Fighting for Dignity: Prevention of Distressing and Harmful Resident-to-Resident Interactions in Dementia in Long-Term Care Homes

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Objectives

Identify...

1. Consequences

3. Contributing factors, causes, & situational triggers

4. Psychosocial strategies prevention and de-escalation
Over a Century-long Problem

"...when walking about groped the faces of other patients, and was often struck by them in return."

Auguste D. Year: 1901

Definition
Resident-to- Resident “Aggression”

“Negative, aggressive and intrusive verbal, physical, material, and sexual interactions between LTC residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm in the recipient.”

(Rosen, Pillemer, & Lachs, 2008; McDonald et al. 2014)
Resident-to-Resident Elder “Mistreatment” Instrument
(Teresi et al. 2013)

- Use **bad words** toward another resident
- **Scream at** another resident
- Try to **scare, frighten, or threaten** with words
- **Boss around** / tell another resident what to do
- **Hit** another resident
- **Grab** or yank
- **Push** or shove
- **Throw things**
- **Threaten** with a cane, fist, or other object
- **Kicking, biting, scratching**, or spitting
- **Going into another res room** without asking or taking/touching/damaging or breaking **other res personal things**
High Prevalence & Incidence

**Lachs et al. (2014):** $n= 2011$ residents; 10 NHs in NY; Resident & staff interviews, chart reviews, direct observation
20% were “mistreated” by a fellow resident in past month (Verbal = 16%; Physical = 6%; Sexual = 1%; Other = 11%)

**Castle (2012):** 249 NHs in 10 states;
Mail questionnaire: $n = 4,451$ nurse aides; past 3 months
The number of resident-to-resident “abuse” cases is high

Scope Review by McDonald et al. (2015) found **high incidence:**
One-third of all cases of “abuse” in LTC homes
Underreporting

“The majority of resident-to-resident mistreatment incidents are not reported in most nursing homes”
- Prof. Jeanne Teresi

Underreporting and poor quality of reporting are major barriers for prevention

MDS 3.0 doesn’t identify target: Staff vs. Residents

Behavioral Expressions labeled as “Aggressive” in people with dementia are mostly...

• Expressions of unmet human needs

• Have meaning, purpose, & function to the person...

• Attempts at communication that need be explored with validation – Judy Berry, president, Dementia Specialist Consulting

• Attempts at gaining control over unwanted, frustrating or threatening situations

• Attempts at preserving identity & dignity

=> BAROMETERS for resident’s tolerance to stressful stimuli...
The Main Psychological Needs of Persons with Dementia

Attachment

Comfort

Identity

Inclusion

Occupation

LOVE

Close Trusting Relationship

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Know the Resident’s Early Life History

20 reasons why can be found at: http://tinyurl.com/l6p6ux4
Case Example
(Johnston, 2000)

Horticulture group activity in VA Medical Center – a group of Veterans are transplanting blooming tulips...

Mr. W became pale, tremulous, agitated, hyperventilated, and pushed another resident...

He was physically restrained and returned to the locked unit

Conversation revealed: Became distressed on seeing the tulips

Life history: During his army service in WWII several of his platoon were killed after being cornered in a tulip field...
Mild to Serious Consequences

Negative consequences for:
Target resident

Exhibitor
Residents witnessing
Care partners (staff)
Family members
Visitors
LTC home
Society

+ Substantial cost implications...
Consequences for Target Residents

- **Psychological**: frustration, anger, anxiety, fear, sadness, depression, social isolation, avoidance of activities

- **Physical**: Injuries and accidents: falls, dislocations, bruises or hematomas, reddened areas, lacerations, abrasions, fractures (e.g. hip), brain injuries

- **Deaths**: Dozens of reports in the media

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Review of 40 Deaths due to DHRRI in Dementia

- **Nature of physical contact**: 32% push/beat-fall episode
- **Time until death** (average): 8 days (32% same day)
- **Location**: 68% inside bedrooms (19 out of 28 episodes)
- **Roommates**: 37% (15 out of 40)
- **Time**: Majority during evening (+ 3 during the night)
- **Weekends**: 62% (18 out of 29)
- **Not witnessed**: 70% (19 out of 27)

