The DON’s & DSW’s Roles in Preventing Resident-to-Resident Altercations

LeadingAge New York

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Objectives

- Understand the importance of care planning and documentation for resident to resident altercations
- Learn techniques for prevention and preventing reoccurrence
- Recognize the keys to investigation, reporting and preventing reoccurrence
How Common are RRAs?

For Nursing Facilities By Group, Sub-Group and Category

<table>
<thead>
<tr>
<th>State</th>
<th>Grand Total All Complaints</th>
<th>Total Complaints</th>
<th>Total</th>
<th>A. Abuse, Gross Neglect, Exploitation</th>
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<tr>
<td></td>
<td>Residents Rights</td>
<td>Nursing Facilities</td>
<td>Abuse, Gross Neglect, Exploitation</td>
<td>Physical abuse</td>
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Source: Administration on Aging (AOA) 2013 National Ombudsman Reporting System Data Tables

Why are incidents not well documented?

- Widely underreported
  - Only the most serious events captured through DOH reporting requirements
  - Residents may have cognitive/visual/other deficits that prevent them from reporting what they see
  - Poor documentation of incidence rate by staff

- Staff may not report because:
  - Yelling/verbal insults are “normal” for a resident
  - Aggressive behaviors are the “norm” for cognitively impaired residents
  - May be targets of abuse themselves and not likely to report
Assessing Behaviors

- Who is responsible for evaluating the resident?
  - Interdisciplinary process:
    - Nursing
    - Social Work
    - Physician
    - Psychologist/Psychiatrist
    - Recreational Therapy

- Evaluation should include:
  - Severity of symptoms
  - Nature of problem
  - Types of intervention in use

After the Assessment

- Development of an individualized behavior management plan that includes:
  - Identification of the problem behavior
  - Information from the resident assessment (triggers)
  - Resident-specific behavioral interventions
  - Ongoing documentation of the resident’s response to the behavioral interventions (outcomes)
  - Ongoing revisions to an individual’s management plan based on observed results

- A systematic plan for where and how to document the effectiveness of the program needs to be put in place
Example

- Incident 1: LPN entered R1’s room and found R2 in front of bed with pants down pushing R1’s head towards his genitals. R1 said she was at the dentist’s office, opened her mouth and said, “see.”
  - R1 has no recall of event and cannot verbalize event
  - SW notes: “did not appear to be affected by it”
- Incident 2: R1 approached R3 in lounge who put his hand under her shirt until staff saw and intervened
  - A/I report: No new interventions needed for R1
  - Family member notified but not provided specifics
    - Had reported prior incidents of finding male belt, shoes and hats in R1’s room
    - Requested room change – room on another unit available but declined as it was also at end of hall
    - Told she could have a companion for R1 but that it would cost money
- Incident 3: R1 found in room of male resident who was in bed with no pants on with R2 touching him
  - R1 had no recall of event. No plan put in place for preventative measures

Example (cont.)

- R1: High risk for elopement related to dementia and poor judgement / Affectionate towards staff and peer residents (hugging and words of kindness)
  - Goal: Remain safe/secure in facility unless accompanied by staff
  - Interventions: If wandering into unsafe area, redirect to safer area / leave her safe / reassess regularly. Monitor for inappropriate behaviors / intervene and redirect as able
  - SW notes: SW aware R1 was involved in sexually inappropriate touching/ behavior by peer resident
  - CCP not revised to reflect R1’s potential for victimization/ potential to victimize others
- R2: Sexually abusive/ aggressive behaviors towards others / documentation states R2 would benefit from small dose of antipsychotic
  - R2’s daughter: did not understand why R2’s room was surrounded by women
  - No evidence of room change despite multiple incidents of continued aggressions and sexually abusive/inappropriate behaviors
- R3 – Moderately cognitively impaired/ physical/ verbal behaviors / wandering
  - Recent GDR of antianxiety med / addition of antidepressant to help with anxiety and decrease libido
  - 13 NN document resident was sexually inappropriate, verbally/ physically aggressive at times towards staff / Wandering into other residents’ rooms
  - SW notes resident can be sexually inappropriate towards female staff and peer residents/ – many interventions put into place including crossword puzzles, games, 1:1 supervision had been used, resident moved to another unit where there was less stimulation
  - Intervention: Give a stress ball for relaxation and redirection
Systems & Issues to Monitor

Communication with Caregivers
- How is behavior-related information being communicated to all responsible caregivers?
  - “No one told me”
  - Not on CNAAR
  - Not where you expect it in CCP
  - Morning Report/ Shift Report

Communication with Family/Representatives
- How are families being made aware of what behaviors are being exhibited?
- Are families made aware of what your behavior management strategies are?
- Can the family provide insight on behavioral triggers that the staff may not be aware of?

