

Residential Aged Care

Communiqué

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EDITORIAL

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Next issue: August 2015



Welcome to the second issue of 2015. In this extended issue we focus on resident-on-resident aggression (RRA). We build on some of the themes from the last issue around the management of Behavioural and Psychological Symptoms of Dementia (BPSD).

Three cases presented highlight the challenges faced by the individual, families, staff and the community in these circumstances. The spectre of legal, particularly the potential for criminal charges where an assault has occurred is frightening for all involved. The cases presented are from Ontario, Canada and reflect similar circumstances that occur in Australia. In Ontario, they have a 'Geriatric and Long Term Care Review Committee' (GLTCRC) who assist and advise the Coroner investigating deaths of older people in residential aged care.

We have two expert commentaries, one is written by A/Prof Dina LoGiudice who is one of our most experienced and skilled geriatricians in Victoria. The other is by Professor Elizabeth Beattie one of our leading researchers in Australia on dementia care.

We also include a short summary of a recent systematic review completed by Briony Murphy, a PhD scholar researching the topic, and include a reference to another recently completed PhD by Margaret MacAndrew.

It is reassuring that research is occurring in Australia on this complex issue, as it is important that we continue to expand our efforts to understand the nature and circumstances of RRA.

This is an area where policy, practice and research are closely intertwined and it is vital each informs the other to enable us to prevent harm to residents whilst ensuring a safe working environment for staff.

CASE #1

A little conversation

Case Number: 2012-10

Case Précis Author: Carmel Young RN,
Ballarat Health Service

Clinical Summary

Ms K an 87 year old female was admitted to a long term care facility in March 2011 as she required some assistance with personal care. Past medical history included dementia, falls, ischaemic heart disease and congestive cardiac failure.

Four days after arriving at the RACS, Ms K was observed scratching a male resident and required redirection by staff. Following this incident Ms K's family told staff at the RACS about her fear of male residents and requested relocation to a ward only for female residents. This was not possible at that time.

About one month later, a male resident wandered into Ms K's room and climbed into her bed. The male was removed without incident. However, Ms K could not settle the rest of the night. A few weeks later, Ms K spent the night wandering in and out of other residents' rooms.

RACS staff should consider the availability for supplemental staffing and preferred accommodation for residents with severe behavioural issues.

Ms K was transferred to a female-only section in August. Later that month in the late evening, Ms K was walking in the hallway, when she stopped to talk to another resident Ms X. During this conversation Ms K was pushed over, falling and fractured a hip. Despite surgery Ms K died within a week from a myocardial event.

Pathology

The cause of death following an autopsy was severe coronary artery disease with evidence of congestive heart failure. The pathologist considered the hip fracture and surgery as contributing factors to death.

Investigation

This case was reviewed because Ms K died as a result of injuries received following an 'assault'. The family of Ms K had also reported the incident to police on the day it occurred. The case review drew on information from the RACS and police.

Ms X was a 70 year old female resident of the RACS who had been there for almost two years. Ms X's past medical history included dementia with paranoid episodes and multiple falls.

At the time of this incident Ms X was on a range of medications to treat the Behavioural and Psychological Symptoms of Dementia (BPSD), which included two antipsychotic agents.

A review of incidents involving Ms X revealed a similar episode in January 2011 after which her family organised staff from an outside agency to sit with her for an hour twice a week. There were also two more episodes in May 2011, when on two separate days Ms X pushed two different residents to the floor.

RACS staff should be reminded to contact their local health services for assistance and information about behavioural support programs and training that are available.

Ms X was seen by a psychiatric clinician and admitted to a behavioural unit for management after the episode involving Ms K. Ms X was in the specialized unit for just under two months and then returned to the RACS.

Coroner's Recommendations

Several recommendations were made which included "residents who are assessed as a danger to other residents should be given priority to receive timely intervention, including admission to a behavioural unit as appropriate, to optimize the behaviour of the resident".

RACS staff should be reminded to contact their local health services for assistance and information about behavioural support programs and training that are available.

RACS staff should consider the availability for supplemental staffing and preferred accommodation for residents with severe behavioural issues.

Author Comments

These circumstances are complex, often very emotive and occasionally volatile. A cool, considered and rational approach by staff is required along with an understanding that we should be drawing in additional support both internally and externally. Part of the complexity is managing two distressed families and addressing whether the incident requires reporting and involvement of police.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:
racc@vifm.org

DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed.

We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

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CASE #2

Time for dinner

Case Number: 2012-11

Case Précis Author: Carmel Young RN, Ballarat Health Service

Clinical Summary

Ms LL was a 97 year old female resident in a secure dementia section of a RACS for about seven months. Past medical history included advanced dementia, hypothyroidism, diverticulosis, rheumatoid arthritis, diabetes mellitus, depression and a left leg ulcer.

