Preventing Resident-to-Resident Aggression in Dementia

Eilon Caspi, PhD, BSW
Postdoctoral Fellow
Geriatrics & Extended Care Data & Analyses Center
Providence VA Medical Center

Robin Bonifas, PhD, MSW
John A. Hartford Faculty Scholar in Geriatric Social Work
Assistant Professor
Arizona State University School of Social Work

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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
Preventing Resident-to-Resident Aggression in Dementia

Dwayne E. Wall

Eilon Caspi
B.S.W. M.A. Ph.D.
“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; Siffford, 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

- **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
- Intervention
- Collaboration
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?

CONTACT INFORMATION:

DR. EILON CASPI
eiloncaspi@yahoo.com

DR. ROBIN BONIFAS
robin.bonifas@asu.edu


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http://eiloncaspiabbr.tumblr.com

Understand, raise awareness, act!