Environment
- Changes to the living environment can alter behaviors
  - Noise, lighting, tv programming choices
  - Shift change / sundowning
- Lack of privacy
  - Used to living alone/with family before admission – transitioned to a communal space – can cause territorial behaviors
  - Sexual behaviors – residents should be assessed for consent and provided with privacy as available for activities
- Roommate assignments
  - Take behaviors into consideration
  - Protect your wanderers
Systems & Issues to Monitor

Activities

- Do you have enough programming?
- Many incidents occur on nights and weekends
- How are you addressing your night owls?
- Are individualized programs actually individualized and updated depending on results?
- Group programs
- Younger psychiatric populations may not mix with older residents with dementia
- Distinguish between behavioral problems related to cognitive deficits vs behavioral problems related to psychiatric symptoms
- Is there enough variety for engagement of all residents who exhibit behaviors?
- Look for residents sleeping during activities and limited interaction as a clue that your programs may need changes

Director of Nursing Responsibilities

- Ensure staff from all shifts understand each resident's individual behavior management plan
- Ensure staff recognize their responsibility to report all resident-to-resident incidents for follow-up
- Ensure appropriate behavior management education is provided on a routine basis
- Ensure that the plan of care is followed on a routine basis
- Ensure that investigations are timely, thorough and NYSDOH report made when appropriate
Director of Social Work Responsibilities

Admissions/ Ongoing
- Ensure that emphasis is placed on resident/ representative interview

Ensure Social Workers are completing an accurate psycho-social history
- Information will be helpful in developing the plan of care

Ensure Social Workers advocate for the resident at all times

Ensure Social Workers actively participate in the development and revision of the plan of care

Participate in investigations related to Resident-to-Resident altercations

CCPs for Behavior Management of High Risk Residents

- Social Workers need to be actively involved in behavior management of high risk residents by:
  - Liaising with family on behavior management approaches they have had success with and what the facility’s plans are
  - Providing recommendations for interventions
  - Ensuring nursing staff are educated related to behavioral symptoms and how to work with the resident to reduce anxiety
  - Making sure psychology/ psychiatry consults are conducted and follow ups made as necessary
  - Addressing environmental changes that could make an impact
    - Room changes – ex. resident too close to doors?
    - Unit Changes – ex. male resident who is sexually aggressive near many women?
CCPs for Behavior Management of High Risk Residents

- Nursing staff needs to be actively involved in behavior management of high risk residents by:
  - Recognizing the need to report all incidents of resident-to-resident abuse
    - Must report incidents of resident-staff aggressive behaviors as well
  - Providing insight on triggers and interventions that they have been successful with for individual residents
  - Look for patterns with each resident to identify what potential causes occur and how we can prevent them – put on your detective hat
  - Actively supervising and monitoring residents who are high risk

Behavioral Plan Development Considerations

- Comprehensive Evaluations on Admission
  - Are we really finding out about:
    - Usual cognitive patterns, moods, behavioral distress and triggers
    - Approaches the family/representative had success with in reducing behaviors
    - Activities based on known hobbies/patterns/routines

- Comprehensive Care Plans
  - Get the resident/resident family involved – especially important when dealing with behavioral symptoms for insight
  - Are goals individualized, measurable, and realistic?
  - Is monitoring consistently conducted and are revisions to the care plan made routinely regarding CCPs for behavior management?
Behavioral Plan Development Considerations

- Brainstorming
  - Every discipline should be participating in development and implementation of the plan of care
  - Leverage the knowledge of the staff member who never encounters issues with a difficult resident
    - Consider using a hint book to help staff
  - The family/representative should be queried for useful info
    - Use the resident’s history to find out what he liked, did and preferred in the past – then use it in the plan of care

Investigations & Reporting

- Need answers to who, what, when, where, why and how
- Get statements from everyone who may have info
  - Did we miss a known trigger
  - Were the staff following the plan of care
    - Did staff intervene
- Investigation summary must be comprehensive
- Determine if a reportable event
Staff Considerations

Behavior modification – for staff

- Cognitively impaired residents may have reduced cognition, but they are more aware of staff emotions/attitudes
- We are sometimes the cause of the exhibited behavior – or we cause an escalation
- Use of non-threatening approaches

Adequate staffing

- Inadequate numbers of trained staff to care for residents with dementia can lead to negative outcomes – residents not being fed, hydrated, toileted or having emotional needs met
- Recognition that residents cannot perform tasks that they no longer remember how to do – treat ADLs differently
- Consider consistent assignment

Monitoring

- Staff burnout
- Appropriate staff members for unit

Example

- Incident: R2 heard shouting in the shower room. R1 seen hitting and punching R2. R2 lying on floor or shower room with bruising, skin redness and pain.