One day in January 2012, Ms LL was entering the dining room using her walker. A male resident, Mr Y approached her from behind, they exchanged a

A puzzling aspect about the incident was the doorway to the dining room was six feet wide with ample room to allow two people to pass at the same time.

few words. Mr Y then pushed Ms LL's shoulder causing her fall to the ground.

Ms LL was transported to the local hospital for x-rays that revealed a fractured and dislocated left humerus and a minimally displaced transverse fracture through the patella of the left knee.

The attempts at closed reduction of the dislocated shoulder failed. The option of surgery for an open reduction was discussed with the Orthopaedic surgery unit and family. The decision was that this would not be beneficial and the best course of action was palliative care provided at the RACS. Two weeks after the incident Ms LL died.

Pathology

The cause of death following an autopsy was pneumonia as a consequence of fractured humerus and fractured patella, as a result of a fall.

Investigation

The review of the case drew on information from the hospital, police and RACS.

Mr Y was an 81-year-old male with dementia, who had been admitted to the secure dementia wing of the RACS from a regional psychiatric service about seven months before this incident. In fact he arrived the same month as Ms LL.

A puzzling aspect about the incident was the doorway to the dining room was six feet wide with ample room to allow two people to pass at the same time.

After this incident the RACS has employed a personal care worker in the evenings to work in the dining room and engage the residents in activities in the lounge and to redirect those that had a tendency to interact poorly with others.

The RACS also proposed to have a manager on-call in the building every weekend and have all managers rotate through day, evening and night shifts in order to provide support to staff.

Coroner's Comments and Findings

There were no recommendations. The GLTCRC noted how complex the circumstances are for management of people with dementia and were supportive of the plans instituted by the RACS.

Resident-to-Resident aggression: A systematic review

By Briony Murphy Doctoral Scholar, Department of Forensic Medicine, Monash University and The Victorian Institute of Forensic Medicine

This is a summary of a systematic review we conducted on Resident-to-resident aggression. We searched all original, peer-reviewed research articles published between 1949 and 2013 describing incidents of resident-to-resident aggression (RRA) in nursing homes.

Due to the volume of journals and research articles now available online, conducting a systematic review is no easy feat. Of the 745 relevant records found through a search of seven academic databases, we identified only eighteen studies that described the frequency, nature, contributing factors and outcomes of RRA, using both quantitative (n=12) and qualitative (n=6) methods.

Overall, the studies indicated that RRA commonly occurred between residents (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. RRA most commonly took place in the afternoon in communal settings and was often triggered by communication issues, invasion of space, or was unprovoked.

Unfortunately there was insufficient and inconsistent information reported across the studies to calculate the prevalence of RRA. This review also identified gaps in the existing literature on RRA for which further research is required including: environmental factors, outcomes, and interventions.

CASE #3

Help us

Case Number: 2012-14
Case Précis Author: Carmel Young RN, Ballarat Health Service

Clinical Summary

Mr W was an 86 year old male resident of a RACS. Past medical history included Alzheimer's Disease (diagnosed at age 75 years), with long standing Behavioural and Psychological Symptoms of Dementia (BPSD), depression and prostate cancer.

One day in October, Mr W may have wandered into another resident's room and pulled her out of bed. His slippers were found in her room and he had blood on his pyjamas. The resident that was injured was in a vulnerable position being bedbound and requiring full assistance with all personal care. The injury was a laceration to her forehead.

Mr W was transferred to another section the following day. Three days later he was transferred to the acute general hospital geriatric unit for further assessment. This admission lasted three to four hours as the acute hospital staff found Mr W's behaviour difficult to manage and so he was transferred back to the RACS with a change in medication to manage the BPSD.

A couple of weeks later, he became ataxic, with a decreased appetite and was unusually drowsy. After discussion with his power of attorney, the decision was made to provide comfort care. Mr W died soon after, approximately one month after the incident with the other resident.

Pathology

The cause of death was not given and there was no autopsy.

Investigation

The Coroner received the report of the death some months after it occurred. The GLTCRC was asked to comment on the management of behavioural and psychological symptoms of dementia (BPSD) in this RACS and system-wide.

The review found that Mr W had had BPSD for at least four years and had significant disinhibition due to frontal lobe damage. There had been several incidents that included wandering into other residents' rooms, inappropriate defecating and urinating, physical aggression and sexually inappropriate behaviour. The family physician, geriatrician, and acute hospital had all been involved in managing Mr W, of note the RACS had put in place over 20 behavioural responses to deal with his behaviour.

