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Violence in the Nursing Homes: Understandings, Management, Documentation and Impact of Resident to Resident Aggression

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1. Introduction

There has been a growing recognition of resident-to-resident aggression (RRA) in long term care facilities. This article reviews these concerns for this and looks at the events themselves. It explores the reasons for its current attention, delineates the types of RRA and examines dynamics of both the resident aggressor and the resident victim. It discusses ways to prevent RRA and interventions during these incidents. It outlines ways to review the RRA event after it has occurred. It highlights required documentation and evaluates the impact of such aggression on the quality of life for all nursing facility residents and staff.

2. RRA Scenario

Bob "Bull" Jones, age 79 strolls into the dining area and is about to sit in his usual seat. However, Dan Walker age 85 with moderate dementia of the Alzheimer Type is already at the table in Bob's chair. Dan yells "I was here first". Bob shoves him hard and says, "It's my chair". Staff quickly separates the two and each will have his meal in his room. Most of the other residents in the dinning are upset; some leave; others eat less than they would have had the incident not occurred; and still seem oblivious to the event. Staff will have a mountain of reports to file and many family members to contact.

3. Background

3.1 Reports of RRA incidents

The statistics of resident-to resident violence are striking and the incidents are growing. "RRA is a ubiquitous phenomenon in nursing home settings with important consequences for affected individuals and facilities." (Rosen et al 2008, pp 1398) "Resident to resident injuries are on the rise in health care facilities. In fact, a nursing home resident has a 1-in-400 chance of being injured by another resident. " (Prevention, 2011) For example, one study over a two week period in a long-term care facility, noted that 2.4% of the residents said that they had been victims of physical aggression by another resident and 7.3% reported being victims of verbal aggression. (Cornell University, 2011) Another investigation looked at occurrence RRA for one eight hour shift. Here, twelve nurses acting as observers witnessed

30 RRA events of which 17 were physical. (Cornell University, 2011) The world wide press has drawn attention to RRA. In 2000, Manhattan woman was suffocated by her 90-year-old roommate in a New York City Long term care facility. (Zambito, 2000) “ Residents of New York City nursing homes have been killed, sexually assaulted and beaten by unlikely assailants in the past few years, their fellow residents” (Zambito, 2000) And in 2009 “Fear in nursing Homes: Assault claims soar” as Packham reported in an Australian newspaper “Violence and sexual assaults against the elderly are increasing, according to new figures. More than 1400 assault allegations were made by nursing-home residents in the past fiscal year -- a record, and a 52 per cent rise on the previous year's figures.” (Packham, 2009 page 22)

There has been a history of reports in both the nursing facilities’ literature and the press about this phenomenon. (Cohen-Mansfield et al, 1990, Packham, 2009, Zambito, 2000) In 1990, Cohen-Mansfield noted that of all the victims of resident physical aggression, 62% were other Residents, 37%, staff and 1% , visitors. (Cohen-Mansfield et al , 1990). However, it was the article by Shinoda -Tagawa in the JAMA “*Resident-to-Resident Violent Incidents in Nursing Homes*” that galvanized attention to RRA. (Shinoda-Tagawa et al 2004). These authors looked at an 1132 initial reports from nursing facilities in 2000 in Massachusetts of resident- to- resident violence. They refined this number ultimately 294 cases in which the resident victim had demonstrated physical evidence of the attack. The injuries included 39 fractures, 6 dislocations, 105 bruises,113 lacerations and 31 reddened region. Still more recently, the works of Rosen and his colleagues that have drawn attention to RRA. (Rosen et al, 2010 and 2008)

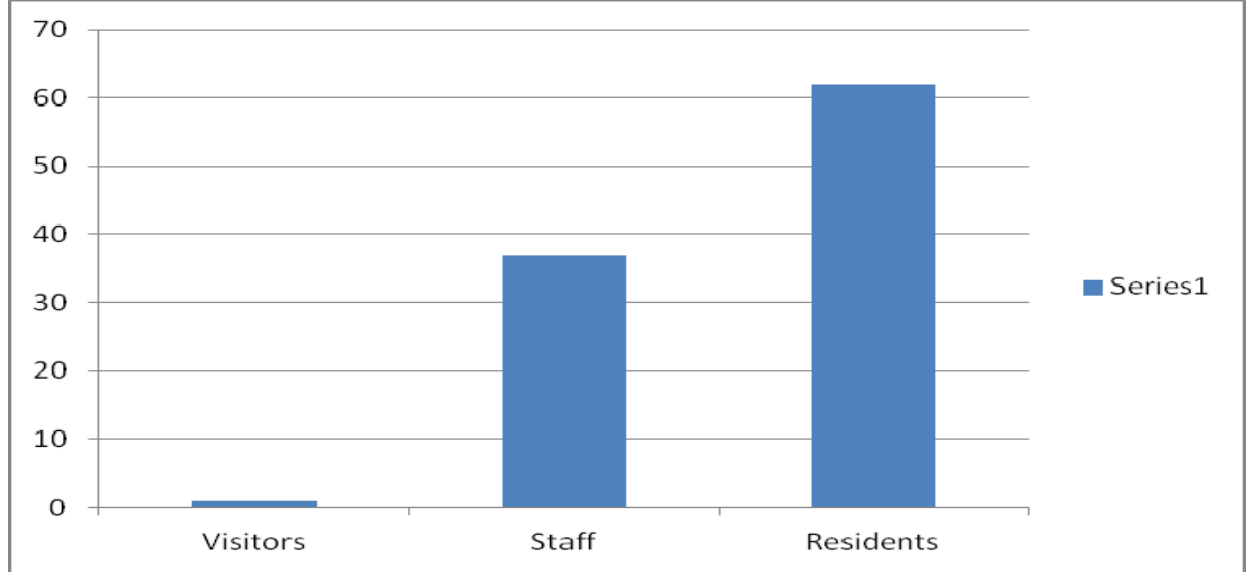


Fig. 1. Who are the victims of Resident Aggression (Cohen-Mansfield et al , 1990).

This author having consulted to long-term care facilities for over a decade has found that staff were much more attentive and more concerned about resident aggression toward staff than RRA. In discussions and training sessions with line staff in over one hundred nursing homes, when asked who is the greatest victim of resident aggression, their answer was staff. When this author cited the work of Cohen-Mansfield, nurses aids, nurses and hospital administrators expressed surprise about the number of RRA incidents. (Cohen-Mansfield et

al, 1990) The statistics made them look more carefully at resident to resident aggressive interactions.

