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Factors contributing to abuse in care homes and nursing homes: Resident-to-Resident harm

Review for the Department of Health

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- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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Introduction

There have been a number of recent and concerning instances of abuse and neglect taking place in care homes in Northern Ireland, for example, at Muckamore Abbey Hospital and Dunmurry Manor care home. In response to these incidents the Department of Health has taken a number of steps, including the commissioning of an independent review, to understand and learn from these incidents.

In order to support the learning from the independent review and provide additional context, the Department has also commissioned SCIE to conduct a rapid review of evidence to understand the contributing factors, which allow abuse, neglect or exploitation of residents to occur in residential settings. The findings from this review have been presented in a separate report.

This present report aims to explore resident-to-resident harm in care homes, also referred to as resident-to-resident abuse. However, there is an important distinction to be made between harm and abuse as abuse occurs within relationships where there is the expectation of trust. That expectation cannot be applied to the relationship between residents. Having highlighted this key distinction, this report reflects the literature and so refers to resident-to-resident abuse (RRA) throughout.

More specifically, this report aims to identify current research, policy and practice about resident-to-resident abuse in care homes. The report explores:

- Definitions and types of resident-to-resident abuse
- Prevalence of resident-to-resident abuse
- Risk factors for resident-to-resident abuse
- Prevention of and interventions for resident-to-resident abuse
- Research gaps
- Potential case studies

1.1 Search strategy

A combination of the search terms presented in the table below were used to search the following databases: Social Care Online, Google Scholar, Google and Epistemonikos (systematic reviews database). Snowballing was used to identify additional references from key studies. This identified 67 papers to review, a large number of which are mentioned in the body or this report.

Population	**Setting**	**Phenomena of interest**
residents resident at risk “other residents”	nursing home residential care care home	abuse neglect violence

co-resident resident-to-resident resident perpetrators client on client resident-to-resident aggression (RRA) resident-to-resident violence (RRV) resident-to-resident elder mistreatment (R-REM) assault OR physical abuse between residents	assisted living	harassment physical abuse emotional abuse sexual abuse financial abuse psychological abuse adult abuse elder abuse elder bullying senior bullying

1.2 Overview of the included literature

Most of the literature reviewed about resident-to-resident abuse comes from the USA (n=41) followed by UK (n=9), Australia (n=8), Canada (n=6), Netherlands (n=1) and Norway (n=1). There has hardly been any research about the issue in the UK, with most of the UK literature, policy or practice documents or news sources identified providing only sources of potential practice examples.

Most of the research is about the prevalence of resident-to-resident abuse or indicators or risk factors for abuse. There have been a few studies about interventions that might help staff to address the issue in care homes, these are:

- **SEARCH Approach** - identification and management of resident-to-resident elder mistreatment (R-REM) in nursing homes (Ellis et al 2014 and 2019)
- **Guardians in residential care** (Cox, 2008)
- **Resident-to-resident elder mistreatment training intervention** (Teresi et al. 2013 and 2020)
- **Staff strategies** (Rosen et al 2008 & 2015; Snellgrove et al. 2015)

There has also been some research about tools or instruments to measure resident-to-resident abuse in residential care. (Ramirez et al. 2013; Teresi et al. 2014; Berry et al. 2017)

Some of the research addresses what good care might look like in care homes, when it comes to safeguarding residents from the abuse from other residents. The dominant theme identified in the literature was providing person centred care.

There is some existing UK guidance or good practice about how to handle resident-to-resident abuse in nursing homes. This includes the new draft NICE guideline on safeguarding adults in care homes (NICE, 2020); SCIE guide on common safeguarding challenges in care homes (SCIE 2012) and a template policy from Croner about 'Safeguarding service users in care homes from the harmful actions and behaviour of other service users' (Croner, 2020).

2. Definitions and types of resident-to-resident abuse

2.1 Terminology and definitions

The most common term used in the literature for resident-to-resident abuse is resident-to-resident aggression (RRA). This 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*." (Teresi et al. 2013; Rosen et al. 2008; McDonald et al 2015)

Other common terms used in the literature reviewed include: resident-to-resident violence (RRV); resident-to-resident elder mistreatment (R-REM) or resident-to-resident abuse.

