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

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* Permission to use the above image was received from Dwayne’s wife Judy Hand
Objectives

Identify...

1. Manifestations and Consequences

2. Contributing factors, causes, & situational triggers

3. Psychosocial *strategies* for 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)
Types of DHRRI

• Verbal
• Psychological
• Physical
• Material
• Sexual
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. (2016): $n = 2011$ 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 low/poor quality of reporting are major barriers for prevention
Gap in Large Datasets

Do not identify target of behavior: Staff vs. Residents

• Nursing Homes
MDS 3.0 (“...toward others.”)


• Assisted Living
National Survey of Residential Care Facilities (2010)
(“...toward other residents or staff.”)

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, personhood, dignity

=> BAROMETERS for resident’s tolerance to stressful stimuli...
A word about words...

• Old culture “biomedical” terms
Behavior symptoms; neuropsychiatric symptoms; Behavior problems; Disruptive behaviors; BPSOD

• Recommended “person-directed” terms
Behavioral Expressions; Expressive Behaviors; Reactive Behaviors; Responsive Behaviors

A word about words...

• Old culture terms:
  Resident-to-Resident...
  “Abuse” / “Abusive”
  “Mistreatment”
  “Violence” / “Violent”
  “Aggression” / “Aggressive”

Suggestion: Describe what you see w/o labeling...
“Be responsive to what their needs might be. It’s all about our approach.

It isn’t us.

It isn’t them.

It’s about their needs.”

– Director of Recreation Therapies
The Main Psychological Needs of Persons with Dementia

Close Trusting Relationship

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Know the Resident’s Early Life History

20 reasons why can be found at: http://tinyurl.com/zmct8lt
Horticulture group activity in VA Medical Center – a group of Veterans are transplanting blooming tulips...

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

He was physically restrained and returned to the locked care home

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...
Case Example
(Moniz-Cook et al. 2001)

Jack, 89 years old, late stage AD

“Aggressive” toward staff, residents, visitors...but can’t verbalize his concern...

Observation (2-month): Total of 19 episodes
Usually: Grabbing, pulling & shaking others

Staff were unable to identify the trigger...
Case Example (Cont.)

Observation (4-day): Only one attack on the psychologist as she put on her green coat prior to leaving...

Life history: Jack belonged to a fishing community where the color green was believed to be unlucky b/c of its association with death...

Intervention (20-month): No green clothes policy

Outcome: Only 1 episode – when a new staff didn’t redirect Jack from the room where a visitor dressed in green...

Behavior reframed: Jack was trying to protect others from the harmful effects of the green clothes...
Reflection Question

“If you had the perfect pill that could take away these behaviors...without side effects...would you give it to these people...even when you know that the pill will not address the unmet needs that cause the behavior?”

– Prof. Cohen-Mansfield, as cited by Dr. Allen Power
Consequences

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

+ Substantial cost implications...
Quotations

• “This is a matter of serious concern. It happens very often and will be fatal.” – Resident

• “Some of them really get afraid of him, and when I say get afraid...I mean get afraid...When they see him coming, they don’t want to sit in the dining room...” – CNA

• “I am afraid that he will hurt someone when we don’t see it...especially someone frail whom he can take down with one blow.” – CNA
Consequences for Target Residents

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

- **Physical Injuries**: Falls, dislocations, bruises or hematomas, reddened areas, lacerations, abrasions, fractures (hip), brain injuries
  

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

  Permission to use the image was received from Frank Piccolo’s wife Theresa
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 (2016):
Next Step...
Analyze Medico-Legal Databases

- **National Coronoial Information System** (Australia) (Murphy et al. 2016; Victorian Institute of Forensic Medicine)

- **Canadian Coroners and Medical Examiner Database** (Canada)

- **Serious Case Reviews → Safeguarding Adult Reviews** (England)

- ? **National Violent Death Reporting System** (U.S.) (CDC’s Division of Violence Prevention); **State & Coroner Records**
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
  – Dementias: bvFTD; VaD; TBI; CTE (Dementia Pugilistica), Korsakoff syndrome
  – Serious Mental Illness (SMI) (e.g. Schizophrenia; personality disorders); 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 and bathrooms (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 or bathroom
- 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

- Low **staffing levels** (Highly stressful working conditions)
- Lack of **training** in prevention of DHRRI in dementia & SMI
- Lack of **support and guidance** from 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 (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…

Cumulative effect of multiple factors in the social and physical environment and at all levels of the organization and beyond – intersect with cognitive impairment and unmet needs – leading to DHRRI

It is an endless culture change journey requiring fundamental changes in practices and organization’s operations & strong and ongoing commitment from all…
What’s the Soil Temperature?
Biomedical vs. Person-directed Care