One way to verify that number of RRA in a long term care facility is to have a hidden camera in the day room. (Sifford KS, Bharucha A, 2010) Without the presence of staff, many RRA events were recorded. These were incidents of verbal and physical aggression. Those videoed observations showed pushing, bullying and uninvited touching.

3.2 Reasons for the growing attention to RRA

There is an emerging concern about RRA and there are a number of reasons for this attention. The growing reports of RRA incidents have generated more awareness and the need for focus on them. The series of cited studies in the background have provided key statistical information as to the number of incidents. These incidents in turn have brought attention to the phenomenon. Perhaps, nursing facilities are dealing better with resident-to-staff aggression which allows them to look more on these events. Maybe staff is simply becoming aware of these disruptions. Certainly, more patients with psychiatric histories are becoming residents of nursing homes rather than being in state hospitals. Then, there is the aging Viet Nam veteran population who are starting to enter nursing facilities. Many of them have a Post Traumatic Stress Disorder (PTSD) which can be accompanied by aggressive behavior. The number of residents with dementia especially of the Alzheimer's type are increasing in nursing homes. (Isaksson U, 2011) In fact, that person with dementia living in the community may have become aggressive due to the cognitive deficiency. That aggressive episode led to that person's admission to a nursing home. Finally, residents' unmet needs can result in RRA. (Sifford, 2010)

Accrediting and government surveying agencies are paying more attention to RRA. For example, Massachusetts Department of Public Health using Complaint and Incident Reporting System had been accumulating data for years. It was through the analysis by Shinoda-Tagawa that that data on RRA caught clinical and public attention. (Shinoda-Tagawa et al 2004). Legal concerns and litigation websites have also contributed to RRA awareness. (A-nursing-home-abuse, 2011) Finally, a number well publicized of homicides as a result of RRA have caught the public's attention. (Zambito, 2000)

4. Types of RRA

The nature of the resident to resident aggression takes three forms: verbal, physical assaults and sexual advances. Rosen and colleagues have delineated 35 types of violence. (Rosen et al, 2008) Furthermore, physical and sexual violence are not necessarily mutually exclusive. There are a wide variety of types of physical attacks ranging from a shove to homicidal attack, from slap to a protracted punching episode and from pushing someone out of the way to pushing someone down a stair way. Similarly sexual violations range from a brief fondling to rape. (Rosen et al, 2010) This paper focuses on physical encounters. It should be remembered that the actual aggression spectrum ranges from yelling, verbal assaults, offensive gestures, pinching, throwing objects, hitting, punching, assaults to homicide. (Soreff & Siddle, 2003)

5. Understanding RRA: The residents- assaulters, their victims, the staff and the environment

There are four key aspects in looking at resident-to-resident aggression: resident who assaulted another resident, the assaulted resident, the staff and the unit's environment.

5.1 The assaulter

What are the defining features of an assaulting resident? There are a number of cognitive issues, personality characteristics, family dynamics, background events, medical illnesses, mental health histories, and nursing home situations which provide clues and explanations for the assaults. Although I will discuss each of these qualities, individuals often have more than one. And commonly, the two or more may interact synergistically. For example, a resident with dementia of the Alzheimer's type may also have a history of being impulsive and was a pugilist (boxer). That combination can result in an individual who is at risk to strike out at other residents.

5.1.1 Cognitive deficiencies

Rosen and colleagues noted that between 80% to 90 % residents in nursing homes have an incidence of cognitive impairment and that disorder leads to behavioral disruptions and aggression. (Rosen, 2008) The question now becomes how do cognitive deficiencies result in RRA. Let us first, review some of the features of cognitive difficulties. These include memory problems, orientation issues and loss of judgment. Cognitive impairment often takes the form of dementia. The most commonly encountered dementia in nursing facilities' population are those of the Alzheimer's type.

5.1.1.1 Memory difficulties

Memory difficulties would be evidenced by not recalling events. Often, residents early in their dementia history would exhibit an inability to recall recent events; e.g. what they had had for breakfast later in the day. Meanwhile, they would have preserved their long term memory. As a result, these persons might keep repeating stories of their youth without appreciating how annoying these adventures are to others hearing them for the thousandth time. As the dementia progressed they would lose distant collections. Recent memory loss becomes distressful to those experiencing it. They in turn may become agitated and then aggressive. For example, one resident 86 year old Bill M has loss of recent memory. He was bothered by this and slightly depressed. He kept asking others what he had for breakfast. They became infuriated with him; he became inpatient with them. One afternoon he shoved another resident who refused to answer Bill's one thousandth inquiry about his breakfast.

Recent recollection loss can result in RRA incident in other way. In this scenario example, Mary W age 79 years old has middle stage Alzheimer's. She places her eye glasses in her dresser top draw in the morning after breakfast. Later that day when she cannot remember where her glasses are, she accuses her roommate Betty K age 86 of stealing them. Betty protests. Mary insists that thief has occurred and she has been robbed. Before staff can intervene she pushes Betty into a chair. In this dynamic, the resident compensates for the memory loss by blaming others and making accusations. In turn, this led to an RRA situation.

5.1.1.2 Orientation issues

Residents with dementia have orientation problems. Orientation can be evaluated in three dimensions: time, place and person. As the dementia progresses the first to go is sense of time: time of day, day of the week, month, and year. The next area to have problems with is the sense of place. The residents do not where they are. Questions like what is your room number , the facility's address, and your state's name will reveal problems here. Finally in severe dementia, the residents lose their sense of who they are. Some will not recall their names.

Orientation loss leads to RRA in several ways. In one scenario the residents wanders into other residents' room believing it is their and altercations ensue. In another instance, for example, Sam H age 78 years old wakes from a nightmares in which he believes he is in jail. He does not recognize his room or roommate. He becomes combative as he demands his freedom.

5.1.1.3 Loss of judgment

Dementia erodes judgment. Residents with dementia at an earlier point in their lives, knew that waiting in line is part of life. Historically, they would patiently stand in line for medications or in a much earlier time they were used to grocery store check-out lines. So with dementia they now become pushing and striking out, when waiting in lines at the nursing home.

