PREVENTING & Dealing With Resident-to-Resident Aggression in Dementia Residents

It Can Be A Real Puzzle
Objectives

- Participants will be able to verbalize understanding of contributing factors, causal factors, & triggers for Resident-to-Resident Altercations (RRA)
- Participants will be able to verbalize usable proactive measures to anticipate behaviors
- Participants will be able to verbalize understanding of the importance of appropriate & thorough assessment and treatment of hypersexuality
Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

.... Or the potential for harm.
Resident to Resident Aggression

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

- The most common form of “abuse” occurring in nursing homes in US (Special Investigations Division, 2001)
- Associated with negative resident outcomes including for victims & perpetrators include:
  - Physical injury
  - Functional decline, mental health deterioration & reduced quality of life
  - Relocation
  - Increased psychotropic medications
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: Resident’s Background Factors

- Male
- Birth order
- Prior occupation
- Pre-morbid personality
- Aggression prior to admission
- Poor quality of relationships
- Depression

- Fronto-temporal Dementia; Vascular Dementia; Early-onset Alz; Korsakoff Syndrome
- Mental Illness (schizophrenia, PTSD)
- Delusions/hallucinations
- Substance abuse (or hx)
Contributing Factors, Causal Factors & Triggers: Physiological/Medical & Functional Factors

- Pain
- Constipation
- UTI
- Incontinence
- Memory Loss
- Visuospatial Disorientation (Wayfinding difficulty)
- Impaired ability to communicate
- Hearing/Vision Loss
Contributing Factors, Causal Factors & Triggers: Situational Causes & 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 between roommates
- Racial/ethnic comments/slurs
Contributing Factors, Causal Factors & Triggers: Factors in Physical Environment

- Noise
- Crowdedness
- Lack of privacy
- Inadequate landmarks/signage
- Hallways (too narrow/”dead ends”)

- Inadequate lighting
- Thermal discomfort (too hot/too cold)
- Indoor confinement
- TV
- Elevators
Contributing Factors, Causal Factors & Triggers: Staff & Organizational Factors

- Low staff:resident ratio
- Burnout
- Lack of training
- Inappropriate approaches ("Elderspeak", body language)
- Inattentiveness to early warning signs & triggers

- Under-reporting
- Poor quality of documentation/assessment
- Tense relationships
- Staff-resident language/cultural mismatch
Perform a Root Cause Analysis

- Why did the incident occur?
- What REALLY triggered the behavior?
- Who was around?
- What was going on?
- Where…environment?
- What time? Is there a trend?
- WHY????
Prevention & De-escalation Strategies

- Strategies at regulatory/oversight, emergency, & 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

- CMS & State regulations addressing RRA
- Address inadequate reimbursement
- Background checks on residents prior to admission
- Improve collaboration between facilities, survey agencies & law enforcement
- Train medical emergency staff & law enforcement personnel
Procedures & Strategies at Organizational Level

- Employ the right people & support them
- Train staff in communication techniques & RRA recognition & prevention strategies
- Address RRA in Policies & Procedures
- Maintain adequate staff-resident ratio
- Recruit & train volunteers to strengthen supervision
- Promote empathy & compassion between residents
- Hold Resident & Family Council Meetings at least monthly
- Set realistic admission criteria
- Conduct pre-admission behavioral evaluation (including home visits if applicable)
- Strengthen reporting policy & quality of documentation
- Improve roommate selection process & monitor existing assignments
Proactive Measures

- Be constantly alert & watch residents vigilantly!
- Be proactive! Stop the vicious cycle of reactivity
- Regularly move around the unit & avoid tendency to congregate
- Remove or secure objects used as weapons
- Enable your physical environment to anticipate the triggers & meet the needs of your residents’ safety & QOL
- Observe & identify *early warning signs*
- Assess for the risk of imminent violence or inappropriate sexual behaviors
- Proactively identify & address unmet needs *before* they escalate
Proactive Measures

