TA BRIEF:

TECHNICAL ASSISTANCE FOR LTCO PRACTICE

The National Long-Term Care Ombudsman Resource Center

LONG-TERM CARE OMBUDSMAN ADVOCACY: RESIDENT-TO-RESIDENT AGGRESSION

Terminology and definitions used to describe resident-to-resident aggression (RRA) vary, but for this brief RRA is defined as "negative and aggressive physical, sexual, or verbal interactions between long-term care residents that (as in a community setting) would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient."[1] Incidents of RRA include physical, verbal, and sexual abuse and are likely to cause emotional and/or physical harm. However, not all incidents of resident-to-resident aggression are considered "abuse," meaning that the resident involved did not willfully harm the other resident. Other examples of RRA include: roommate conflicts, invasion of privacy and personal space, verbal threats and harassment, unwanted sexual behavior, using personal property without permission, and destroying personal property.

The purpose of this brief is to provide an overview of resident-to-resident aggression in order to assist Long-Term Care Ombudsman (LTCO) programs in effectively responding to complaints involving resident-to-resident aggression, as well as help prevent RRA and reduce the prevalence of these incidents.

Learn about Resident-to-Resident Aggression (RRA)

Incidents of resident-to-resident aggression occur in all types of long-term care facilities, including nursing homes and board and care facilities. Although LTCO advocacy approaches may differ depending on the incident, residents involved, type of facility, and size of the facility, the LTCO advocacy strategies and recommendations to prevent and reduce incidents of RRA provided in this resource are applicable to all long-term care communities.

Resident-to-resident aggression is a serious issue that has a significant negative impact on all residents involved, but incidents are often not reported and investigated. Research regarding the prevalence of RRA is limited, yet information from a variety of sources suggests RRA occurs fairly frequently. Despite these limitations a variety of possible risk factors for RRA have been identified.[2] A primary risk factor is cognitive impairment, in fact, one study found that "cognitive impairment, and worsening cognitive impairment in particular, conferred a five-fold risk of mistreatment in victims."[3]

Risk Factors	
Resident Characteristics	**Facility Characteristics (environmental and care)**
Residents with significant cognitive impairments such as dementia and mental illness.	Inadequate number of staff.
Residents with behavioral symptoms related to dementia or other cognitive impairment that may be disruptive to others (e.g., yelling, repetitive behaviors, calling for help, entering other's rooms).	Lack of staff training about individualized care in order to support residents' needs, capabilities, and rights (e.g., resident-centered care, abuse prevention, care for those with limited capacity, dementia, and mental health needs).
Residents with a history of aggressive behavior and/or negative interactions with others.	High number of residents with dementia.
	Lack of meaningful activities and engagement.
	Crowded common areas (e.g., too many residents in one room, equipment/obstacles in common areas).
	Excessive noise.

[1] Jeanne A. Teresi, Mildred Ramirez, Julie Ellis, Stephanie Silver, Gabriel Boratgis, Jian Kong, Joseph P. Eimicke, Karl Pillemer, and Mark S. Lachs, A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial, International Journal of Nursing Studies (2013), 644–656.

[2] Information in charts from: Division of Geriatrics and Palliative Care, Weill Cornell Medical College, Cornell University and Research Division, Hebrew Home at Riverdale. Documentation of Resident to Resident Elder Mistreatment in Residential Care Facilities. Mark Lachs, Jeanne A. Teresi, Mildred Ramirez, Karl Pillemer, Joy Soloman, and Kimberly van Haitsma (March 28, 2014) and Eilon Caspi, Deaths as a Result of Resident-to-Resident Altercations in Dementia in Long-term Care Homes: A Needs for Research, Policy, and Intervention, Editorial, JAMDA (2016).

[3] Tony Rosen, Karl Pillemer, and Mark Lachs, Resident-to-resident aggression in long-term care facilities: An understudied problem, Aggression and Violent Behavior (2008), doi: 10.1016/j.avb.2007.12.001

Understand the Importance of Individualized Care in Preventing and Reducing RRM

A 2014 study of resident-to-resident aggression found that "a person-centered approach to the management and prevention of these incidents is crucial" and "it is through identifying incidents and documenting them, that patterns of resident's behaviors can be identified and individual strategies planned, implemented, and assessed."[4]

As experts in residents' rights and person-centered care, it is critical that LTCO advocate for comprehensive assessment and care planning in order for residents to receive individualized care.

Regardless of the type of long-term care facility, all residents have the right to live in a safe environment that supports each resident's individuality and ensures they are treated with respect and dignity. Since there are no federal regulations for assisted living facilities (also known as board and care or residential care facilities) requirements are different in each state; however, all states require that residents be protected from abuse, neglect and exploitation. LTCO are encouraged to be familiar with applicable state requirements for these facilities.