Relational aggression is defined as a manipulative, non-physical form of aggression using rumour or gossip. (Benson and Beckmeyer, 2013)

2.2 Types of abuse

The most common types of resident-to-resident abuse identified by Rosen (2008) and Lachs (2016) are:

- verbal abuse 100% - with screaming or yelling being the most common
- physical abuse 94%
- sexual abuse - inappropriate touching 38%

Similarly, Myhre et al (2020), in their study of nursing homes in Norway found the main types of co-resident abuse were:

- hitting, kicking, pushing and throwing things
- verbal abuse
- violation of resident's privacy
- stealing or destroying a resident's assets
- sexual assault

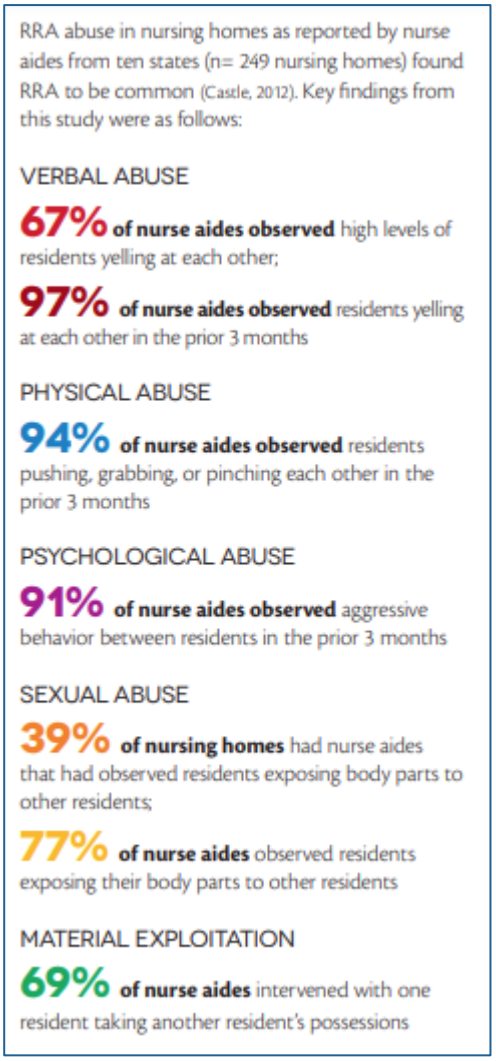
Resident-to-resident aggression (RRA) was described as the biggest issue related to abuse in this study and a daily challenge for the participants These findings are illustrated in more depth in the table below:

From: Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect

	Co- residents "A normal part of nursing home life"	*Relatives "A private affair"*	Direct Care staff *"An unthinkable event"*
Physical abuse			
Hitting, kicking, pushing, and throwing things	X		X
Rough handling		X	X
Use of force or restrain		X	X
Psychological abuse			
Verbal abuse	X	X	X
Violation of resident's privacy	X		X
Financial abuse			
Stealing or destroying a resident's assets	X	X	X
Sexual abuse			
Sexual assault	X		X
Neglect			
Neglect of user participation		X	X
Health care neglect			X

(Source: Myhre et al. 2020)

A large study conducted in the USA in 249 nursing homes) found similar levels of the different types of abuse, as illustrated in the diagram below (Castle, 2012):



Finally, a few other studies conducted in the USA also found similar findings. For example, Magruder et al. (2019) report that in their study that verbal/psychological abuse was the most reported type of abuse and sexual abuse was the least reported. Moreover, assisted living

residents had disproportionately high rates of financial exploitation. A study by Pillemer et al. (2012) identified 5 major forms of resident-to-resident abuse that occur in nursing homes:

- invasion of privacy or personal integrity;
- roommate issues;
- intentional verbal aggression;
- unprovoked actions; and
- inappropriate sexual behaviour.

Rosen et al. (2016) demonstrated that participant nurses rarely documented abusive behaviour or informed supervisors or colleagues from other sectors. The results also demonstrated that the professionals did not act in almost 25% of the cases of RRA, suggesting that many workers consider this type of aggression normal and inevitable and do not take actions in these cases. This was also the view of Myhre et al. (2020) that found that some care managers stated that the risk of harm caused by resident-to-resident aggression was something residents must accept when living in a nursing home: *'There is a predictable risk, when living in nursing homes, [of] such incidents; there is a foreseeable risk that this will happen'.* This demonstrates that resident-to-resident abuse is normalised.

2.2.1 Sexual abuse and sexual assault

A systematic review of sexual assaults in nursing homes (Smith et al, 2018) found that in one study using 15 focus groups, sexual assault was discussed by 18% of the participants in 38% of focus groups. Inappropriate touching as a component of sexual assault was discussed more than any of the physical assault components, with the exception of punching and fighting (38% and 44%, respectively) (Castle, 2012b).