  - R1: Severely impaired cognitive functioning
    - Behavioral symptoms directed towards others included hitting, pushing and grabbing
    - Interventions: 1:1 observation every shift / monitor behavior / administer meds / provide redirection with frequent follow up
    - On 1:1 monitoring but went missing when CNA took his tray to discard the food he had been throwing from it

  - R2: Moderately impaired cognition / Ambulates independently with supervision / Takes shower after being set up by CNA with frequent monitoring
    - CCP: Interventions are to anticipate all care needs / provide cueing and supervision as needed
Identifying stressors for interventions

Individual stressors that may impact the resident:
- Fatigue
- Excess stimuli
- Lack of pain management
- Unmet physical needs – hungry/ sick/ thirsty
- Nutritional deficiencies may aggravate behavioral symptoms
- Unfamiliar caregiver
- Changes in routine
- Changes in environment
- Personal space/ privacy
- Expectations of the resident that exceed current abilities
- Frustration at not being understood
- Feedback that is negative or restrictive, or infantilizes
- Boredom

Unmet Resident Expectations
- Assist me
- Make me feel safe and secure
- Bond with me
- Make me feel a part of the group
- Allow me to be involved in life in a significant way
- Protect my rights and individuality

Interventions

General Interventions
- Entering the resident’s reality vs. trying to orient to staff reality
- Reminiscence Therapy
- Aromatherapy
- Touch/ Massage
- Music Therapy
- Social activities
  - Snacks/ walks/ conversations
- Sufficient Staff

De-escalation
- Use of active listening
- Not making assumptions
- Control the environment
- Change the environment
Interventions for Aggressive Behaviors

• Distraction
  • Social activities - Snacks/ walks/ conversations
  • Exercise (younger populations)
  • Sports
  • Exercise equipment

• Sexual Behaviors
  • Crafts that require use of hands
  • Stuffed toys/animals
  • Clothing that opens in the back/ lacks zippers

• Population-appropriate activities/ groups

• Wandering:
  • Use of stop signs/ barriers
  • Redirection from other residents’ rooms/ personal spaces
  • Scheduled monitoring for predatory behaviors (1:1 as appropriate)
  • Painting exit doors/ fire doors to reduce wandering

Example

• Incident: R1 (sitting at table in dining room) felt R2 (standing) was too close to her and asked the staff to move her. Staff responded: “NO. R2 is just looking out the window and not bothering anyone.” R1 shoved R2 to the ground, but claims she did not push the other resident.

• R1: Low cognitive functioning / impulse control tendencies / personal space concerns
  ◦ Activity CCP: No details about individual tasks
  ◦ CCPs for Physical aggression/other: Generic, no triggers ID’ed
  ◦ Noted as aggressor in report / said to be agitated for several hours and yelled at peers when she thought they were doing something wrong

• R2: Low cognitive functioning
  ◦ Documentation: Missing physician documentation / All CCPs generic
  ◦ No preventative measures for recurrence found
  ◦ All interventions reactive rather than proactive – “will redirect”
  ◦ Focus is on medication rather than non-pharmacological interventions
Preventing Reoccurrence

- Staff need training on and to understand that:
  - Behaviors are a form of communication for an unmet need from a person who may not be able to verbally communicate
  - Identifying the root cause of a behavior to address it (identifying triggers) is more effective than trying to eliminate the behavior
    - Reporting incidents is essential for the detective work that goes into identifying triggers
    - Time of day, change in environment, pain, family visits and other changes that cause behaviors begin to show in patterns
  - Nonpharmacological interventions should be tried before resorting to meds
    - “Agitation” as rationale

- Remember . . . Sometimes we are the cause of the behavior

Preventing Reoccurrence

- Environmental Practices:
  - Reduce noise, crowding of common areas, and reduce clutter
  - For residents who wander or need supervision, ensure they have somewhere to go where they are unrestricted, yet safe
  - Provide an environment where meaningful activities are conducted to engage residents based on their individual needs but that are also group-appropriate
    - Mixing different populations with various cognitive abilities and ages may result in more problems even if the programming is good
  - Ensure adequate supervision can be provided and that staff are actively engaged and watching residents vs. doing other work
Requirements of Participation

- Compliance With RoPs
- Quality of Life and Quality of Care
- Person-centered care planning
- Restraints
- Pain Mgmt.
- Staff competency & training
- Drug Regimen Review
- Residents without mental/behavioral health disorders
- Residents who display mental/psychological adjustment difficulties

Q&A

- Thank you for having CMS Compliance Group present today!
- Questions?