- Assess physical discomfort/medical needs
- Recognize & alleviate pain
- Be informed about previous altercations
- **Work as a team!**
- Enhance communication between staff & managers
- **All staff should know the life history** of residents through care plan
- Determine what makes the resident lose temper or become angry
- Determine what triggers encourage resident to reach out sexually
- Build close trusting relationships with residents
Proactive Measures

- Provide a structured, consistent daily routine…but be flexible
- Engage residents in meaningful activities (CRITICAL)
- Monitor content on TV & 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
Proactive Measures

- Minimize environmental change
- Stability is essential
  - Limit the number of caregivers
    - Reward caregivers that work well with a resident
  - Minimize the number of room changes
  - Structure breeds improvement
  - Addition of medications within the first 4 weeks after a change in environment will not likely be helpful
Proactive Measures

- Control the amount of stimulation
  - Too much stimulation commonly is a causal factor for behaviors
    - Shift change, dining room, activities, bright lights
    - Big screen TV, heat & cooling vents
  - Too little stimulation can lead to feelings of:
    - Isolation
    - Loneliness
    - Desire to be where the action is!
General Strategies

- Not every intervention works with every resident
- Not every intervention works every time
- The key is flexibility
- Often the environment triggers behaviors
- Look around to see what is happening on the unit
Immediate Strategies During Episodes

• “Engage in a swift, focused, decisive, firm & coordinated intervention” (Soreff, 2012)
• Immediately defuse “chain reactions”…anxiety is contagious
• Re-direct residents from the area & pay attention to unintended victims & residents with poor judgment regarding safety
• Offer the person to take a walk together
• Distract/divert to a different activity or change the activity
• Refocus/switch topic to resident’s favorite conversation topic
• Position, reposition, or change seating arrangement
• Protect all residents
Immediate Strategies During Episodes

- Physically separate residents
- Avoid conversations in loud/crowded places
- Slow down!
- Never approach from behind/side…usually approach from front
- Establish eye contact unless culturally or otherwise inappropriate
- If resident starts to walk away, don’t try to stop him/her right away
- 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! The resident will “mirror” your emotional state and respond to your body language & tone of voice
- Be sincere…dementia residents are able to detect insincerity…avoid smiling
- Be firm & 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 but encourage expression of feelings (fear, anger, frustration) but in a safe location
Immediate Strategies During Episodes

- Encourage a compromise
- Allow resident to “save face”
- Never argue, reason, correct, or criticize a resident
- Acknowledge & agree even if resident 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 dementia)
- Avoid questions that challenge the short-term memory
- Listen to feelings, not facts; respond to emotions, not behaviors
- 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 resident for permission
- Behaviors are usually not intentional so try not to take it personally
- “If what you are doing is not working, STOP! Back off—give the person some space & time. Decide of what to do differently. Try again (Teepa Snow). Don’t leave resident(s) alone when unsafe!
- Seek assistance from co-workers, especially staff that resident trusts
- Be consistent in approach across shifts, staff, weekends
- Notify interdisciplinary team & physician of episodes
- Promote restraint-free care environment
Immediate Strategies During Episodes

- Remove all unnecessary persons from immediate environment
  - Bystanders escalate stimulation & situation
- Remove objects
- Find the staff member that knows the elder the best
- Keep calm (getting angry or frustrated makes the situation more explosive)
- Ensure all unmet needs are met (food, water, smoke)
- Adequate analgesia
- Lower lights, provide soft music
- Offer comfort food
Immediate Strategies During Episodes

- **Staff member**
  - **Interpersonal space**
    - Maintain a distance; do not crowd; get out of personal space
    - Maintain equal attitude; don’t stand above; get on eye-level
    - Move slowly
  - **Eye contact**
    - Intermittent: do not stare
    - Face animated congruently; avoid being expressionless
    - Be aware of & control any idiosyncratic winking or grinning which can be misinterpreted
    - Be calm but serious, you want to get their attention
Immediate Strategies During Episodes

• **Staff member**
  • **Posture**
    • Be relaxed, have open hands in front of you
    • Avoid appearance of rigidity which conveys fear
    • Avoid clenched fists, which conveys hostility
    • Avoid crossing arms which conveys closed attitude
    • Avoid face-to-face confrontations
  • **Touch**
    • If possible, do not touch elder if it upsets the elder
    • Use acupressure points on hand for calming effect
    • Always prepare the elder if you are going to touch them
Immediate Strategies During Episodes