A Care Quality Commission (CQC) report (2020) about sexual safety found that sexual incidents happen in all types of adult social services. Types of sexual incidents reported to the CQC (March to May 2018) were:

- 48% sexual assault
- 11% exposure and nudity
- 8% sexual harassment
- 5% allegations of rape
- 8% 'Undefined or other', included grooming and giving intimate care without appropriate respect and dignity

A concerning picture from some of the most harmful sexual incidents reviewed as part of the CQC report show some services have allowed harmful behaviours to be accepted and unchallenged. People who use services are not protected from harm where a lack of respect or knowledge becomes a normalised part of working practice. The report found that sex is often treated as a taboo subject, with providers, staff and families sometimes reluctant to raise issues. This means predatory behaviour can be missed or normalised. The report concludes that a lack of awareness of good practice in sexual safety and sexuality can place

people at risk of harm. It recommends that cultures are developed where people and staff feel empowered to talk about sexuality and raise concerns.

Other reports have also raised concerns and issues about residents who show a sexual interest in others. Myhre et al. (2020) report that care managers viewed this sexual interest as an ethical dilemma for them. On the one hand, they want residents to have a healthy sex life in the nursing home, but on the other hand, this is difficult when a resident has dementia and may not be competent to give consent. Several care managers reported that what seemed to be voluntary sexual interest between residents could not be that, after all.

2.2.2 Bullying

Research associated with resident-to-resident bullying in senior living facilities (i.e., senior bullying), has been growing in recent years due to anecdotal stories in the popular press. In a small study (n=19) set in a senior living facility in the USA, 52.9% of residents had observed senior bullying at least once. Verbal and social bullying were equally observed by participants, with the majority of bullying being observed in common areas. Perpetrators and victims were reported to be mostly female. However, only 10.5% of the sample felt that bullying was a problem at their facility (Ira, 2018)

Another study conducted in the USA in one facility (n=98) also found that 25% of residents had seen or heard another resident being bullied at some point. Social bullying was reported at the main form of bullying. (Jeffries et al 2018)

Finally, care managers (Myhre et al. 2020) have described psychological abuse as acts of ‘everyday bullying’ and threats made among residents. They interpreted these situations as a normal consequence of the dementia disease in the individual resident. One care manager noted, ‘*What I think is the challenge is the everyday bullying. It is seen as normal behaviour for that group of residents’*.

3. Prevalence of resident-to-resident abuse

Research regarding the prevalence of resident-to-resident abuse is limited, yet information from a variety of sources suggests it occurs fairly frequently. Some studies (Castle, 2012; McDonald, Sheppard et al., 2015; McDonald, Sheppard et al., 2015; Rosen, Pillemer, & Lachs, 2008) have shown that the prevalence of this abuse is higher than that of staff-to-resident abuse and represents a third of the complaints filed in nursing homes (McDonald et al., 2015). Another study found that resident-to-resident aggression made up 22.22% of all types of abuse in nursing homes (Touza, 2019)

Similarly, Lachs et al (2016) revealed that 407 of 2011 residents from ten facilities had experienced at least one resident-to-resident event over one month observation, showing a prevalence of 20.2%, and the most common form was verbal abuse. Trompetter et al. 2011, in the Netherlands, examined resident-to-resident relational aggression and subjective well-being in assisted living facilities and found that 19% of residents reported prevalence, compared to 41% of nurses reporting prevalence. Finally, Gimm et al. (2018), in a large nationwide USA study, found 7.6% of assisted living residents engaged in physical aggression or abuse toward other residents or staff in the past month, 9.5% of residents had exhibited verbal aggression or abuse, and 2.0% of resident engaged in sexual aggression or abuse toward other residents or staff.

On the other hand, a recent Australian study (Joyce, 2019) found that resident-to-resident abuse in aged care facilities lower than in other reports, with only 7.6% of residents reported as targets, and 6.9% exhibited aggression.

Some studies (McDonald et al., 2015; Ellis et al., 2014; Tromopetter et al, 2011). also report on the impact and consequences of resident-to-resident abuse. They report that it has been associated with:

- a reduction in life satisfaction and increased risk of depression, anxiety, and loneliness
- low self-esteem and overall negative mood
- injuries such as falls, fractures, lacerations and cuts
- a higher likelihood of experiencing neglect by caregivers and non-receipt of care after suffering sexual abuse.