5.1.1.4 Problems with executive functions

Dementia robs residents of their executive functions. Remember the old slogan: engage mind before putting mouth in gear. Before dementia they used to know there was a time and place for things. For example, Walter K age 74 years old had evidence of middle stage of Alzheimer's. He had led a privileged life with a nanny and his family had other live-in help. However, as an owner of local Southern five and dime store he had learned to keep his prejudices to himself and his close friends. As he aged and his executive functions slipped, he began to tell everyone exactly what he thought of them. In called several of the African-American nursing aids *slaves*. He did not limit his opinions to just staff. He regularly insulted other residents. He called one woman out for being too fat. He then questioned her birth and heritage. His insults resulted in many heated discussions at that nursing home and one RRA event.

5.1.2 Personality elements and gender issues

Many authors have attributed RRA to the initiator's personality. (Cohen-Mansfield et al , 1990; Enmarker et al, 2011; Soreff & Siddle, 2003,) Enmarker et al in the landmark article, *Management of person with dementia with aggressive and violent behaviour: a systematic literature review* wrote "The results could be summarized in two themes: 'origins that may trigger violence' and 'activities that decrease the amount of violent behaviour'. Together, the themes showed that violence was a phenomenon that could be described as being connected to a premorbid personality ..."(Enmarker et al, 2011, pp. 153) A study of nursing assistants stated "Findings gained from semi-structured interviews revealed that CNAs perceive initiators of RRA 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." (Sifford-Snellgrove,

2011, pp 1) And although the majority of residents in many nursing homes are women, often it is males who are most of the RRA instigators.

What are the personalities related to RRA? They include the following characteristics: impulsiveness, a controlling posture, angry, aggressiveness, inflexibility, quarrelsomeness, jealousy, demanding, bullying, and impatience. It is easy to envision these qualities resulting a resident who might engage in RRA. Joe M age 72 years liked to describe himself at a demanding S.O.B. who always got things done quickly. His theme song was Frank Sinatra's *"I did my way"*. He regularly fought with other residents in the day room over which television show was to be watched. On more than one occasion he pushed others out of the way so he could see his baseball game.

One particular personality pattern associated with residents becoming aggressive is paranoia. The residents see or feel that others are arrayed against them. They view others are plotting against them and wanting to take things from them. They look at their environment as harmful and threatening. They are always on guard. They believe others getting more attention or privileges than they have. In turn, their persecutory view of the view may indeed provoke others to be distant and distrustful of them. For example, Jerry G age 77 years old believed others get better care and food than he did. He saw unit rules as deliberating designed to make him miserable. Finally, he dumped all his food on his table mate's lap, proclaiming that his portions were smaller than all the other residents.

5.1.3 Intrapersonal dynamics

In understanding RRA there are two interconnected senses and one defense mechanism which can be responsible for a resident striking out. The two inter-related attitudes are the sense of loss and the feeling of dependency. The defense mechanism is displacement.

5.1.3.1 Sense of loss

Let us first look at residents' sense of loss as a possible trigger for RRA. Long term care facilities serve a vital component in the continuum of geriatric care. Yet, to enter such an institution, regardless of the needs it serves and the importance of the care it provides, many residents feel a sense of loss. Imagine condensing your life's possessions into one room. And that resident may be sharing that room with a person who is initially a stranger. Furthermore, this is for people who up until their nursing home admission, had been living on their own, making all their daily decisions and arranging their own affairs. Often, the residents have a sense of loss which can result in the feelings depression or anger or both. Some people react aggressively in response to this sense of loss when they are first admitted. Sarah H age 79 years old resented her family placing her in a nursing home. She stroke out at anyone who attempted to placate her.

5.1.3.2 Loss of independence

Not only do residents give up their homes upon entering a long-term care facility, they also must accept a level of dependency. In the United States, independence is a valued quality and highly prized. The American state of New Hampshire has as its motto, "Live free or Die". Iconoclastic figures; such as John Wayne in the movies displays a national pride in being and maintaining autonomy. Nursing homes by their very nature require a degree of

dependency. And as with the sense of loss, residents may rebel against curtailment of freedoms with belligerent behavior toward staff and other residents.

5.1.3.3 Displacement

Displacement is the classic psychological mechanism where one person (person A) is frustrated or angry at one individual (person B). But instead of telling B one's feelings, that individual transfers them to a third person (person C). The common example involves you being annoyed and irritated at your boss. However, you are not secure in your employment status; you dare not voice disapproval. Instead, you go home and yell at the family dog. The displacement means taking it from one object and putting on another. This displacement frequently happens when the object of anger is someone in authority ; .e.g. a police officer, physician or a teacher. Let us connect this to nursing homes . Staff do have authority over residents. And yes, on occasion staff can mistreat residents. (Natan, 2010). However, the resident is still dependent on that staff. For example, Sally K age 85 years old has just been refused a p.r.n.(as needed and asked for) medication for her headache by a nurse. She is very annoyed at the staff nurse but also likes her and does not want to be seen as a complainer. On the way back from the nursing station, after the nurse has been again told Her that she cannot have that medication, she kicks Heather T's wheelchair. This is a classic example of displacement resulting in a RRA incident.

5.1.4 Interpersonal interplays

Of all the thus far discussed causes, interpersonal relationships leading to a physical altercation is the easiest to comprehend and perhaps prevent. Nursing homes represent in the words of Goffman a total institution. (Goffman, 1961) That means residents sleep, play and work in the same place. Residents live there. Living together can promote great friendships and also create protracted conflicts. Their daily interactions can lead to antagonist relationships. Little idiosyncrasies over days and weeks can be wearing on others. For example, William T age 77 years old liked to command attention at meals and enjoyed 'guiding' the table conversations. Over time he became very annoyed with Victor L's age 81 years old cracking his knuckles at the table. At lunch one day William slapped Victor's hand. Staff quickly separated the two.

The same interpersonal bond or antagonism can develop between roommates. In this situation the interaction is much more intensified. Because of this roommate dynamic, their interaction is much more heightened and prolonged. It is not just sporadic or at meal times; it is all day and night. Again that type of sustained, seemingly relentless interaction can magnify differences and disputes. Most acts of RRA are either in the victim's room or in the hallway. (Shinoda-Tagawa et al 2004) The roommate interpersonal conflict may account for that observation of the resident's room as the site of RRA.

5.1.5 Biographical contributions

Residents' past life can finish clues as to their present behavior and potential for RRA. Although it may occur in many ways, let us focus on two particular life experiences: family dynamics and prior profession.