• Verbal Interventions
  • Report & reflect to the elder what you observe about their behavior & what they say
  • Redirect: with dementia you may not be able to get them to change the way they think so your goal is to change the way they feel, & the thinking will follow
  • Tell the elder it’s ok to be angry but staff will not let him hurt someone else
  • Get help as needed
Immediate Strategies During Episodes

- Accept what the elder says (not doing so will create an argument)
- Be calm, modulated, firm (do not shout)
- Anticipate shame, vulnerability, loss of self-esteem
- Express concern & desire to protect the elder from harm
- Acknowledge the elder’s power to make decisions
Immediate Actions in ALL Cases of Abuse

• Separate the elders using a calm, non-threatening approach: **FIRST STEP IS ALWAYS TO GET ELDER TO SAFETY...ALWAYS**
• Speak to both elders calmly & clearly
• Manipulate the elder’s environment to remove the cause of potential trigger for the behavior
• Redirect the elder by involvement in diversion of interest to the elder
Post-Episode Strategies

- Administrator &/or DON will be notified immediately when an elder to elder altercation has occurred
  - Incident will be reported to KDADS within 24 hours of incident (24 hours NOT 1 working day) & investigation will be provided to KDADS within 5 working days
- Monitor and adjust care to reduce negative outcomes
- Involve entire Interdisciplinary team including family in developing an adequate care plan
Post-Episode Strategies

• In all cases of elder to elder altercations, the elder’s primary care physician must be notified
• Staff member responsible will start Incident Report & will conduct Root Cause Analysis of situation to develop effective interventions
• Social service staff will provide follow-up documentation on both elders to ensure that both the potential abuser & the elder who may have been abused receive one-on-one supportive counseling along with appropriate documentation on efforts in clinical record and care plan
• All staff will be in-serviced at least annually & as needed about ANE & how to spot the warning signs of an elder to elder altercation to prevent incidents from occurring
Post-Episode Strategies

• PROTECT, PROTECT, PROTECT
• Reassurance, reassurance, reassurance
• De-briefing procedures & meetings (“360-degree approach)
• Conduct detailed documentation of sequence of events & triggers identified
• Consult with physician/nurse for first aid, evaluation, medical cause, meds change, etc)
• Inform & consult with family about episode & psychological/physical state
• Evaluate need for change in seating arrangement or bedroom/roommate
• Get Social Service staff involved
Post-Episode Strategies

- Complete Root Cause Analysis on behaviors
- An assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team, with input from the elder’s family and a care plan will be created, identifying the goals and approaches to prevent future occurrences
- Elders identified at risk for altercations must be monitored on an ongoing basis related to changes & triggers that would initiate behaviors
- Assessment of interventions should be used to prevent behaviors on an on-going basis
- Realize & DOCUMENT what works & what doesn’t work
- There is no single way to get an agitated elder to calm down, and what works today may not work tomorrow & what works for you may not work for others
Post-Episode Strategies: Investigation

• Complete Root Cause Analysis on all behaviors including action plan (immediate care plan intervention)
  • What is the behavior?
  • When did it occur?
  • Where did it occur?
  • What happened before & after the behavior?
    • Causal factors/mitigating factors
  • What happened as a result of the behavior?
  • Is behavior old or new?
Post-Episode Strategies: Investigation

• Is behavior a symptom of an unmet need?
  • Hunger, thirst, mobility, pain, boredom, loneliness
  • Medications
    • Narcotics, muscle relaxants
    • Chemotherapy
    • Antidepressants, antipsychotics, benzodiazepines
  • Medical problem
    • New pain
    • UTI, hyponatremia, dehydration
    • COPD/hypoxia
Abatement Plan for Immediate Jeopardy

• If you receive notification that your facility is in an IJ, first ensure that the residents in your center are safe. After that, begin working on your abatement plan and plan of correction to abate the situation.