Editorial in JAMDA (January 2016):
Next Step...
Analyze Medico-Legal Databases

• **National Coronial Information System** (Australia)
  (Murphy, Ibrahim, Bugeja, & Pilgrim, 2016: Monash University; Victorian Institute of Forensic Medicine)

• **National Violent Death Reporting System** (U.S.)
  (CDC’s Division of Violence Prevention)

• **Canadian Coroners and Medical Examiner Database**
  (Canada)
Contributing Factors, Causes, & Triggers

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Common Causes & Triggers

• Resident history & background factors (traumas; personality; “aggression” prior to admission; poor relationships; depression)

• Physiological, medical, functional causes
  – Pain; constipation; dehydration; UTI; delirium; hallucinations; delusions
  – Specific dementias: bvFTD; TBI; CTE (Dementia Pugilistica), Korsakoff syndrome
  – Serious Mental Illness (SMI) (e.g. Schizophrenia) and PTSD

• Factors in the physical environment

• Situational causes and triggers

• Care partners and organizational factors
Contributing Factors in the Physical Environment

- Segregation of a large number of people with dementia
- Large unit size and layout limiting supervision
- Inadequate landmarks/signage (wayfinding difficulties)
- Crowdedness
- Noisy, over-stimulating, & hectic environment
- Lack of privacy and private away spaces (beyond bedroom)
- Private vs. shared bedrooms (conflicts b/w roommates)
- Indoor confinement
- Hallways (too narrow; “dead ends”)
- Inadequate lighting & glare
- Too cold or hot
- TV
- Elevators
- Access to sharp/dangerous objects
Situational Causes and Triggers

- Frustration with being institutionalized / Lack of control & choice
- Boredom
- Situational frustrations / interpersonal stressors
- Miscommunications and misunderstandings; misperceptions
- Invasion of personal space
- Problems with seating arrangement
- Intolerance of other’s behavior (Repetitive questions; unwanted touching)
- Taking another’s belongings / Competition for limited resources
- Unwanted entry into one’s bedroom
- Conflicts b/w roommates (about “rules” for using the bedroom)
- Racial/ethnic comments/slurs
- Discrimination and hostility towards people who are LGBT

Theme: Unmet Human Needs
Care Partners & Organizational Factors

- Biomedical...vs...Person-directed & relationship-based care:
  Arcare, Helensvale, Australia: [http://tinyurl.com/jxldwfv](http://tinyurl.com/jxldwfv)

- Inhumane **staffing levels** (Highly stressful working conditions)
- **Lack of training** in prevention of DHRRI in dementia & SMI
- **Lack of support and guidance** of direct care partners by managers
- New, inexperienced & **unsuitable** direct care partners
- **Tensed** and dysfunctional **relationships** b/w employees
- Hierarchical organizational structure
- Care partners **burnout**
- **Inappropriate approaches**, attitudes, & communication style
- **Inattentiveness** to early warning signs of distress & frustration
- Language or cultural **mismatch** (care partners-residents)
Prevention and De-escalation Strategies

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Prevention and De-escalation Strategies

We all want a magic bullet/quick fix...but the reality is...

It’s the cumulative effect of multiple factors in the social and physical environment and factors at all levels of the organization and beyond – intersect with the resident’s cognitive impairments and unmet needs – lead to DHRRI

It is an endless culture change journey requiring fundamental changes in practices and organizational operations & strong and ongoing commitment from all...
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 Regulatory/Oversight, Emergency & Law Enforcement Levels

- Adequate Reimbursement / Incentive System
- Bridge gap in M.D.S. 3.0
- Adequate reporting and measurement tools
- Improve Nursing Home Compare Website
- Build small PDC Behavioral Units (dementia; SMI)
- Understand and protect from Sex Offenders
- Develop discharge policy to avoid wrongful evictions

- Proactively address Assisted Living “ticking time bomb”
Strategies at Regulatory/Oversight, Emergency & Law Enforcement Levels

- Regulations; Policies and Procedures (NHs & ALRs)

