigil Dementia System)
- Care-Media technology (Research) (Bharucha et al. 2006)

Immediate Strategies During Episodes

- “Engage in a swift, focused, decisive, firm, and coordinated intervention” (Soreff, 2012)
- Immediately defuse “chain reactions” (Anxiety is contagious!)
- Redirect resident(s) from the area (and pay attention to un-intended victims & residents with poor judgment re safety)
- Offer the person to take a walk together
- Distract/divert to a different activity / change the activity
- Refocus/switch topic to his/her favorite conversation topic
- Position, reposition, or change seating arrangement

Immediate Strategies During Episodes

- Physically separate residents
- Avoid conversations in loud/crowded places
- Slow down!
- Never approach from behind/side… Usually from the front
- Establish eye contact (unless culturally/otherwise inapprop.)
- If he starts to walk away, don't try to stop him right away (Berry, 2012)
- Maintain a safe distance (slightly beyond striking range)
- Speak at the level of the eyes
- Speak *with* the resident, not *at* the resident

Immediate Strategies During Episodes

- Stay calm! They *will* "mirror" your emotional state… (Strum et al 2013) and respond to your body language and tone of voice…
- Be sincere. Many are able to detect insincerity… / Avoid smiling
- Be firm and direct (rather than angry or irritated)
- Identify & address underlying needs behind the aggression
- Use short, simple, familiar words/sentences & one-step directions
- Never ignore the emotions of a resident. Encourage expression of feelings (fear; anger; frustration) but in a safe location…

Immediate Strategies During Episodes

- Encourage a compromise
- "Save face"
- Never argue, reason, correct, or criticize a resident
- Acknowledge & agree even if he/she is incorrect (unless unsafe)
- "Validate the subjective truth, internal reality, & feelings of the person, no matter how illogical, chaotic, or paranoid…" (Feil, 2012)
- Avoid using Reality Orientation (in mid-to-late stage AD)
- Avoid questions that challenge the short-term memory
- Listen to feelings, not facts; Respond to emotions, not behavior
- Turn negatives into positives; Avoid using words: "No" & "Why?"

Immediate Strategies During Episodes

- "Never command/demand. Instead ask for their help" (Berry, 2012)
- Provide frequent reassurance; Apologize sincerely
- Ask the person for permission
- It is (usually) not intentional. Try not to take it personally

- "If what you are doing is not working, STOP! Back off – Give the person some space and time. Decide of what to do differently. Try again!" (Teepa Snow). Don't leave resident(s) alone when unsafe!

- Seek assistance from co-workers (esp. those resident trusts)
- Be consistent in approach (across staff, shifts, & weekends)
- Notify interdisciplinary team and physician re episodes
- Promote restraint-free care environment (Flaherty, 2004; Wang & Moyle, 2005; Möhler et al. 2011; Tilly & Reed, 2006)

Post-Episode Strategies

- Reassurance, reassurance, reassurance!
- De-briefing procedures and meetings ("360-degree" approach)
- Conduct detailed documentation of the sequence of events & triggers (**Behavior Log** – Caspi, 2013)
- Seek emotional support from a trusted co-worker/supervisor
- Consult with physician/nurse (first aid; eval. medical cause; meds change)
- Inform & consult with family re episode and psychological/physical state
- Evaluate need for change in seating arrangement or bedroom/roommate
- In extreme circumstances (e.g. potential for immediate harm), consider transfer to psychiatric hospital / neurobehavioral unit for evaluation

Conclusion

Implement…

Assessment-based Anticipatory Care Approach

(Christine Kovach)

Toolkit:

- Recognizing Early Warning Signs (Caspi, 2012)
- Discomfort Scale (Hurley et al. 1992)
- Behavioral Log (Caspi, 2013)
- R-REM Instrument (11 items) (Teresi et al. 2013)
- Brøset Violence Checklist (Almvik et al. 2007)

- Interdisciplinary Screening Form (Caspi)

- Behavior Intervention Plan Form (Dr. Paul Raia)

Research findings regarding "best practice" social work roles for addressing RRA

DR. ROBIN BONIFAS

Resident-to-Resident Aggression

- “Negative and aggressive physical, sexual, or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient” (Rosen, Pillemer, & Lachs, 2007, p. 78).