Finally, one study examined 1296 deaths due to external causes in nursing homes in Victoria, Australia (deaths reported to the Coroners Court). The study found that 7 (0.5%) of these deaths were due to episodes of RRA (Ibrahim et al 2015) The actual proportion of deaths due to episodes of RRA is likely higher given the fact that a substantial number of these fatal episodes are not reported to coroners.

4. Risk factors for resident-to-resident abuse

An overview of the risk factors for resident-to-resident abuse are highlighted in the diagrams below that were identfied in the literature reviewed. Some of these are discussed in more detail in the following sections.

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.

Source: Long-Term Care Ombudsman advocacy: resident-to-resident aggression

Risk Factors

- Crowded environment
- High number of residents with dementia
- Cognitive impairment of both victim and perpetrator
- Behavioral disturbances that occur with residents with dementia
- Comingling of individuals with psychiatric illness or a previous psychiatric history who may bring with them to the nursing home associated psychiatric behaviors

(Cohen-Mansfield & Libin, 2005; Lachs, Williams, O'Brien, Hurst, & Horwitz, 1996; Nijiman & Rector, 1999; Lachs et al., 1996; as cited in Ellis et al., 2014)

4.1 Characteristics and vulnerabilities of resident perpetrators and victims

A number of studies report that in the majority of incidents, the resident perpetrator had a cognitive impairment (89.9% in Joyce, 2019; 90% Murphy et al., 2017; Rosen et al., 2008). In fact, one study found that "*cognitive impairment, and worsening cognitive impairment in particular, conferred a five-fold risk of mistreatment in victims."* Similarly, the main cause of resident-to-resident aggression reported by care managers in a study in nursing homes in Norway was symptoms of dementia, especially in the initiator, but also in the victim (Myhre et

al., 2020). Another study found that perpetrators of resident-to-resident sexual assault often suffered from dementia, cognitive impairment, and disinhibition (Rosen et al., 2008).

Ferrah et al (2015) conducted a systematic review to identify contributing factors and outcomes of RRA in nursing homes. They found that RRA commonly occurred between exhibitors with higher levels of cognitive awareness and physical functionality and a history of aggressive behaviours, and female targets who were cognitively impaired with a history of behavioural issues including wandering.

A large study in the USA, using data from 2000 (Shinoda-Tagawa et al 2004), found that in resident-to-resident violent incidents, the injured residents were more likely to be cognitively impaired, exhibit symptoms of wandering, be verbally abusive, and have socially inappropriate behaviour than the controls. Residents who were classified as needing extensive assistance and being severely dependent had a significant reduction in being injured. Residents in an Alzheimer's disease unit were almost three times as likely to be injured than those living in other units. Injured residents were more likely, perhaps unknowingly, to "put themselves in harm's way," be verbally aggressive, and be cognitively impaired. The study findings suggest that interventions to prevent these incidents should focus on the behaviour of the injured persons.

Another study (Murphy et al., 2017) explored the frequency and nature of deaths from resident-to-resident aggression (RRA) in nursing homes in Australia. This research identified 28 deaths from RRA over a 14-year study period. Most exhibitors of aggression were male (85.7%), and risk of death from RRA was twice as high for male as for female nursing home residents. Almost 90% of residents involved in RRA had a diagnosis of dementia, and three-quarters had a history of behavioural problems, including wandering and aggression. RRA incidents commonly occurred in communal areas and during the afternoon and involved a "push and fall." Seven (25%) RRA deaths had a coronial inquest; criminal charges were rarely filed.

Finally, in a USA study (Sifford-Snellgrove et al., 2012), that explored nursing assistants perceptions of the characteristics of both the victims and initiators of resident-to-resident violence (RRV) found that:

- initiators of RRV are perceived to be "more with it" and to have "strong personalities," a "short fuse," and "life history" that make them prone to inflict harm on other residents.
- victims of RRV were described using phrases such as, "they don't know," "can't communicate," and "gets around good."

4.2 Situational characteristics of resident-to-resident abuse

Two studies reported that RRA was most frequent in dining and residents' rooms, and in the afternoon, although it occurred regularly throughout the facility at all times (Rosen, 2008; Ferrah et al., 2015).