RE-EXAMINE DHRRI-specific PRACTICES, DEFINE ROLES, and TRAIN:
- Government Accrediting & Surveying Agencies (State and Federal/CMS)
- Ombudsman program
- Police officers
- Medical Emergency personnel
- APS
- Medicaid Fraud Control Units
- Coroner/Medical Examiner Agencies

- Death Certificates

=> Collaboration and timely information transfer b/w all agencies (e.g. b/w Police & State Survey Agencies) and b/w agencies & LTC homes
Coordinated Inter-Agency Strategy

• “For the cause of assuring safety in long-term care, it means the coming together of expertise including the appropriate government officials, community agency workers, long-term care administration, frontline staff, family caregivers, researchers…..and the media” – Social workers Eleanor Silverberg, Angela Gentile & Victoria Brewster

Critical Government Initiatives

Canada


Australia

Strategies at Regulatory/Oversight, Emergency & Law Enforcement Levels

“One of the challenges is that we have a system where it is up to nursing homes to pretty much police themselves” – Professor Laura Mosqueda

“What worries Prof. Karl Pillemer is not that nursing homes can’t find ways to reduce residents’ mistreatment of each other, but that they won’t face much pressure to try”

– Paula Span, New York Times, quoting Prof. Pillemer
Procedures & Strategies at the Organizational Level

• Address DHRRI in your Policies and Procedures
• Set realistic admission and discharge criteria
• Conduct pre-admission behavioral assessment
• **Employ the right people** & train and support them!!!
• Implement **consistent** (“dedicated”) assignments
• Implement mechanisms for knowing residents’ life histories
• Develop **roommate selection** and reassignment policy
• Strengthen **reporting policy** (Culture of blame → Learning)
• Improve **quality** of documentation
• Regularly hold **Resident & Family Council** meetings
“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”

– Prof. Jiska Cohen-Mansfield
Encouraging Research Findings

- Early warning signs and situational triggers can be observed in the majority of these episodes (Caspi, 2013; Snellgrove, 2013)

- DHRRI tend to occur in patterns (time of day, location, events, people, objects)

- A small number of residents account for a large portion of DHRRI (Malone et al., 1993; Negley & Manley, 1990; Allin et al. 2003; Almvik et al. 2007; Bharucha et al. 2008)
Proactive Measures

• “The best way to handle aggressive behaviors is to prevent them from occurring in the first place”
  – Judy Berry, president, Dementia Specialist Consulting

• “The only way to manage behaviors in persons with dementia…and I mean the only way...is to prevent them in the first place...but unfortunately we spend most of our time reacting to the behavior when we should be reacting to the cause” – Jan Garard, RN, MN Department of Human Services

Fire Inspector vs. Fire Extinguisher (Dr. John Brose)
Walking Group Intervention  
(Holmberg, 1997)

• Frequent and distressing RRI during early evening hours at a care home for people with dementia...

• Intervention: Immediately after dinner volunteers led a 30-minute walking group for 3 consecutive days (Comparison: 4 days without walking groups)

• Outcome: 30% reduction in “aggressive” incidents during 24 hours after walking... (RRI & Resident-Staff)
Proactive Measures

- **Train in caring for and communicating with people with dementia:**

- **Protect care partners** (e.g., Train-the-trainer non-violent self-protection techniques – TJA PSI): [http://www.tjapsi.com/hc_index.htm](http://www.tjapsi.com/hc_index.htm)

- **Strengthen info transfer / Be informed about previous episodes**
- **Ensure everyone knows residents involved in DHRRI**
- **Promote teamwork!**
- **Provide structured/consistent routine** (but be flexible...)
- **Instill empathy/compassion between residents**
Proactive Measures

• Be constantly alert. Watch residents vigilantly!
• Identify and respond to early warning signs of distress/anxiety
• Be proactive! “Stop the vicious cycle of reactivity” (Zgola, 1999)
• Regularly move around the unit (avoid congregating in 1 place)
• Modify the physical environment (dementia-friendly guidelines)
• Remove or secure objects used as weapons
• Ensure content on TV is enriching, calming, and therapeutic
• Ensure active presence of managers (evenings, weekends, & holidays)
• Recruit volunteers (e.g. “Buddy System” for new residents – Judy Berry)
• Install emergency call buttons & use hand-held radios
• Use assistive technology (e.g. Vigil Dementia System)
Meaningful Activities

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Encourage Creativity
Case Example

When bored...a resident with dementia engaged in “aggressive” behaviors toward other residents...