Federal requirements and surveyor guidance for nursing homes certified as a Medicare and/or Medicaid nursing home provider emphasize the importance of individualized care planning to prevent and reduce incidents of RRA. The Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP, Guidance to Surveyors for Long Term Care Facilities, states that the "facility is responsible for identifying residents who have a history of disruptive or intrusive interactions, or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility should identify the factors (e.g., illness, environment, etc.) that increase the risks associated with individual residents, including those (e.g., disease, environment) that could trigger an altercation. The care planning team reviews the assessment along with the resident and/or his/her representative, in order to identify interventions to try to prevent altercations."[5] The chart below provides recommendations to prevent and reduce incidents of RRA that LTCO can share with all long-term care providers as they are applicable to residents in nursing homes and assisted living facilities.[6]

Recommendations to Prevent and Reduce Incidents of RRA	
Environmental Considerations	**Care Practices**
Clear common areas of clutter, reduce noise and overcrowding.	Develop comprehensive care plans. Provide individualized, resident-centered care and implement best practices for supporting residents with behavioral symptoms related to cognitive impairment.
Provide areas for supervised, unrestricted, safe movement.	LTC facility staff training (including training on person-centered care, dementia and mental illness) and facility policies regarding how to prevent, recognize, respond, report, and document RRA.
Identify environmental influences on behavior and adjust accordingly (e.g., temperature, lighting).	Identify residents with risk factors for RRA, and a history of RRA, and develop care plans to address their needs and monitor closely.
Promote meaningful activities and opportunities for engagement for all residents based on individual needs, interests, and abilities.	Identify root causes of behavioral symptoms and reduce or eliminate those causes (e.g., pain, boredom, loneliness).
	Implement consistent staffing assignments so staff and residents are more comfortable with each other and staff are more familiar with resident needs and changes in behavior.
	Ensure adequate staffing levels in order to meet resident needs and provide supervision.

[4] Lachs, M., Teresi, J., Ramirez, M. 2014. Documentation of Resident to Resident Elder Mistreatment in Residential Care Facilities. Doc. No. 246429. Award No. 2009-IJ-CX-0001.
[5] CMS SOM Appendix PP. F323. http://ltcombudsman.org/uploads/files/library/som107ap_pp_guidelines_ltcf.pdf
[6] Recommendations from RRA research and CMS SOM Appendix PP. F323. Links to additional information, such as "Culture Change" and "Resident-Centered Care" is available in the "Resources" section. http://ltcombudsman.org/uploads/files/library/som107ap_pp_guidelines_ltcf.pdf

Speak with Residents about Their Rights and RRA

LTC Ombudsman programs may provide residents (and Resident Councils) with information regarding their rights, especially their right to be free from harm, including resident-to-resident aggression. Fact sheets regarding residents' rights and individualized care, including a brochure and large font fact sheet about Resident-to-Resident Mistreatment, are available on the **National Consumer Voice for Quality Long-Term Care (Consumer Voice)** website.[7]

Discuss the Responsibilities of Long-Term Care Providers to Provide Individualized Care, Protect All Residents from Mistreatment, and Respond to Incidents of RRA

Share information and resources regarding the responsibilities of long-term care providers in supporting residents' rights, protecting residents from mistreatment, and reporting allegations of abuse.[8]

As stated earlier, there are no federal requirements for assisted living facilities so LTCO are encouraged to become familiar with state regulations and share applicable information regarding provider responsibilities to ensure the safety of all residents and investigate and report incidents.

In regards to Medicare and/or Medicaid certified nursing homes, according to the CMS SOM Appendix PP, Guidance to Surveyors, if a resident "willfully" harmed another resident the incident is to be reviewed as abuse by surveyors and reported as abuse by facility staff. However, if a resident did not intend to harm the other resident (or intent cannot be determined) the incident is to be considered a "resident-to-resident altercation" and would be reviewed by the survey under tag F323 (42 CFR 483.25(h)(1) and (2), F323, Accidents and Supervision).[9] Regardless of intent or whether the incident is considered abuse or a crime, "CMS expects long-term care facilities to take any necessary action to prevent resident-to-resident altercations to every extent possible."[10] In addition to sharing consumer fact sheets regarding RRA with providers, residents, family members, and others (link below in "Resources"), LTCO programs may offer to provide in-service training regarding residents' rights, individualized care, and prevention of RRA and mistreatment.