Resident-to-Resident Aggression

- The most common form of "abuse" occurring in nursing homes in the U. S. (Special Investigations Division, 2001)
- Associated with negative resident outcomes including for victims and perpetrators:
  - Physical injury (Shinoda-Tagawa et al, 2004)
  - Functional decline, mental health deterioration, and reduced quality of life (Rosen, Pillemer & Lachs, 2007)
  - Relocation (Teaster et al, 2007)
  - Increased psychotropic medications (Malone, Thompson, & Goodwin, 1993)

Resident-to-Resident Aggression

- The majority of incidents occur in the context of dementia and are reactions to a perceived threat (Lachs et al, 2007).
  - Communication deficits hinder their ability to make needs known
  - Cognitive deficits limit mechanisms for coping with stress

Study Rationale

- One of the most common strategies employed to address RRA in nursing homes is for staff members to make a referral to the facility social worker (Rosen et al, 2008).

- Yet, studies are non-existent regarding how social workers respond to such referrals or how they collaborate with other professionals in doing so.

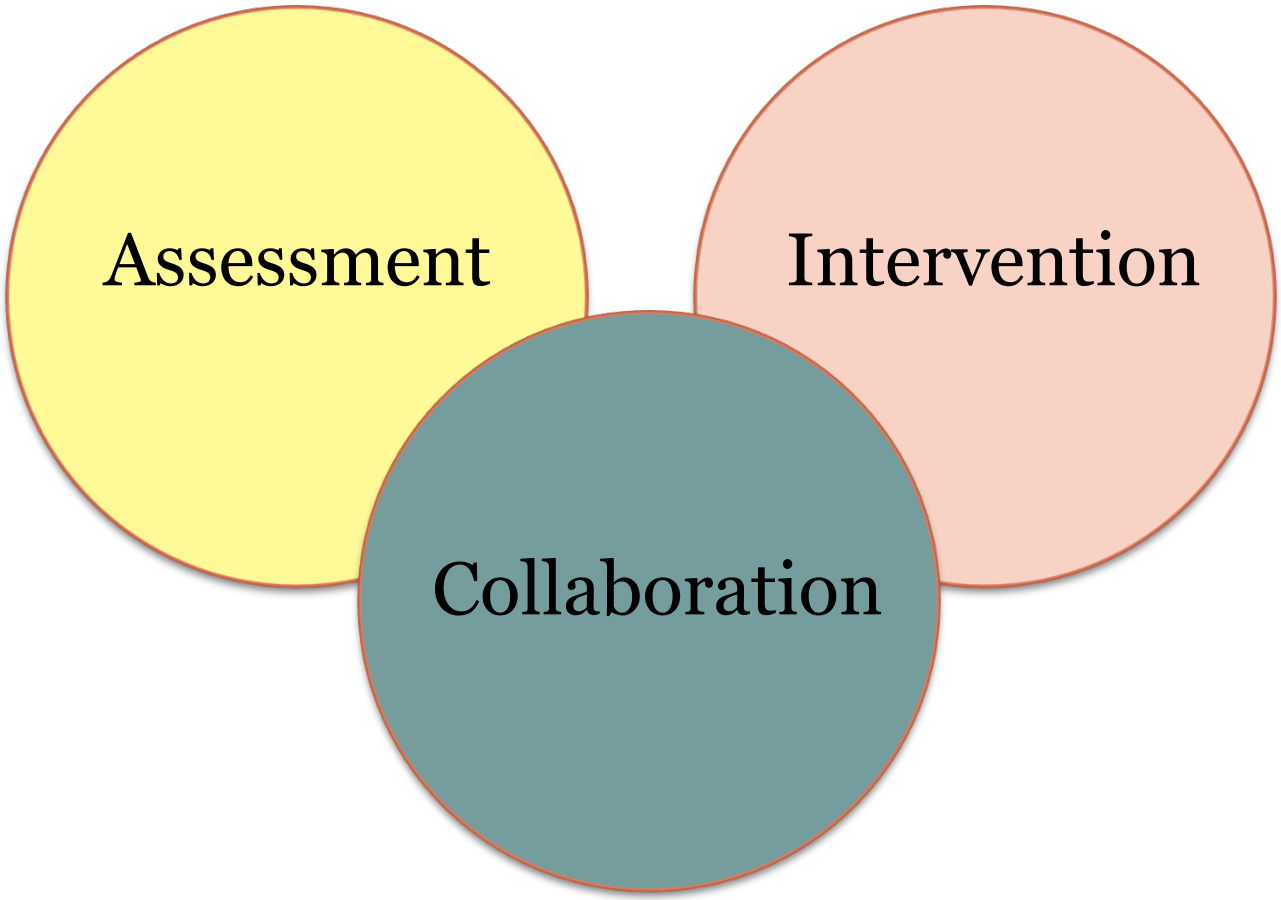
Study Purpose

- Identify “best practice” assessment and intervention strategies social workers utilize to effectively address RRA, and how they collaborate with nursing colleagues in the RRA management process.