**Warmth Survey** (Eden Alternative)
(Employee, Elders, Family)

**Qualities:**
Optimism – Pessimism
Trust – Cynicism
Generosity – Stinginess

Link: [http://www.edenalt.org/resources/warmth-surveys/](http://www.edenalt.org/resources/warmth-surveys/)

Arcare, Helensvale, Australia (You Tube): [http://tinyurl.com/jxldwfv](http://tinyurl.com/jxldwfv)
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

- Reimbursement; Performance/Outcomes Incentive System
- Bridge gap in M.D.S. 3.0
- No “Willful Intent” (“deliberate”) = Reportable as “Accident”
- Adequate reporting and measurement tools
- Improve Nursing Home Compare
- Require 90%-95% private bedrooms in new LTC homes
- Build small (6-8 person) highly staffed and specialized LTC homes for high risk people with dementia. Same for SMI
- Understand and protect from Sex Offenders
- Ban pre-dispute arbitration clauses in admission contracts
- Avoid wrongful evictions (follow new NH Regulations)
Assisted Living “ticking time bomb”
– Prof. Catherine Hawes

**Articles**

“Detecting, Addressing and Preventing Elder Abuse in RCFs” (Hawes & Kimbell, 2009)

“Mistreatment in ALFs” (Philips & Guo, 2011)

**Documentary**

Life and Death in Assisted Living. PBS Frontline
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)
- Ombudsman program
- Police officers
- Medical Emergency personnel
- APS
- Medicaid Fraud Control Units
- Coroners/Medical Examiners

- 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

• A Need for a National Strategy
Government Initiatives

Canada


Australia

- Dementia Behaviour Management Advisory Service: http://dbmas.org.au
- Severe Behaviour Response Teams (HammondCare)
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” – Prof. 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
- Follow new Reqs re Care Plans (e.g. 48 hours after admission)
- 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
Guiding Principle

“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, Dementia Specialist Consulting

• “...but unfortunately we spend most of our time reacting to the behavior when we should be reacting to the cause” – Jan Garard, MN DHS

*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**
- **Be clear about circumstances in which the need to share information (e.g. serious concerns) overrides resident’s confidentiality**
- **Teamwork!**
- **Provide structured/consistent routine** (but be flexible...)
- **Instill empathy and 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 care home (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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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 cannot 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
Encourage Creative Approaches

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
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 & 1-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; nursing & medical treatment; evaluation of medical cause; change in meds)

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

• Consider **change in seating arrangement**

• Consider change in **bedroom/roommate** assignment (follow new Regs)

• **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
• Well coordinated
• 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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<td><em>/</em>/_</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. 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 / case mix).
   New NH Regs (Facility Assessment: Resident population & Facility Resources)

Resources: Consumer Voice: [http://tinyurl.com/hyv3kkh](http://tinyurl.com/hyv3kkh)

2. Require training all employees in DHRRI in dementia & SMI:
   • Understanding
   • Recognition
   • Documentation / Reporting
   • Individualized Care Planning
   • Prevention
   • De-escalation

   + New expanded NH Regs and required topics re training (483.95)
     (e.g. Dementia Management and Resident Abuse Prevention)
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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Conceptual Framework
Prevention of Distressing and Harmful Resident-to-Resident Interactions (DHRRI) in Dementia

Contributing* Factors, Causes,* & Triggers*
- Resident’s History & Background Factors
- Physiological/ Medical & Functional Causes and Factors
- Situational Causes and Triggers
- Factors in the Physical Environment
- Care Partners & Organizational Factors

Assessment*
- Recognizing Early Warning Signs
- Behavioral Expressions Log
- Resident-to-Resident Elder Mistreatment Instrument (Teresi at al. 2013)
- Brøset Violence Checklist (Almvik & Woods, 1999)
- Evaluation of Urgency of DHRRI Form
- Interdisciplinary Screening Form

Development of Individualized Intervention*
- Behavior Intervention Plan Form (Dr. Paul Raia)

Prevention & Deescalation Strategies*
- Strategies at the Regulatory/Oversight, Emergency & Law Enforcement Agencies Levels
- Procedures & Strategies at the Organizational Level
- Proactive Measures
- Immediate Strategies During Episodes
- Post-Episode Strategies

Reduction of DHRRI*

Ineffective Intervention*

Developed by Eilon Caspi Ph.D.
Interview with Debbie – daughter of 87 years old Dorothy Stultz who died in 2012 after being pushed by a male resident in a nursing home:

https://www.youtube.com/watch?v=j4fK9y6cKfg
Contact Information

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