He wanted to work and feel useful...

The care team bought him a *manual lawn mower*...

He is now using it all the time to mow the lawn outside and it reduced his ‘aggressive’ behaviors. “This is the best $79 I’ve spent.” – Judy Berry
Experts’ Opinion

“Activities are the main weapon against behavior difficulties and violent behavior” – Dr. Paul Raia

“If a person with dementia is engaged in a meaningful activity, the person can not simultaneously be exhibiting problematic behavior” – Dr. Cameron Camp

Unless...

Unmet medical need; fatigue; remote trigger from past; something negative in physical environment; activities not planned or delivered professionally or incompatible to resident’s preferences, abilities, disabilities
But the reality is...

Most residents are **not engaged** in activities **most of the time** in NHs (Cohen-Mansfield et al. 1992; Burgio et al. 1994; Schreiner et al. 2005; Wood et al. 2005)

**Boredom = The enemy of a subgroup of residents with dementia!**

“**A resident who is at most risk of an assault is bored!**”

- Administrator of a nursing home
Research Findings

Evening = Vulnerability Time Period!

- Half of distressing RRI episodes occurred between 5pm – 8pm (Donat, 1986)

- Half of DHRRI incidents requiring police involvement occurred between 4pm – 10pm (Lachs et al. 2007)

Most NHs do not offer meaningful activities during the evening hours. A missed opportunity

- Higher number of direct care partners during evening hours was found to reduce distressing RRI (Donat, 1986)
“A wise lawyer will first approach the activity director and ask: ‘How did you engage the resident in a way that would have prevented the violence/injury against my client?’”

– Dr. Paul Raia, Alzheimer’s Association, MA
Immediate Strategies During Episodes

“The behavior can not be changed directly, only indirectly by changing either our approach or the person’s physical environment”

– Dr. Paul Raia
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
• Avoid overcrowding resident (will strike if feels “cornered”)
• Offer to take a walk together
• Distract/divert to a different activity or change the activity
• Refocus/switch topic to his/her favorite conversation topic
• Position, reposition, or change seating arrangement
Immediate Strategies During Episodes

• Physically and skillfully separate residents
• Avoid conversations in loud/crowded places
• Slow down!
• Avoid approaching from behind/side...usually from the front
• Establish eye contact (unless threatening/culturally inapprop)
• If he starts to walk away, don’t try to stop him right away (Judy Berry)
• Maintain a safe distance (slightly beyond striking range)
• Speak at the level of the eyes (never above the resident)
• Speak with...not at the resident
Immediate Strategies During Episodes

• Try to stay calm! They will “mirror” your emotional state!

• They’ll respond to the unspoken...even if you said the right thing! (Jan Garard)

• Be sincere. Many people with dementia can detect insincerity

• Be firm and direct (rather than angry or irritated)

• Use short, simple, familiar words/sentences & one-step directions

• Never ignore their emotions... Encourage expression of feelings (frustration; anger; fear) but do it in a safe way and location...
Immediate Strategies During Episodes

• Encourage a compromise

• “Save face”

• Avoid arguing, reasoning, correcting, or criticizing a resident with dementia

• “Validate the subjective truth, internal reality, & feelings of the person, no matter how illogical, chaotic, or paranoid...” (Naomi Feil, Validation Method)

• Avoid using Reality Orientation (in mid-to-late stages of Alzheimer’s disease)
  Avoid questions that challenge short-term memory (“Didn’t I just tell you...?”)

• LISTEN TO FEELINGS, less to facts; RESPOND TO EMOTIONS, not to the behavior

• Identify & proactively address underlying needs behind the words and behaviors

• Turn negatives into positives; Avoid using words: “No!” ”Don’t...” & “Why?”
Immediate Strategies During Episodes

- “Never command/demand. Instead ask for their help” (Berry, 2012)
- Apologize sincerely when things go wrong...
- Ask the person for permission
- It is (usually) not intentional. Try not to take it personally!
- Be patient and supportive. They face an avalanche of losses!!!