Methodology

- Semi-structured interviews were conducted with 90 staff members from ten skilled nursing facilities.
  - Social services personnel (17)
  - Directors of nursing (10)
  - Licensed nursing staff (18)
  - Certified nursing assistants (45)
- Twenty individual interviews and 14 group interviews were conducted
- Ages ranged from 18 to 61
- Facility tenure 3 months to 16 years
- 85 % women (freq = 77)

Findings: Key Social Work Roles for Addressing RRA Effectively



Assessment

1. Gathering information about RRA incidents
2. Ruling out potential causal factors contributing to RRA incidents
3. Determining the psychosocial impact of being victimized

Gathering Information

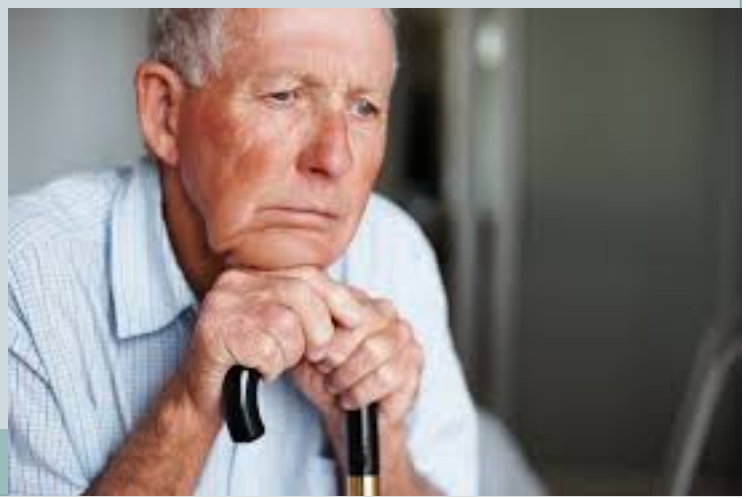
- Involves careful investigation
- Completing ad-hoc individual interviews
- Collecting witness statements
- Participation in planned team discussion

Ruling Out Causal Factors

- Considering physical factors
- Assessing psychological factors
- Evaluating environmental factors
- Determining past triggers

Determining Psychosocial Impact

- Follow-up visits to assess how the victim is doing
- Determining staffs' perception of the victim's emotional status
- Observing mood/behavioral/emotional symptoms
- Monitoring changes in usual interaction patterns and routines



Intervention

1. Determining appropriate interventions
2. Employing preventative approaches
3. Delivering psychosocial interventions

Determining Appropriate Interventions

- Ad-hoc communication with staff following RRA incidents
- Planned team meetings to discuss alternatives
- Incorporating a strengths-based framework
- Incorporating a person-centered framework
- Employing differing approaches for dementia versus non-dementia residents

Preventative Approaches

- Preadmission screening of potentially aggressive residents
- Setting the tone for a calm, respectful facility or unit milieu
- Making thoughtful roommate assignments
- Importance of “Knowing your residents”

Psychosocial Interventions

- Monitoring adjustment to change to allow early intervention
- Negotiating roommate difficulties
- Facilitating room changes
- Providing supportive counseling to minimize psychosocial harm

Psychosocial Interventions

- Serving as a liaison with families
- Facilitating support groups
- Negotiating behavioral contracts
- Initiating procedures for managing extreme situations

Social Work-Nursing Collaboration

1. Consultation to determine triggers
2. Intervention planning
3. Collaborative intervention delivery
4. Barriers to collaboration

Consultation to Determine Triggers

- Ad-hoc individual interviews with other disciplines
- Planned team meetings to discuss RRA incidents
- Active review of other disciplines' documentation

Intervention Planning

- Sharing knowledge about residents' needs and preferences with other disciplines to inform the overall plan of care

- Planned team-based discussions to develop plans of care collaboratively with other disciplines

Collaborative Intervention Delivery

- Care coordination with other discipline
- Synchronous or asynchronous intervention by each discipline
- Collaboratively evaluating intervention effectiveness

Barriers to Collaboration

- Social workers inconsistently notified of RRA incidents
- CNAs not positioned to share knowledge of residents' needs or effective approaches

Presenter-Participant Dialogue

IMPLICATIONS FOR PRACTICE

OR

WHAT DO THESE FINDINGS MEAN FOR YOU?

Implications: Your Thoughts

- Dr. Caspi shared causes and strategies
- Dr. Bonifas shared what social workers are doing
- What gaps exist?

Questions?

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Blog/Archive/Center for Prevention of Resident-to-Resident Aggression in Dementia

To access the free resources posted on the center, please go to:

http://eiloncaspiabbr.tumblr.com

Understand, raise awareness, act!