Caspi's small study (2016) about episodes of fatalities from RRA found that most of the reviewed episodes were not witnessed by staff (70%; 19 of 27) and took place inside bedrooms (68%). The findings add to a previous pilot study using video cameras 24/7 in the public spaces of a dementia care home showing that nearly 40% of episodes of physical RRA were not witnessed by staff. More than one-third of the episodes (37%) were between roommates, which may indicate serious problems in roommates' assignment and/or ongoing monitoring (Caspi 2016). Most episodes (for which there was a report on the time of the episode) took place during the evening/late evening hours (81%; 13 of 16 episodes; 2 other

episodes took place during the night), whereas close to two-thirds of the episodes (62%; 18 of 29) took place on weekends (Caspi, 2016).

Another study by Caspi (2015) that studied aggressive behaviour between residents with dementia in long-term care residences in the USA found that the majority of incidents were situational-reactive (circumstance-driven) and therefore potentially modifiable, for example problematic seating arrangement.

4.3 Triggers and other risk factors for abuse

Snellgrove (2013) suggests two types of triggers for resident-to-resident abuse:

1. Active triggers: involved the actions of other residents that were intrusive in nature, such as wandering into a residents' personal space, taking a resident's belongings, and so forth.

2. Passive triggers: did not involve the actions of residents but related to the internal and external environment of the residents. Examples were factors such as boredom, competition for attention and communication difficulties.

Rosen (2008) also lists a number of triggers or other risk factors for abuse:

- Calling out or making noise
- Territoriality or challenges with communal living
- Roommate inability to compromise preferences
- Impatience
- Loneliness, abandonment, or frustration with institutionalization
- Jealousy

Another study (Jain et al 2018) found that the potential causes of RRA included:

- maladaptation to nursing home life,
- transfer of pre-existing issues into the nursing home environment,
- physical environment and;
- staffing-related issues.

Resident-to-resident aggression was commonly viewed by participants as dangerous and unpredictable or, conversely, as expected behaviour in a nursing home setting.

The diagram below from the Long-Term Care Ombudsman, research briefing, presents five main types of triggers.

1. *Hostile interpersonal interactions* (angry attempts at social control, arguments, disproportionate response to normal interaction, sarcasm or jeering, accusations)
2. *Invasion of privacy or personal integrity* (incursion on personal space, invasion of room privacy, clearing a way through congestion, inappropriate caregiving)
3. *Roommate problems* (roommate disagreements, belligerent roommate)
4. *Unprovoked actions* (verbal or physical assault without cause or warning)
5. *Inappropriate sexual behavior* (unwanted sexual advances and intentional nudity or exposure in the presence of other residents)

[1]Other terms used to refer to this type of elder mistreatment are resident-to-resident abuse, resident-to-resident elder mistreatment, and resident-to-resident relational aggression, but this brief will use the term resident-to-resident aggression (RRA).

[2]Listed in order of frequency (from highest to lowest) reported in Pillemer et al., 2011.

5 THEMES OF RRA EVENTS

5. Prevention of and interventions for resident-to-resident abuse

5.1 A multi-factorial and multi-disciplinary approach to prevention

Touza (2019) reviewed the evidence about interventions used to prevent elder abuse in long-term care facilities and found that measures to prevent RRA, to a large extent, are the same as those used to prevent cases of staff-to-resident abuse, including professional training, development of person-cantered care practices, and the use of a multidisciplinary approach. The analysis of the reviewed articles in Touza (2019) demonstrates the need for a comprehensive approach, which considers the interactions between individual and contextual factors, and creation of relevant social policies in developing effective preventive strategies that target institutional neglect (Schiamberg et al., 2011).

This was also echoed by Bonifas et al. (2015) in their USA study that identified 3 assessment and intervention strategies social workers use to address RRA:

(1) assessment approaches include gathering information, applying knowledge of causal factors, and determining psychosocial impact;

(2) intervention approaches comprise determining appropriate interventions, applying preventive approaches, and delivering psychosocial interventions; and

(3) collaborative strategies include mutual assessment consultations, joint intervention planning, tandem intervention delivery, and maximising professional strengths.

The findings illustrate social workers' extensive involvement in responding to RRA incidents and the importance of social worker-nurse collaboration, especially with direct care workers.

Finally, the Long-Term Care Ombudsman, in their research review (2018) also identified the changes needed to both care practices and environmental conditions to help prevent incidents of RRA:

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.

(Long Term Care Ombudsman, research review, 2018)

5.2 Staff education and training interventions

The literature has stressed that nursing staff should play a vital role in identifying and managing aggressive interactions between older people. This will help avoid serious consequences for residents living in aged care facilities (Ellis et al., 2014). However, many nursing staff may not recognise these behaviours as forms of abuse, and instead think of them as normal behaviours which cannot be changed. This indicates the need to develop educational programs to assist staff engaged in the management of resident-to resident abuse in aged care facilities.