• Abatement plan needs to be approved by the State agency & CMS Regional office before the IJ is considered to be abated.
Abatement Plan for Immediate Jeopardy

- Needs to be completed ASAP because if you receive a per diem civil money penalty (CMP), a delay in submitting your POC will increase your fine.
- Immediately begin an investigation and complete a Root Cause Analysis (RCA)
- (So can/should we start our training/inservicing before receiving the 2567?)
Abatement Plan for Immediate Jeopardy

- Questions to answer during the investigation:
  - What happened?
  - How did it happen?
  - What system failed that allowed this to happen?
  - What does the facility need to change immediately to keep the residents safe and ensure it doesn’t happen again?
Abatement Plan for Immediate Jeopardy

• The plan needs to include:
  • The immediate corrective action for the situation—what are you implementing immediately to correct the issue?
  • Training:
    • What was covered?
    • Was the policy revised?
    • Did you complete re-education on the current policy?
    • What date & time was training completed for all staff?
    • Send the sign in sheets for all staff to State agency by fax or scan & email
  • Follow up monitoring
    • Who is responsible, how often & for how long?
Abatement Plan for Immediate Jeopardy

- Example: each situation will be different. 
  There is NO one-size fits all abatement plan
- Follow the general outline to determine the root cause & determine what you will implement to correct it
Abatement Plan for Immediate Jeopardy-Example

• What happened? Hot water temperatures in excess of 140 degrees with resident access
• How did it happen? Water temps were not checked in dining room and was tied to kitchen hot water temps
• What system failed? Routine water checks did not include dining room sink
• What does facility need to change to ensure it doesn’t happen again? Facility will check every water source daily x 1 week then weekly, including dining room sink
Abatement Plan for Immediate Jeopardy-Example

• The Plan:
  • Include documentation of the following:
    • The immediate corrective action for the situation—what are you implementing immediately to correct the issue?
      • Water shut-off to that sink until a plumber was able to get a part & come to facility
Abatement Plan for Immediate Jeopardy-Example

- Training:
  - What was covered?
  - What date & time staff were all trained?
  - Send sign-in sheets for all staff
  - Will educate all maintenance staff of water temperature requirements & documenting on water temp log
  - In-service will include revised policy
  - What to do if temps are found in excess of 120 degrees
  - Policy will be revised & discussed during training
Abatement Plan for Immediate Jeopardy - Example

- Follow-up Monitoring
  - Who is responsible?
  - How often?
  - For how long?
  - Maintenance director will review the logs then give a report to administrator monthly
Resident-to-Resident Sexual Behaviors
Dementia-Driven Sexual Abuse

- Dementia-driven resident-to-resident sexual abuse is the most common form of sexual abuse in nursing homes
- Verbal, physical or both
- Significant issue
  - Resident
    - May develop aggression, agitation
    - May be asked to move (but surely not in our state)
  - Staff
    - Usually young female
    - Need education to recognize & manage
    - Adds to burden, turnover
Sexuality in Nursing Homes
Fundamental Truths

- We are all sexual beings from birth to death with a fundamental need for touch & sexual self-expression
- Conditions in nursing homes & ALs may hamper the satisfaction of this need
- Sexuality is generally a challenging issue for many healthcare workers because it is a sensitive, emotional, and “taboo” topic shrouded in misinformation & fear
Sexuality in Nursing Homes
Fundamental Truths

• Sexual interest does not decrease in older adults residing in nursing homes but the focus on genital sex does; there are fewer opportunities for sexual activity & an increased need for activities such as hand-holding & kissing
• All residents have a new home where they are entitled to dignity, warmth, caring & YES, even an active & satisfying sexual life
• Sexuality in older adults is rarely discussed in an open & constructive manner
• Nursing staff & family members may require additional education on “sexuality and older adults” in order to create an environment in which healthy sexual self-expression is supported (Examine your own attitudes toward sexuality in older adults & enable open discussion among staff about personal attitudes toward sexuality
Sexuality in Dementia