5.1.5.1 Family dynamics

5.1.5.1.1 Birth order

One's place in the family can often be viewed as determinant of certain life-long characteristics. (birth order, 2011) The only child may be self-centered and have difficulty sharing. The oldest child may become bossy and demanding. The middle child get lost in the family and the youngest is 'the baby' and feels inferior. Although these are stereotypes and there are many exceptions, others have found some validity to this concept. So certain residents may carry this birth order baggage into their new surroundings. For example, Paula P age 77 years old was the oldest of seven children. Since both her parents worked she was the 'family boss'. She was in charge when the parents were not around. She carried this mantle into her marriage and into all of her activities. In the nursing home she often told other residents what to do. One day pulled too hard on her roommate's blouse when her roommate refused to pick up some paper from the floor.

5.1.5.1.2 Nuclear family position

The nuclear family usually consists of the mother, the father and the children. If there is an extended family there can be also be grandparents and therefore grand children too. In some families these positions can carry certain roles and responsibilities. In the great musical *Fiddler on the Roof*, there is one song featuring ideas: "I'm the papa" and "I'm the mama". Some residents carry these roles in their long-term care environment. So as the father or the mother they excrete their roles on other residents and perhaps initiating an RRA incident.

5.1.5.2 Previous career

The potential for RRA can be found in the assaulter professional background. Certain jobs carry with them authority, power and prestige. It is often hard for those individuals to relinquish the controls built-in to their prior occupations. Although not limited to this list some of the jobs that come to mind include the following: physicians, people of the cloth, those in law enforcement, teachers, judges, top executives, military officers and lawyers. They were used to commanding immediate attention and people following their orders. In the setting of a nursing home those commands often go unheeded. One resident, a retired army general. George P age 77 years old even into his 'golden years' wanted everyone to call him the "the General" and if he could, he would love to have people salute him. One day another resident wanders into his path; he pushed him aside and announced "the General" coming through.

5.1.6 Medical problems

Medical problems especially those unrecognized by the resident and the staff can play a big part of RRA. Here is where the convergence of a cognitive deficient and a physical problem meet. Often, if the residents were unaware of the condition, they therefore cannot alert staff to the issue. An acute medical disorder such as a urinary tract infection (UTI) or even constipation can move that person to aggression. One resident with Alzheimer's developed pneumonia. Her response to lung insult was to hit another resident. Once her infection was treated with an antibiotic, she was no longer violent.

5.1.7 Pain

There is a close connection between the medical condition called pain and RRA. (Leone, 2009) As Leone and associates noted, "Many SNF [Skilled Nursing Facility] and NH [Nursing

Home] have not adopted a uniform plan to assess and treat pain for their residents despite published literature that demonstrates that the implementation of scales improves detection and treatment of pain.” (Leone, 2009, pp 67) The source of the pain could come after either an acute or chronic medical illness. Again, if the residents had full cognition often they would complain staff and hopefully get relief. Instead, aggression becomes the manifestation of that discomfort. Grammy Nancy J age 69 years old used to love to knit. As arthritis of her hands not only curtailed her knitting but also became a huge source of her pain. She liked to see herself as a bit of a stoic but when her pain flared so did her temper and she shoved her friend aside. Attention and proper treatment of residents’ pains can forestall aggression results. (Leone et al 2009)

5.1.8 Mental disorders

Many residents in nursing homes have mental illnesses and in some cases that disorder can contribute to RRA. There has been a general increase of residents with both mental illnesses and dementia in the last decade and especially those with depression. (Fullerton et al 2009) As in the area of a medical condition, treating the mental illness may decrease the RRA. These residents with mental illnesses can experience their symptoms heightened if they also have cognitive difficulties. For example, a resident with both an anxiety disorder such General Anxiety Disorder (GAD) and Alzheimer’s’ may experiences more episodes of uncontrollable fear , apprehension and terror than if that person only had dementia. Bagchi and associates have noted “The NNHS [National Nursing Home Survey], produced the most valid national-level estimates of residents with a mental illness--nearly 102,000 with a primary diagnosis in 2004 (6.8% of residents), of which about 23,000 were under age 65 and 79,000 were aged 65 and older.” (Bagchi et al, 2009 pp. 958)

Rather than review of all mental illnesses that residents may have, let us look at several serious and persistent mental disorders and show how each might contribute to RRA. These are Bipolar Disorder, Major Depression, Schizophrenia, Posttraumatic Stress Disorder (PTSD) and Generalized Anxiety Disorder (GAD).

5.1.8.1 Bipolar disorder

Bipolar Disorder also known as Manic-Depressive Disorder has as its dominant feature extreme mood swings over time from periods of severe, debilitating, profound depression and then times of super-energy, high productivity, distractibility, and not sleeping called mania. (DSM IV, 2000) The section on Major Depression will address the RRA aspects of the depressed phase; here the focus is on mania. It can be very destructive in terms of the resident’s behavior. The grandiosity of mania can involve delusions of elevated self worth and self-power. Some persons in manic phase have thoughts that they have great power and proclaimed to themselves to be a deities, presidents or kings or queens.. It is accompanied by agitated, sleeplessness and irritability. John H age 67 years old had a life-long history of Bipolar Disorder. When he stopped taking his mood stabilizing medication, in this case Lithium he would become high. As he mood increased so did he sense of his power and this was accompanied by demands of people literally bow down for him. When another resident refused this gesture, John struck him. Later after a brief psychiatric hospitalization, he returned to the nursing home on the proper dose of medication and apologized to the other resident.

5.1.8.2 Major depression

The **5.1.3 Intrapersonal dynamics** section looked at the sense of loss and loss of dependence as mental situations which cause the resident to feel sad. Here the focus is on a clinical depression. Depression is commonly encountered within the nursing home residents. (Fullerton et al 2009) Furthermore, the incidence of depression within the nursing home population has been increasing. (Lemke SP, Schaefer JA, 2010) A Major Depression is often similar in features to the depressed phase of the Bipolar Disorder. Both are characterized by loss of appetite, weight loss, sleep difficulty, thoughts of death, inability to function, suicidal ideation and loss of concentration. In the feelings of despair and futility they may strike at others residents. Again, the treatment of the depression with antidepressants can be decisive.