The review noted that a psychiatrist in geriatrics (psychogeriatrician or aged mental health psychiatrist) was not involved and that the RACS had not availed itself of the existing resources to educate staff on the specific needs of a care team to cope with active behavioural problems.

Coroner's Comments and Findings

The GLTCRC made several recommendations at different levels in the aged care and health care systems. These included collective action by RACS, RACS staff, health and aged care professionals: should ensure that comprehensive and consistent documentation when describing the details involving incidents of physical aggression; ensure that records surrounding the deaths of residents are accurate; continue to provide education to staff in methods of assessing, documenting and managing behavioural and psychological symptoms of dementia.

The review found that Mr W had had BPSD for at least four years and had significant disinhibition due to frontal lobe damage.

The experience of witnesses called by the Coroners Court for an inquest

This is a preview of an article scheduled for publication in the June 2015 issue of the Clinical Communiqué written by Katherine McGrath MB BS, FRCPA, FAICD who is the Chair, Coronial Council of Victoria.

The Coronial Council was established in 2008 to advise the Attorney General on ways to improve the process of death reviews undertaken by the Court to ensure it met the community's expectations. One of the first issues brought to the attention of the Council was the apprehension of those people who through their work end up participating in court proceedings as a witness. The Council was asked to consider how best to support those staff from health, emergency and police services that may experience this stress.

A survey was commissioned and invited staff from these organisations to volunteer to keep an interactive journal and undergo an in depth interview to record their experiences and their views on the process.

In response to these concerns, the Coronial Council and Coroners Court developed a series of interactive videos on the Coroners Court website to give more information about how the Court operates and what is expected of those called as witnesses. The information is tailored to the variety of reasons why a person may be called e.g. as a police witness, as an expert witness, as a witness to aspects of the deceased person's life and care that may be relevant to the inquest.

These videos are available at <http://www.coronerscourt.vic.gov.au/home/about+us/virtual+tour/>

CLINICAL COMMENTARY #1

A holistic approach: safety for all requires training, advocacy and policy

Dina LoGiudice MBBS PhD FRACP, Clinical Associate Professor, National Ageing Research Institute, and Melbourne Health, Melbourne, Victoria, Australia

Resident-to-Resident Aggression (RRA) in residential aged care services is a common, yet poorly recognised and under researched issue. These three case studies highlight the tragic consequences of RRA on the residents, their families and staff.

With the ageing population, it is likely that in absolute numbers, incidents of RRA will become more common. RRA is a heterogeneous condition that describes the abuse of one resident by another resident and may encompass physical, verbal, sexual, psychological and material abuse. The outcomes include worsening functional decline, psychological and physical impairments, and death. It is thought to be common although due to the diverse characteristics of the term exact figures are unknown, even in cases where significant injury or death is caused, with presumed numerous cases of unreported incidents.

The three cases described highlight the complexity and consequences of RRA. In all three situations either victim or perpetrator had dementia often of severe degree and were on psychotropic medications, indicating a previous recurrent level of Behavioural and Psychological Symptoms of Dementia (BPSD). Specialist or hospital services were involved in some cases, but for a limited time. The residents were frail, and in two cases a palliative approach was undertaken.

Although acute hospitals do not provide optimal environment for the confused older people, their potential to link with other outreach services can assist.

Available research describes a common profile for RRA. Predominantly the victim is a woman who is cognitively impaired, displaying changed behaviours and BPSD, and may be less physically disabled. On the other hand the perpetrator is more cognitively aware and functionally able, with a history of aggression. Triggers such as calling out, intrusiveness and wandering in the setting of poor communication of those with dementia can lead to a situation resulting in RRA.

RRA is an emotive issue involving those who may not have capacity for intent, in a setting where residents have a right to be safe from physical aggression and harm.

It is distressing for all those concerned, including residential care staff, particularly when the outcome is death. The environment plays a major part, where vulnerable people with cognitive impairment are required to live communally with issues such as lack of privacy, noise, and intrusive behavior, that may potentially trigger aggressive responses from co-residents.

Appropriate, frequent and practical training is required for residential care staff to improve competencies in recognition, prevention and de-escalation of RRA, which needs to be fully supported by management. Caring for aggressive residents is extremely challenging and stressful for staff and needs to be recognized as such. Skill in open communication with family and friends of those who are involved in incidents of RRA is required.

In the cases described specialist and hospital services were utilized, but only briefly and without adequate follow up. Local support may vary in regions, but statewide services such as Dementia Behaviour Management Advisory Services (DBMAS), Old Age Psychiatry services including outreach, and Aged Care services supported by geriatricians are available.