A key educational program to inform nursing and care staff of the management of resident-to-resident elder mistreatment (R-REM) in nursing homes that was identified in the literature is the **SEARCH** programme (Support, Evaluate, Act, Report, Care plan, and Help to avoid).

The goal of the SEARCH approach is to support staff in the identification and recognition of R-REM as well as to suggest recommendations for management. Ellis et al (2019) are currently conducting a randomised control trial of the approach in aged care facilities in Australia. (Ellis et al 2019)

The key parts of the framework include:

1. Support: support all residents involved in the incident.

2. Evaluate: evaluate the situation and the environment to identify those who were directly or indirectly involved in the incident as well as risk factors or precipitating events.

3. Act: act immediately. The actions taken will depend on the type of incident and the environment where the incident occurred

4. Report: report and document all incidents of R-REM according to the nursing home protocol. Many incidents of R-REM are not reported.

5. Care plan: care plans should be used to document interventions or strategies to attempt to manage incidents of R-REM, avoid or minimize incidents of R-REM, and ensure the safety of all residents.

6. Help to avoid: helping to avoid incidents of R-REM is the role of all staff who need to be actively involved in the discussion and development of management strategies and care plans

The table below outlines this approach in more detail.

THE SEARCH APPROACH TO R-REM MANAGEMENT

Support	• Support injured residents until help arrives. • Listen to perspectives of all involved residents. • Validate resident fears and frustrations.
Evaluate	• Evaluate what actions are needed. • Monitor resident behavior. • Evaluate and support all residents who were involved in or witnessed an event because violence can be upsetting for others also.
Act	• Seek medical treatment when indicated. • Verbally try to stop the incident. Support the initiator's feelings instead of criticizing this person because criticism will intensify the incident. • Call for other staff or security to help move or separate residents who do not get along. • If personal items are missing, assure the resident that a room-by-room search will be conducted to locate the items. • Ensure that this search is conducted promptly. • Evaluate and support residents who were involved in or witnessed the event because violence can be upsetting for all. • Follow up with residents after upsetting incidents to make sure that they are okay. • Acknowledge resident grievances and concerns.
Report	• Initiate investigation of serious incidents when warranted. • Notify the nursing supervisor and administrator. • Contact families if appropriate. • Document the event in the resident care plan. • Initiate the facility protocol and procedures for reporting R-REM.
Care plan	• Formulate a plan for both the initiator and the victim. • Talk with the care team about the best way to intervene and avoid R-REM. • Document threatening behaviors. • Recognize and document residents' preferences for privacy and routines. • In severe cases, seek medical or psychiatric evaluation. • Monitor residents to potentially avoid future incidents.
Help to avoid	• Have adequate staff in congregate settings. • Avoid crowding people and their equipment into small spaces. • Reinforce resident safety as a nursing home priority. • Educate residents about dementia-specific behaviors, such as rummaging. • Remind residents that people with dementia are often unaware that their behavior may be disturbing to others. • Take inventories of personal belongings. • Recognize risk factors for R-REM (e.g., wandering, memory disorders, noisy or threatening behaviors). • Separate residents who are known to have negative interactions with one another.

Note. R-REM = resident-to-resident elder mistreatment.

Source: Ellis et al, 2014, p117

Another resident-to-resident elder mistreatment training intervention is reported by Teresi et al (2013) which works with direct care staff to enhance knowledge of R-REM and increase reporting and resident safety by reducing falls and associated injuries. It consists of three modules. Teresi et al (2020) are conducting a large randomized controlled trial to evaluate this intervention (underway). Results from the testing so far showed significant increases in staff knowledge post training. Additionally, falls, accidents, and injuries were reduced. (Teresi et al 2013 & 2020)

As discussed above, a number of educational interventions have been proposed to prevent RRA. However, very few studies have evaluated the effectiveness of these interventions, and larger reviews on this topic are necessary (McDonald et al., 2015).

5.3 Staff prevention strategies and practices

Caspi (2015) identified twelve effective staff prevention strategies for dealing with aggressive behaviour between residents with dementia. These include:

1) Being alert.
2) Being proactive (vs. being reactive).
3) Being informed about previous incidents in which a certain resident was involved in an aggressive behaviour or about a history of confrontations between two residents.
4) Redirecting a resident from an area where the aggressive behaviour took place.
5) Offering the person to take a walk.
6) Separating.
7) Positioning, repositioning, or changing seating arrangement.
8) Refocusing or switching the topic or subject.
9) Distracting the person to a more pleasurable activity, diverting to a different activity or changing activity.
10) Staying calm.
11) Never arguing with a resident involved in the aggressive behavior.
12) Seeking help from other staff members.