5.1.8.3 Schizophrenia

Like Bipolar Disorder, schizophrenia represents a life-long illness. It is marked by hallucinations and delusions. The hallucinations can include hearing voices. In certain cases the hallucinations can take the form of commands telling the resident to hurt themselves or others. Delusions are false beliefs often of the persecutory type such as that FBI or the KGB are after them. Hallucinations and delusions can lead to RRA. For example, Beatrice K age 77 years of age had a life-long history of schizophrenia and many psychiatric hospitalizations. When she was off her medications delusions of others plotting to harm her or take sexual advantage of her emerged. One night she thought her roommate was going to attack her so she slapped her and ran from the room. As a result of her attack, she was committed to local psychiatric unit. Once her anti-psychotic medication regime was reinstated, her delusions decreased.

5.1.8.4 Posttraumatic Stress Disorder (PTSD)

In PTSD the resident carries within one's self often for a lifetime the residue of a traumatic event. The incident could be a violent attack, a sexual assault as a child or as an adult, combat, the Holocaust, 9-11, an earthquake or a bad accident. The traumatic event could have been short lived or prolonged. The residents would have had experiences in which their lives were endangered. There are three major categories of symptoms: re-experiencing, avoidance and hyperarousal. (DSMIV 2009) Any one of these three types of reactions can result in RRA. In the first the resident relives often seeming in real time the dreadful episode. This vivid recollection is a flashback. Suddenly, they are re-experiencing it in the present moment. A loud noise might lead one to believe he is in combat again. Nightmares reflect a method of re-experiencing the traumatic event and can be very disturbing. In avoidance some residents will isolate themselves. With hyper vigilance the resident is always on heightened alert; they are perceiving danger at any time. For many veterans of Viet Nam the war still rages in the minds and when in a nursing home it can continue to play out there. For example, Al G age 65 years of old, a combat veteran of Southeast Asia, kept having flashbacks and nightmares. In one flashback triggered by a flash of lightning, he suddenly threw three other residents out of the way as he ran for cover.

5.1.8.5 Generalized Anxiety Disorder (GAD)

What is the difference between fear and anxiety? In fear you know the danger and have the sensations and emotions of arousal. In anxiety you are on edge and anxious without any identifiable source. This is very distressing. Residents with prolonged, protracted anxiety

find themselves literally grabbing on to other residents and clinging on to them. This might be perceived as the other resident as an assault.

5.1.9 Substance abuse

Substance abuse either in current usage or in the past occurs within the nursing home population and can result in RRA in several ways. According to an investigation of 368 residents in France long-term facilities, the researchers found “The study confirms that the prevalence of chronic at risk consumption is high in nursing homes” (Leurs et al, 2010, pp 280). The first way involves a long history alcohol use resulting in dementia. In turn, that dementia as outlined in the 5.1.1 Cognitive deficiencies can lead to RRA. A second mechanism usually occurs with newly admitted residents with unrecognized alcohol or other substance problems. In these instances the resident undergoes withdrawal. For some withdrawal can usher in combative behavior.

The third situation happens when the resident becomes acutely intoxicated with alcohol. On face value this seems unlikely. But it does occur. In one scenario the family may take the resident out for a celebration usually for a birthday. While away, the resident drinks too much and returns intoxicated. Another example happened with Bill W age 55 years of age. He had a history of drinking before entering the facility and had been admitted because of several severe medical problems. His room was on the first floor and the nursing home was located in moderate sized city. Not infrequently Bill would slip out of his room’s window and go to a nearby pub. On one of his forays into town he consumed more whiskey than his usual amount. He returned late at night drunk and belligerent. When his roommate attempted to comfort him, Bill pushed him over.

Each resident is unique; each nursing home is unique. However, the above review of causes of RRA provides a beginning to understanding the assaulter. It also offers clues as to prevention and intervention.

5.2 The three types of resident victims

5.2.1 The un-intentional victim

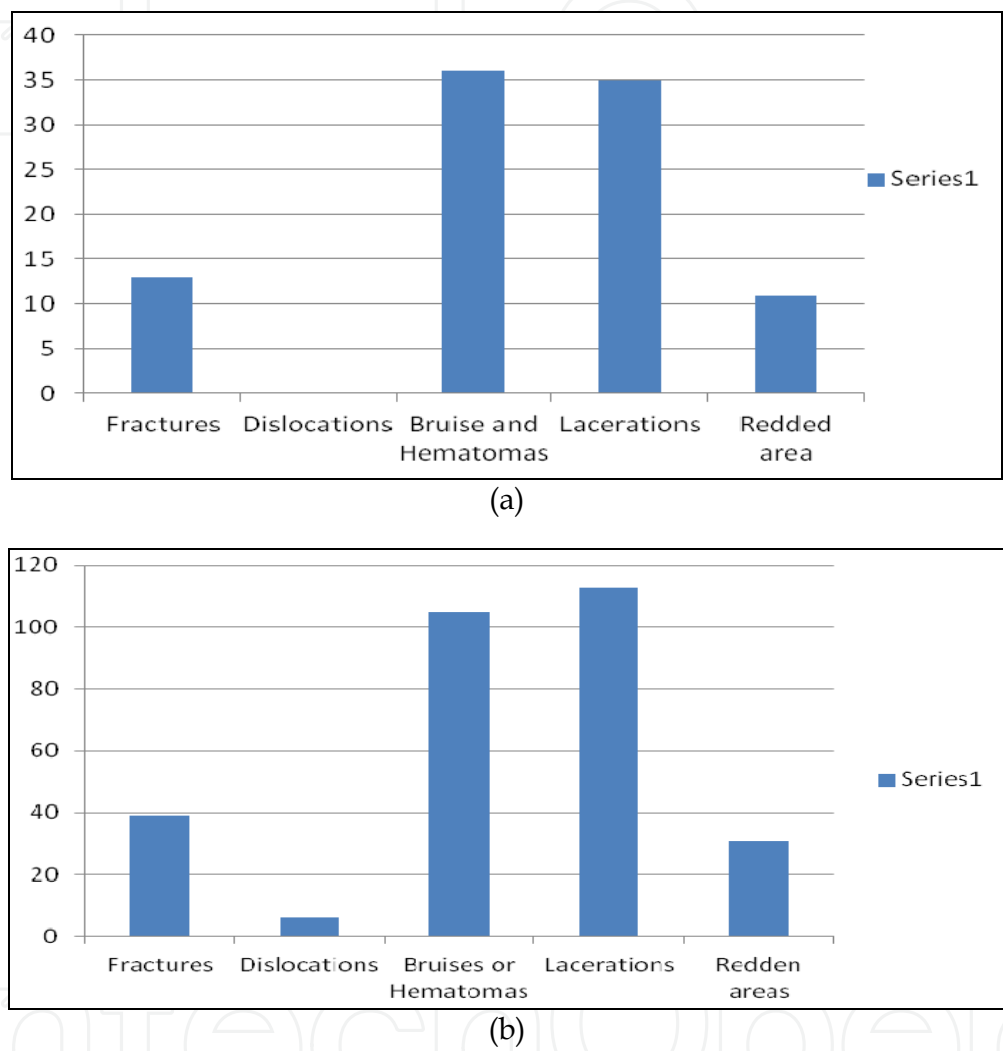
Often another resident unwittingly may become the object of an assault. This most frequently occurs when that other resident has dementia. (Shinoda-Tagawa et al 2004) Out of this cognitive deficient, that resident may unintentionally provoke another resident. This could happen if one resident wandered into another’s room. The assault may see that action as an invasion of one’s space and privacy and retaliate physically. Or that resident forgets one’s seat in the dining area and innocently antagonize another resident by taking the other’s chair as in the article’s initial scenario. The victim may simply wander into the path of an angry resident. It is not uncommon that two residents with dementia through mutual misunderstandings may precipitate a physical altercation.