Timely requests, prior to escalation to a crisis are important. Although acute hospitals do not provide optimal environment for the confused older people, their potential to link with other outreach services can assist. In one case a resident was sent back to the facility after being admitted to an acute hospital for only a few hours, as hospital staff could not manage his BPSD. This is disappointing for residential care staff that are seeking support and guidance, and highlights the importance of good working relationships with acute and sub-acute services to facilitate good practice, and limit unnecessary admissions and investigations.

Once a person with dementia requires residential care, their prognosis is poor, and a palliative approach should be considered. Discussions with family regarding advanced care directives, with ongoing communication and education about dementia and its prognosis will facilitate end of life care and futile treatment, and unnecessary investigations, additional medications or transfers to acute hospitals.

Finally RRA requires a public health approach. The public may read 'horror stories' in the press about an incident of RRA that provides a negative and skewed view of the situation. The importance of accurate documentation and reporting of incidents of RRA will assist in highlighting this important problem. In addition, ongoing research to inform training, advocacy and policy is required to ensure safety for all in residential care settings.

Once a person with dementia requires residential care, their prognosis is poor, and a palliative approach should be considered. Discussions with family regarding advanced care directives, with ongoing communication and education about dementia and its prognosis will facilitate end of life care and futile treatment, and unnecessary investigations, additional medications or transfers to acute hospitals.

COMMENTARY #2

Crossing Personal Privacy boundaries: the potential for negative outcomes.

Professor Elizabeth Beattie (RN, PhD, FGSA) Director, Dementia Collaborative Research Centre: Carers and Consumers and Professor of Aged Care and Dementia, School of Nursing Queensland University of Technology.

In the situations described in Mrs K (Case #1) and Mr W (Case #3) both residents had impaired wayfinding and wandering behavior as part of their behavioural symptom profile. In severe dementia it is highly likely that many residents have issues with getting lost within the facility, not recognizing their own room and spend time searching

for their own space and recognizable features in the environment.

In both cases the occupant of the room was probably disturbed in their private space – Mrs K had her space

intruded on by another resident climbing into her bed, an episode that appeared to end without negative outcomes for her. Yet she was then unable to sleep and wandered into the rooms of other residents and walked about late in the evening. Mr W seems to have entered another resident's private space and pulled her out of bed. We cannot know what was actually going on in the thinking of these residents but what we do know is that boundary transgression (BT) is a dimension of wandering that is distressing for the resident whose space is intruded upon, the resident who cannot find their way and mixes up their own private spaces with those of others, staff and resident's families.

However, contrary to anecdotal reports that put BT as occurring very frequently, a recent observational study by QUT PhD graduate Dr Margaret MacAndrew showed that BT occurred only about 5% of the time a resident who wanders is active. She also found that it tends to occur in those residents less able to walk directly from one point to another without diversion, in those residents

who are most mobile and at the time in the day the resident is most active.

The early recognition that a resident is experiencing excessive walking and wayfinding loss (wandering), especially that involving BT, is very important because of the possibility that, amongst other issues, the resident may be put in a situation like Mrs K and Mr W – transgressing private boundaries of other residents and/or finding themselves either the victim or unwitting perpetrator of resident-on-resident aggression.

The negative consequences of RRA for residents who wander can result in personal injury from physical aggression, verbal aggression, social marginalization and isolation and removal from the RACS. Getting a realistic assessment of BT involves close observation of the resident's movements over a couple of

Greater attention to 1:1 planned interaction with the resident – by the staff or family and visitors- at times of peak wandering activity can also improve social inclusion and help build relationship.

consecutive days to identify exactly what spaces attract them, how frequently and which of these involve intrusion into

the private spaces of other residents.

Environmental modifications (e.g. using familiar personal objects, clear and simple signage, closed doors), communication techniques (e.g. consistent verbal and nonverbal wayfinding prompts) and engagement in meaningful activities can all be helpful in reducing BT.

Greater attention to 1:1 planned interaction with the resident – by the staff or family and visitors- at times of peak wandering activity can also improve social inclusion and help build relationship. Reducing or removing the BT factor may reduce or remove one common impetus for RRA, especially alongside the use of highly person-centred care approaches.

RESOURCES

1. Revisit RACC Vol 10 Iss 1 which examined some aspects of BPSD
2. Revisit RACC Vol 9 Iss 4 which examined aspects of palliative care
3. Ferrah N, Murphy BJ, Ibrahim JE, Bugeja LC, Winbolt M, LoGiudice D, Flicker L, Ranson D., Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. *Age and Ageing*: 2015
4. A short article about Margaret MacAndrew PhD research on dementia related wandering is available at <https://www.qut.edu.au/health/about/news/news?news-id=86181>
5. Dementia Friendly Environments is a resource that helps us towards working to provide an environment that best enhances the needs of residents with dementia. <http://www.health.vic.gov.au/dementia/>