- Just because an individual’s cognition declines does not necessarily imply that sexual intimacy and desires also decline or disappear.
- Oftentimes, sexual interest declines and sexual apathy ensues, but although rare, a disturbing behavioral outcome of dementia for some individuals is hypersexuality or inappropriate sexual expression.
- This is a significant challenge to caregivers and families and if not properly addressed has the potential to disrupt family and professional relationships because of its antisocial nature.
- Should be assessed as a part of the symptom cluster of behavior disturbances associated with dementia.
Sexuality in Dementia

• Disruption to the neural pathways related to the sex drive
• Sexual manners are learned behaviors that might be forgotten in dementia
• Psychological need for intimacy that has been unfortunately sexualized; Residents with dementia might feel disconnected from others with the loss of speech and the ability to communicate their desires
• Dementia resident may just crave the sensation of touch itself
• Consequently, they act out on a strong need for human connection and touch as a result of “iatrogenic loneliness;” (attitudes and organizational structure that discourage or fail to accommodate any form of intimate expression or relationship within the institutional setting)
Approaches to Inappropriate Sexual Behavior in Residents with Dementia

• Look for triggers & causal factors
  • Motivations for sexual behaviors
    • Forgot clothes
    • Too warm
    • Delirium
  • Medications that can stimulate hyper-sexuality:
    • Benzodiazepines
    • Dopamine agonists
    • Androgen supplements
Management of Inappropriate Sexual Behaviors by Dementia Residents

- **Sequential Approach**
  - Start with non-pharmacological methods
    - Remove precipitating factors
  - Distraction
    - Crafts
    - Consistent redirection
    - Enhanced communication
    - Give them something to touch & hold on to
  - Opportunities to relieve sexual urges
  - May need to consider moving/separating individuals
  - Stop medications that may be contributing
Management of Inappropriate Sexual Behaviors by Dementia Residents

• If disrobe inappropriately
  • Try adaptive clothing that makes disrobing more difficult
• If handles genitals
  • Check for infections or clothing that is binding or causing discomfort
• Getting in bed with another resident
  • Quietly remove resident & return to their own bed
  • Remind resident of boundaries (early stage resident) but do not scold or berate either resident
Management of Inappropriate Sexual Behaviors by Dementia Residents

- Inappropriate touch or advances on another resident
  - Physically separate
  - Gently & firmly indicate the behavior is inappropriate & remind of boundaries
  - Divert resident & redirect them to another activity
  - Keep resident in view & immediately intervene if it appears resident is approaching another resident (1:1…once you know of potential or actual behavior)
- Medication may be considered as a last defense if the behavior is not easily managed
Medications Are The LAST Resort

- Any medication given for inappropriate sexual behavior is Off-label & requires FREQUENT assessment for effects & adverse side effects & Risk/Benefit Statements by ordering physician
Medications Are The Last Resort

- Antidepressants
  - SSRIs (first line)
    - Sertraline
    - Mirtazapine
  - TCAs
  - Trazodone
- Anticonvulsants
  - Gabapentin
  - Carbamazepine (may decrease testosterone)
- Cholinesterase Inhibitors (Conflicting results)
  - Rivastigmine
  - Donepezil
- Antiandrogens
  - After failure of antidepressant
    - Medroxyprogesterone
    - Cyproterone
    - Finasteride
- Hormonal Agents
  - Estrogens
  - Leuprolide
- Miscellaneous
  - Cimetidine
  - Beta Blockers
  - Pindolol
  - Ketoconazole
  - Spironolactone
What NOT To Do

• Ignore the behavior triggers
  • Really…it won’t magically go away

• Get upset
  • Your emotional response to the behavior has a great deal to do with making it better or worse

• Tell the resident it’s “inappropriate”
  • If they knew that…
ALWAYS REMEMBER

- The person is **NOT** THE PROBLEM
- The **PROBLEM** is the need or feeling that the person is trying to communicate with the behavior
Thank You

- Alana Johnston, RN/KDADS NW Regional Manager
  - Alana.Johnston@ks.gov
  - 785 317 2635
- Linda Farrar, RN/BSN/LNHA
  - linda@licamedman.com
  - 785 383 3826