5.2.2 The provoking victim

Then there are residents who deliberately antagonize others. Living together over a protracted time can lead to close and supportive relationships between residents or as in this case result in bitter feuds. Imagine two frustrated, annoyed, and disgusted residents arguing about some small item leading a physical fight.

5.2.3 The bystander victim

Finally, some residents are simply innocent by-standers. Sadly, this could be called ‘being in the wrong place at the wrong time’. A belligerent resident strikes out at any one whom he happens to pass in the hallway that day. Kevin J age 75 years of age was enraged at being ‘there’ in the nursing home. He hated the food and wanted to just go out and have beer. He charged down the too narrow corridor knocking over any staff and residents in his path.



Results During the first incident, 294 residents sustained fractures (n = 39), dislocations (n = 6), bruises or hematomas (n = 105), lacerations (n = 113), and reddened areas (n = 31). Graphs from data provided by Shinoda-Tagawa, T., Leonard, R., Pontikas, J., McDonough, JE., Allen, A., Dreyer, PI, *Resident-to-Resident Violent Incidents in Nursing Homes JAMA* 291:591-598. Feb. 2004.

Fig. 2. Resident-to-resident violent incidents in nursing homes: injuries to the victim: (a) by percentages, (b) by number of types of injuries to the resident victim.

5.3 The staff

Although not the focus of this chapter, staff can contribute to RRA in a number of ways. Insufficient numbers of clinical staff, in general and specifically nursing aides can result in residents’ needs not being fully attended to. As a consequence, a resident feels neglected.

(Sifford, 2011) In turn, the annoyed resident can displace one's frustration on another resident as outlined in 5.1.3. 3 Displacement. In some facilities, many of the staff have as their first language one that is different than the residents. This results in communication problems and agitation leading to RRA. For example, Sara B age 79 years old was in a long-term facility where many of the aides spoke primarily Spanish. She had cognitive impairment and her language was English. She told her family that she was in a Mexican hospital. Out of her miss perception and frustrations, she struck out at her roommate.

5.4 Environmental contributions

Lastly, the environment itself can contribute to the aggressive episode in several ways.

5.4.1 Too stimulating

The milieu may be too stimulating, confusing, and hectic. Crowdedness especially in certain areas such as the nursing station, dining room or day room can produce a noisy, disrupting and discomforting situation. These circumstances challenge residents especially if they have cognitive deficient. Certain television programs which are too loud and violent can be instigators as well as radio stations featuring music which appeals to a younger generation. The time of day can be a factor with early morning with the transition from sleep to activity being a particularly aggressive period in many facilities.

5.4.2 Architectural contribution

Aspects of the architecture have been implicated. Too narrow hallways, too little area around the nurses' station and too constrained access to the elevator can contribute to RRA. In one unit had many residents who needed wheel chairs. This resulted combative behavior at the bottleneck of all of them trying to get into one small elevator. Location can play a role in that many assaults occur either in the resident victim's room or in the hallway. Shinoda-Tagawa et al 2004) Therefore, rooms where staff cannot watch what is occurring can contribute to RRA.

In one long-term care facility housed a large number of veterans in wheel chairs. The building was old and had just one slow elevator. Most of the residents lived on the first floor; the majority of their daily activities e.g. meals, recreation, crafts rooms and day room were on the second floor. As a result of this architecture residents fought for their place on the elevator. Daily they would ram others in wheel chairs striving to gain access to the elevator. Both staff and residents were aware of the situation, but solutions to that problem eluded them. Finally, low lighting can be a factor. Decreased lighting such as in the winter months coupled with visual difficulty can lead to *sun-downing*, agitation because of decreased sun light.

6. Prevention

The best way to manage RRA is to prevent it. The key to prevention is to understand the causes of RRA and then address them. That is the reason for the detailed review of possible etiologies.

First, let us review some of specific causes and methods to approach them. This will be followed by some general ideas to decrease RRA.

6.1 Specific indications

6.1.1 For the assaulter

6.1.1.1 Cognitive deficiencies

Residents with cognitive deficiencies not only are clinically challenging but also require approaches geared to their issues. They need more supervision and monitoring than other residents. Staff should have training focused on their problems. Care plans should incorporate interventions tailored to that resident's uniqueness as well as dementia care issues in general.

6.1.1.2 Sense of loss

As the sense of loss can be underlying RRA, so then methods to provide a sense of gain should be initiated. If going to the nursing home represents a loss, then being there can offer an opportunity to have a sense of place and achievement. Individualizing the residents' rooms and tailoring activities can help. Provide residents with individualized activities and events such as a birthday party. Many residents overtime develop a sense of pride in their room and unit. Grammy Gail B age 87 years old welcomed visitors to her room. She had decorated it with pictures of her family and friends. She had her own sitting and entertaining area within it which she loved. Although protesting her family's decision to 'institutionalize' her, eventually she has come to see that facility and especially her room as her 'home'.