Rosen (2015) also identified some common staff responses to resident-to-resident elder mistreatment (R-REM) in nursing homes in the USA. These include:

- physically intervening/separating residents
- talking calmly to settle residents down
- no intervention
- verbally intervening to defuse the situation.

Less common staff responses were notifying a nurse or documenting in behaviour log.

5.4 Person centred care

A person-centred care approach was considered most effective for managing and responding to RRA (Jain et al., 2018.) A movement towards person-centred care that promotes understanding of individual care needs is favoured as an approach to reducing RRA. Increased reporting of both minor and major incidents of RRA will help to identify patterns and inform appropriate responses. However, a cultural shift is first required to recognise RRA as a manageable and preventable health care and adult safeguarding issue.

A USA study (Pillemer et al. 2012) that sought to identify the major forms of RRA that occur in nursing homes found that there is diversity in the types of RRA, which suggests the importance of considering personal, environmental, and triggering factors, and the potential

for emotional and physical harm to residents. The findings from (Pillemer, 2012) suggest the need for person-centred and environmental interventions to reduce RRA.

Moreover, Snellgrove et al (2015), in their study that explored strategies developed by nurses' assistants in the USA to prevent and manage resident-to-resident violence in nursing homes identified one overriding theme, "Putting Residents First" which the staff described as a conscious effort to put themselves or a beloved family member in the place of the resident while administering care. Within this theme, there were three related subthemes:

- Knowing the residents
- Keeping residents safe
- Spending quality time.

5.5 Other approaches and interventions

Grigorovich et al. (2019), in their Canadian study that explores the ethics of resident-to-resident aggression suggests that a more ethical approach requires attention to the structural conditions of long-term care that both foster aggression and constrain prevention efforts. Grigorovich advocates using a model of relational citizenship that offers a theory of embodied selfhood and relationality as essential to human dignity, thus entailing human rights protections. The application of an ethic based on this model offers a more holistic prevention strategy for resident-to-resident aggression by drawing attention to the critical need and obligation to promote human flourishing through system level efforts.

Cox (2008) proposes that a reformulated and strengthened role for guardians that would help to combat elder abuse be introduced in the UK. Cox (2008) argues that it has been shown within the residential care context that guardians would bring in a quality control dimension that is both 'outside the system' and fully 'on the side' of the individual resident. No one is presently able to speak up for these persons in this way. (Cox, 2008)

There is also some evidence in the literature about the potential benefits of using assessment tools to help prevent abuse. For example, the Aggressive Behaviour Risk Assessment Tool (ABRAT) may help identify potentially aggressive residents in long-term care homes. (Berry, et al. 2017). Additionally, the Resident-to-Resident Elder Mistreatment (R-REM) measure is another potential tool that could be used. (Ramirez et al 2013; Teresi et al 2014)

5.6 Recommendations from professional guidance and good practice guides

There are a number of published guides that offer advice relating to preventing resident-to-resident abuse.

For example, SCIE's Commissioning Care Homes: common safeguarding challenges guide includes a section about physical abuse between residents, and presents a prevention checklist:

- All residents are assessed in terms of their risk of being abused or of abusing others.
- Physical screening takes place to rule out infections which could alter behaviour.

- Staff are trained to identify the causes of challenging behaviour and understand that it may be used as a method of communication.
- Where risks are identified, plans are in place to support individuals and to prevent and reduce the risk of abuse.
- Care home staff are trained and competent in the management of challenging behaviour and supported by community health care professionals.
- Medication is reviewed regularly, whenever behaviour changes and at least every six months.
- Investigations are carried out to assess for medical or other reasons which may be causing behaviour that is difficult to manage.
- Where there are ongoing issues between individuals, the care home takes a multi-agency approach to long-term resolution.
- All incidents of abuse between residents are recorded and reported under local safeguarding procedures. Close family or friends should be informed unless there is a legitimate reason for not doing so.

Another guide is one published by Croner (2020) on safeguarding service users in care homes from the harmful actions and behaviour of other service users. This guide includes information on:

- Principles
- General Approach
- Prevention
- Procedures for When Abuse Has Occurred or is Alleged to Have Occurred
- Training

Finally, whilst the NICE guide on safeguarding adults in care homes covers all types of abuse in care homes, not just resident-to-resident abuse, it does provide some relevant guidance and suggests what ‘good should look like’ in relation to providing training and support to the alleged abuser during and an enquiry or investigation. i.e.