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

- Seek assistance from co-workers (esp. those the resident trusts)

- Be consistent in approach (across staff, shifts, days, weekends)

- Promptly notify interdisciplinary team and physician re episodes
Recommended DVD


Techniques demonstrated:

• Release from a grab
• Deflecting a strike or a kick
• Dealing with your hair pulled
• Planned containment
• Unplanned containment

Link to Terra Nova Films: http://tinyurl.com/hveq5tr
Post-Episode Strategies

• **Provide** (adult-to-adult) reassurance!

• **Hold de-briefing** procedures and **meetings** (a “360-degree” approach)

• **Document** sequence of events/triggers leading to DHRRI (**Behavior Log**)

• **Seek emotional support** from a trusted co-worker or supervisor

• **Consult with nurse and physician** (1st aid; evaluation of medical cause; change in meds)

• **Inform & consult with family** (timely; reliably; value their input/insights)

• Consider **change in seating arrangement** or **bedroom/roommate** assign.

• **In true emergency** (e.g. potential for immediate harm), **consider transfer** to psychiatric hospital / neurobehavioral unit for **evaluation**
Assessment is Key

Characteristics of effective individualized assessment:

• Proactive
• Comprehensive
• Interdisciplinary
• Whole person & Person-directed
• Life course perspective
• Needs-based
• Persistent / Systematic
Assessment-based
“Anticipatory Care Approach”
(Prof. Christine Kovach)

What’s in your quiver?

- Recognizing Early Warning Signs of Distress (Caspi)
- Behavioral Expressions Log (Caspi)
- R-REM Instrument (Teresi et al. 2013)
- Brøset Violence Checklist (Almvik et al. 2007)
- Evaluation of Urgency of DHRRI Form (Caspi)

- Interdisciplinary Screening Form (DHRRI & dementia-specific) (Caspi)

- Behavior Intervention Plan Form (adapted from Dr. Paul Raia)
# Behavioral Expressions Log (5Ws/IOS)

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<tbody>
<tr>
<td>/</td>
<td>Time</td>
<td>Location</td>
<td>Who was there?</td>
<td>Cause / Trigger</td>
<td>Describe intervention, if any</td>
<td>Describe outcome</td>
<td>Make a suggestion for future</td>
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**What?** Detailed description of the behavioral expression and what happened (sequence of events) BEFORE and AFTER the behavior:

______________________________________________________________________________
______________________________________________________________________________

Persistent use of the log often enables to identify patterns, causes, and situational triggers – the basis for individualized interventions
Will was hitting residents “for no reason”  
(Raia, 2011)

Keeping a Behavioral Expressions log revealed:

The hitting occurred only in the activity room [Where?]
Never at night [When?]
Never struck the same person twice [Who?]
Only on sunny days but not on all sunny days [What?]
Only if he sat on one side of the room [Where?]  
The sun was glaring in his eyes. He thought the residents were playing with the light switch... [Why?]

**Intervention**: Drawing down a shade when he is in the room  
**Outcome**: Hitting discontinued; Psychotropic meds avoided...
Two Recommendations

1. Train all employees in DHRRI in dementia & SMI:
   • Understanding
   • Recognition
   • Documentation
   • Individualized Care Planning
   • Prevention
   • De-escalation

2. Low and dangerous staffing levels in many U.S. nursing homes:
   Harrington et al. (2016): [http://tinyurl.com/jgtt4uu](http://tinyurl.com/jgtt4uu)

=>

Pass legislation & fund adequate staffing levels (adjust for acuity)
The Consumer Voice for Quality LTC: [http://tinyurl.com/hyv3kkh](http://tinyurl.com/hyv3kkh)
Policy Goal

“We talk about violence-free schools...

Why we don’t talk about violence-free nursing homes?

What about ending violence in nursing homes as a policy goal?”

- Professor Karl Pillemer
Questions / Discussion

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The International Center for Prevention of DHRRI in dementia in LTC Homes:
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