6.1.1.3 Loss of independence

Many residents see themselves as trapped and 'jailed' in a nursing home. They feel robbed of their autonomy. Perhaps, as they see it there is some reality to that perception. However, the more choices residents have the more they can feel in command of their lives. Whenever possible, the more decisions they can make, the better they may feel about their lives. Areas where they can make determinations include in their meals, daily schedule, activities, entertainment and visitors.

6.1.1.4 Address medical problems

A medical problem can be behind a RRA. Here early detection and treatment represent the keys to solving those issues. Regular medical, dental and podiatrist evaluations help. Charting of vital signs can offer clues in changes in their physical status. Once identified, medical issues must be addressed. Medical problems which cause discomfort and pain are the subject of the next prevention section.

6.1.1.5 Recognize and manage pain

Pain constitutes one of the cardinal determinants of RRA. Many authors have commented on this. "It was found that if the origin of violent actions was the residents' pain, it was possible to minimize it through nursing activities." (Enmarker et al, 2011, pp. 153) Using a system of charting pain can be very useful. Asking and then recording the residents' pain levels not only focuses staff attention to pain but also allows one to see its direction overtime. Many nursing homes use pain charts with illustrations or a series of faces smiling ☺ to

frowning ☹ for residents to identify their pain level. This is especially effective if the resident has cognitive deficits. By staff taking the initiative and asking residents about their pain level, the residents with dementia can have their discomfort recognized and treated.

6.1.1.6 Treat mental illness

Mental illness must be detected and treated. One of the great achievements of modern psychiatry has been its ability to provide treatment to patients with mental disorders. Psychiatry has ushered in an era of psychopharmacology. Historically, patients with mental illness were placed in large institutions with little hope of relief of their symptoms. Now there are specific medications for specific diagnoses. For residents with Major Depression, antidepressants are effective. Those residents with Bipolar Disorder, mood stabilizers such as Lithium have proved quite useful. For residents with schizophrenia a number of anti-psychotic medications that has proven valuable. Mental illnesses such a Bipolar Disorder and Schizophrenia are severe and persistent illnesses. (Soreff, 1996) They are life-long and therefore, they go with the resident into the nursing home . But they can and should be treated throughout the persons' life including in the long-term care facilities.

6.2 The victims

There are a number of ways to prevent other residents from being victims of an aggressive resident depending on the type of victim: un-intentional, provoking and bystander. In the first instance, the un-intended victim, the resident with cognitive deficits may wanders into the path of aggressive resident. The key here is to prevent that resident from being in the area of the assaulter. With the provoking resident, separation of the two antagonists remains the best way to avoid an altercation leading to RRA event. In the bystander situation, good practice involves keeping other residents away from an assaulting resident.

6.3 The staff

Staff and staffing remains the key ingredient in prevention. This means insuring an adjacent number of trained staff for the number of residents. Furthermore, administrators must develop and deploy nurse education programs on how to deal with residents with dementia. (Narevic et al 2011; Williams et al 2005) The formula is simple: the more the combative your resident population, the more personnel you need. But it not just numbers alone. Those doing direct care must be trained in understanding and dealing with resident aggression. (Soreff & Siddle, 2003)

6.4 Environment

Two facets of the environment prove key to decreasing RRA. The first is creating a comforting and safe milieu. The second encompasses architectural elements.

6.4.1 The milieu

The goal remains to create and maintain a not too stimulating, comforting and safe milieu. This can be accomplished in a number of ways. As noted deploy staff in appropriate numbers who have training to work with residents with dementia and deal with aggressive residents. Then control the noise in the building, the corridors and the day room. Make sure

there is a system to monitor the television programming and the TV's volume. As will be discussed under general aspects, have ample recreational activities.

6.4.2 Architecture

Building design and unit arrangements can decrease RRA. As Shinoda-Tagawa and his colleagues have pointed out the resident victim's room was the site of the assault. Therefore, the residents' rooms if possible should be visible from the nursing station. (Shinoda-Tagawa et al 2004) Ideally, there would be a central nurse station from which all residents' rooms could be observed. Rooms farthest from that station stand at higher risk for incidents to occur. Additionally, attention must be paid to the roommate selection process.

The more lighting means less aggression. Dark areas and 'sunning downing' can promote aggression. One nursing home each day as evening comes on, simultaneously increase the hallway and day room lights. Eliminate congested areas at the nursing station and the elevator entrances. This can be done by limiting the number of residents served per station; e.g. 24 residents for each station can decrease the number of residents seeking help at that station. Since many of the assaulting residents have impulse control problems, having two elevators per unit minimizes the residents' waiting time. The two elevators were particularly effective when there were many residents in wheel chairs. Wide corridors promote easy passage through the unit and can decrease residents bumping into each other.

6.5 Documentation for prevention

As will be discussed in 10.0 Documentation, using the unit records of RRA can actually be used to decrease violence. By tracking aggressive episodes the facility can have a better idea of times and areas where the assaults occur. For example, if there are many incidents on weekends or on a certain unit, then they can deploy more staff then and there.

6.6 General approaches

Two general approaches to nursing home care can serve to decrease RRA and increase residents' satisfaction, improve their quality of life, promote their autonomy and challenge their sense of loss. The first are individualized treatment plans. The second is activity therapy.

6.6.1 Individualized therapy

"The optimal management of aggressive and violent actions from residents with dementia living in nursing homes was a person-centered approach to the resident." (Enmarker et al, 2011, pp. 153) Each resident must have a detailed and specific treatment plan. Each resident is unique and that plan must reflect that person's individual characteristics. This is where information about the resident's family, birth order, profession, interests, hobbies and fears can be compiled. The more the care is tailored to the individual resident, the better the care and the less the RRA.

6.6.2 Activity therapy

"Activities that decrease the amount of violent behavior'." (Enmarker et al, 2011, pp. 153) Certain programs can help prevent aggressive episodes. Having residents engaged in

unit activities and physical activities not only benefits the participants but also can remove the residents from a situation which an assault might have occurred. Through these activities the residents can regain their sense of independence and become creative. In one facility the activities were based in part on the residents' interests and hobbies. Life-long hobbies could finally be achieved.

Here is an example of a creative activity which decreased RRA. One unit developed an activity group for those residents who had gastronomy tubes and therefore they could not eat in the conventional way. For them, not being able to eat and having to mix with eating residents during meal times was stressful. Certain of these residents had been known to be disruptive when they saw other residents enjoying breakfast, lunch or supper. By those with gastronomies having their own group activity away from the dining area at meal times, the members felt less stressed and more satisfied and their number of RRA episodes decreased.