- 1.8.21 Be aware that when the alleged abuser is another resident, they may also need support. Manage the risks between residents while any enquiry takes place.

There are also a few authors and public bodies that highlight good practice in preventing resident-to-resident abuse. For example, Hirst (2015) suggests that aged care facilities need to:

- Educate staff on resident-to-resident abuse to facilitate recognition of it when it occurs.
- Provide guidelines for staff to follow when resident-to-resident abuse occurs.
- Ensure accurate and complete documentation to facilitate reporting, managing, and preventing resident-to-resident abuse.

- Use a person-centred approach versus a provider focus, tailored to meet the needs of the unique individual resident.
- Assess for triggers that may contribute to abuse by one resident to another (e.g., pain, hunger, delirium).

Additionally, the CQC (2020) recommend the following relevant good practice in relation to sexual incidents:

- Staff should feel confident to speak up if they have concerns about harmful behaviour of people who use services or other staff.
- Providers should work with relevant community groups to give staff and people who use services support and access to information on sexual safety and sexuality.
- Guidance should include: how to recognise the changes in physical appearance, feelings and behaviours that indicate sexual abuse and harassment of people who use services and how to raise issues, while remaining vigilant with those who are unable to articulate their concerns.

6. Research gaps

Many authors have argued that resident-to-resident elder mistreatment (R-REM) has become a global issue of concern; however, it is still an understudied research area and the occurrence of R-REM in aged care facilities has not received adequate attention; even though R-REM is a potentially serious issue for older people living in aged care facilities (Ferrah et al., 2015; Lachs et al., 2016; Lindner et al., 2007; Murphy et al., 2017; Ellis et al 2019).

Similarly, resident-to-resident aggression (RRA) is a serious issue that has a significant negative impact on all residents involved, but incidents are often not reported and investigated. (Long Term Care Ombudsman). Ferrah et al. (2015) conducted a systematic review to identify contributing factors and outcomes of RRA in nursing homes and found that limited information exists on organisational factors contributing to RRA and the outcomes for targets of aggression. Moreover, very little evidence-based literature currently exists on intervening to reduce or eliminate RRA (Rosen et al 2008). Specifically, there is a paucity of studies concerning educational programs in nursing aimed at managing and reducing resident to resident elder mistreatment in aged care facilities. However, the work by Ellis developing the SEARCH approach is promising (Ellis et al 2019).

Finally, McDonald et al. (2015) identified the top five research priorities as:

(a) developing/assessing RRA environmental interventions;

(b) identification of the environmental factors triggering RRA;

(c) incidence/prevalence of RRA;

(d) developing/assessing staff RRA education interventions; and

(e) identification of RRA perpetrator and victim characteristics

7. Potential case studies

Included below are a list of potential case studies for further review and consideration

- **Allan Wallace**, 86, died three weeks after an altercation with a fellow resident at Mapleford Nursing Home in Huncoat. **Source**: LancsLive. (2016). Dementia sufferer died after suffering injuries in care home row. Available at: **https://www.lancs.live/news/local-news/dementia-sufferer-died-after-suffering-11544905**
- **May Miller**, 95, was assaulted by a fellow resident just four days after moving into Beech House care home in Halesworth. Source: Nixon Matthew. (17 Feb 2020). Woman, 95, dies after care home assault. Eastern Daily Press. Available at: **https://www.edp24.co.uk/news/crime/95-year-old-woman-dies-after-tragic-care-home-assault-1-6517963**
- An incident occurred between two residents (one male and one female) in a care home; As a consequence of this the female resident (FR) fell and hit her head. Despite emergency treatment, she subsequently died from a subdural bleed which occurred as a direct result of falling and hitting her head. (Consequence UK, 2016)
- The SEARCH intervention programme described earlier also includes some case studies:
  - Mary: verbal altercations between two women, one with dementia;
  - Bill: masturbating in front of another resident;
  - Alice and Betty: hitting and screaming in the TV room.

Finally, a useful source for keeping up-to-date or for case studies is a USA blog dedicated to prevention of episodes of RRA in dementia was launched in April 2012 and consists of news and free resources on this form of behaviour. It is called **Prevention of Harmful Interactions Between Residents in Dementia blog** and can be accessed here**:**

https://eiloncaspiabbr.tumblr.com/

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