> ***Regardless of intent, all residents have the right to be protected from mistreatment and facilities are required to ensure the safety of all residents and investigate allegations of abuse and incidents of mistreatment.***

Include Information about RRA in Training for LTCO Staff and Volunteers

Include information about RRA in training for LTCO program representatives (staff and volunteers), especially when discussing the role of LTCO in responding to allegations of mistreatment. Resources regarding resident mistreatment include: the **NORC Curriculum**, examples of LTCOP initial certification training manuals, and NORC training materials and webinars (link below in "Resources").

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[7] 42 CFR 483.10 Resident Rights http://www.ecfr.gov/cgi-bin/textidx?c=ecfr&SID=e5d3af40a300a1dbbea73a7392115694&rgn=div8&view=text&node=42:5.0.1.1.2.2.7.3&idno=4

[8] Find links to the federal nursing home requirements in the NORC Library http://www.ltcombudsman.org/NORC-library.

[9] "*Willful* means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act." CMS SOM Appendix PP. F323. http://ltcombudsman.org/uploads/files/library/som107ap_pp_guidelines_ltcf.pdf

[10] CMS Survey & Certification Letter titled "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility" http://www.cms.gov/Medicare/ProviderEnrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf

LTCO Advocacy Strategies

LTCO responses to complaints involving resident-to-resident aggression may include, but are not limited to, the following:[11]

- Request consent to pursue a complaint from the resident(s) or representative(s) of the resident(s).
- Determine appropriateness of what, if any, resident-identifying information can be disclosed, based on resident (or resident representative) consent;
- Ensure the facility has addressed the immediate safety needs of all impacted residents (to the extent possible in consideration of disclosure limitations).
- Communicate with your supervisor (e.g., a volunteer consults with their staff LTCO) and follow applicable state LTCO program policies and procedures regarding consultation, communication, and complaint investigation. For example, in a situation involving two residents consult with your supervisor to determine if you advocate for both residents or if you need to seek the assistance of another LTCO in order for each resident involved to have a separate advocate.
- Support the resident(s), as much as the resident(s) want you involved, during the complaint investigation process.
- Seek resident(s) direction for resolution and provide information about available services (e.g., facility social worker, counseling, behavioral health).
- Advocate for documentation of the incident, as well as thorough assessment and care planning, for each impacted resident after the incident. Planning should include measures to maintain resident safety, meet their needs after the incident (e.g. counseling), and prevent future incidents (e.g., modification of the environment, separation of residents, proper staff supervision).
- Discuss potential risk factors of RRA that may have been involved in the specific situation and how to address those factors (e.g., environmental considerations, behavioral symptoms).
- Remind the facility of their requirement to document, investigate, and report the incident per federal and/or state requirements, as applicable.
- Share information with the facility administrator and staff about responding to, and preventing future, incidents of RRA (such as the "Recommendations to Prevent and Reduce Incidents of RRA" chart from this brief).

[11] See *Responding to Allegations of Abuse: Role and Responsibilities of Long-Term Care Ombudsmen* for additional advocacy strategies. http://ltcombudsman.org/uploads/files/issues/responding-to-allegations-of-abuse_0.pdf

RESOURCES

National Long-Term Care Ombudsman Resource Center (NORC)

- **Elder Abuse/Elder Justice Issue page** (includes resident-to-resident mistreatment fact sheet) http://www.ltcombudsman.org/issues/elder-abuse-elderjustice
- **Culture Change Issue page** (information regarding individualized care and LTCO advocacy) http://ltcombudsman.org/issues/culture-change
- **Ombudsman Training** (NORC Curriculum, Training Programs and In-Services, LTCOP Certification Manuals, NORC Training and Webinars) http://www.ltcombudsman.org/ombudsman-support/training

National Consumer Voice for Quality Long-Term Care (Consumer Voice)

- Information for LTC consumers, including fact sheets regarding individualized care (individuals living in nursing homes, assisted living, or receiving home and community-based services care) http://theconsumervoice.org/issues/recipients
- Resources for family members http://theconsumervoice.org/issues/family
- Resources for advocates (resident-directed care information and fact sheets) http://theconsumervoice.org/issues/for-advocates

National Center on Elder Abuse (NCEA)

- For additional information regarding elder abuse, neglect or exploitation visit the NCEA website at www.ncea.aoa.gov or call 1-855-500-3537.
- Locate a local or state elder abuse coalition or learn how to create or participate in an effective elder abuse taskforce: http://www.ncea.aoa.gov/Stop_Abuse/Teams/Local/index.aspx

CONTACT US

If you have questions about this brief or would like to share some of your LTCOP's activities or challenges regarding resident-to-resident aggression, please email ombudcenter@theconsumervoice.org or call 202-332-2275.

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