7. Interventions

The focus of these interventions is those conducted by staff within the facility. In some incidences police are involved. (Lachs et al, 2007) The intervention is two phased based upon whether the resident-to-resident violence is about occur or if it is actually in progress. The former is an extension of the prevention process while the latter involves halting the assault.

7.1 RRA is imminent

There are a number of de-escalation techniques which can often avert a pending resident-to-resident attack. These include redirection and fib-lets. A comprehensive knowledge of the residents proves invaluable. Here is another example of a prevention when RRA is imminent. In the situation of the provoking victim, if staff recognizes that two particularly antagonistic residents are about to be alone in the day room, they can act to separate them before there is an altercations.

7.1.1 Redirection

One key approach involves the redirection of the threatening resident. This technique can be especially effective if the resident has dementia. Molly S age 77 years old was getting herself very distraught over the way others with were behaving in the day room. She demanded that they all watch one particular television show. The other residents preferred a different program already in progress. A nurse's aide observing this build up of Molly emotions quietly went to her side and asked if she would like a cup of tea. Molly agreed and they went off together and the crisis was averted. Molly S through re-direction of her attention was diverted from the television show.

7.1.2 Fib-lets

Another method is the use of fib-lets or little white lies. This is designed for residents with dementia. By staff acknowledging the reality of the resident's perception, they can often calm one of them down. (Soreff 2003) In one nursing home, many of the residents used to work in a local mill. Their lives revolved around that factory's schedule. One resident Betsy

G age 87 year old had moderate cognitive impairment. She insisted every day at 4 PM she had to get the bus home to take care of her children. When staff had pointed out to her that she was not a worker anymore and that her children were adults, Betsy would hear none of it. She insisted that she must get the bus at 4 PM. Ultimately, they staff came up with an idea, they contact a local bus company and obtained a Bus Stop sign. They placed it next to a bench in the corridor. At 4 PM when Betsy clamored that she must get to the bus, a nurse's aide walked her over to the 'bus stop'. Within a few minutes Betsy had forgotten about getting home and moved on to another activity.

7.2 During RRA episode

Once a violent episode erupts swift, focused, decisive and firm intervention is required. This means immediately separating the two residents and moving all other residents from the area. Securing physical distance between the two residents is the top priority. Yet at the same time all other residents must be removed for the combat zone. The intervention must be a well orchestrated and coordinated team effort. Having many staff available and working in a directed, coordinated fashion can bring the combative behavior to a prompt conclusion. The assaulting resident must be removed from the area but also not be left alone.

The initial scenario illustrates many of these points. Bob "Bull" Jones, age 79 strolls into the dining area and is about to sit in his usual seat. However, Dan Walker age 85 with moderate dementia of the Alzheimer Type is already at the table in Bob's chair. Dan yells "I was here first". Bob shoves him hard and says, "It's my chair". Staff quickly separates the two and each will have his meal in his room. Most of the other residents in the dinning are upset; some leave; others eat less than they would have had the incident not occurred; and still seem obvious to the event. Staff will have a mountain of reports to file and many family members to contact.

That scenario highlights many of the major aspects of intervention: swiftness and decisiveness. For the intervention, there must be staff training, preparation drills, and team work. During the eruption there were many tasks which had to be done: separation of two residents, moving other residents out of the way, and protecting visitors.

Immediately after the RRA has been handled, staff must physically assess both the victim and the assaulter and treat any medical problems. .

8. After the intervention

After a RRA event things hopefully return to normal in the facility. However, it has been the author's experience that several meetings should be held afterwards. One should be with the assaulting resident; one with the victim; one for all the other residents; one with the assaulter's family; one with the victim's family and finally one for the staff.

8.1 The assaulter

This meeting with the resident initiating the violence is most effective if the assaulter is cognitively competent. If the resident has dementia, this may not be too productive. It does give that resident an opportunity to talk about the event and in some cases actually leads to

an apology. Minnie L age 90 years old has severe and painful arthritis. One afternoon when her joint pain was particularly severe she weakly slapped her roommate Mary M. The staff immediately separated the two. When Minnie met with the social worker, she was mortified by her own behavior and then apologized to the staff member and her roommate.

8.2 The victim

After the RRA event, staff should meet with the victim. Again this is best when the resident is cognitively aware. This gives the resident an opportunity express one's feelings about the attack.

8.3 The family of the attacker

It is important that staff notify and meet with the initiating resident's family. In some cases where transfer is appropriate, the family will want to know the reason. The family or guardian of the resident will then hear about the event from the staff rather than from other sources. In some cases the meeting may prompt that family to provide useful care information which could help prevent another of the episode. Neil G age 86 years old became agitated while watching a documentary on World War II and shoved his nursing home friend. Later when staff met with his family, his son mentioned his father's south Pacific combat experiences. This information helped staff to better care for Neil and to pay attention to the television programs he might watch.

8.4 The victim's family

Again it is important that staff inform the family before they hear it from other sources. All too often a family member coming on a regular visit could be shocked to hear for the first time that the loved one had been attacked. This also gives staff an opportunity to tell the family steps taken to insure their loved one's safety.

8.5 Meeting with other residents

Residents having witnessed the attack may feel threatened and not safe. Again this type of meeting is particularly relevant when most of the resident are cognitively aware. The meeting allows to residents to voice their concerns and gives staff an opportunity to assure them of their safety.

8.6 Staff meeting

Finally, there should be a staff meeting to review the entire episode which will serve many purposes. The tone of the meeting should be assuring, educational, healing rather than punitive and fault finding. It gives staff a chance to express their feelings about attack. Furthermore, staff often can be discouraged by working a stressful combative environment. They had sought employment to help people not to be 'policemen'. It offers an opportunity to learn from the RRA episode. What did they do right? And in what areas could they improve their response? It also provides the nursing home leadership an opportunity to be supportive of their staff.

9. Documentation

Documentation plays an important role in RRA as both a record of the intervention and as for prevention. In both cases those documents become critical in risk management and for accreditation.

9.1 Recording the intervention

Each RRA event must be documented. It should be recorded in the assaulter's and the victim's charts. Those charts are one of the key places to best document care issues. However, in those charts, only identify the resident whose chart you are writing in. Therefore, in the victim's chart, do not identify by name or medical record number the assaulter. And in the attacker's chart, do not identify the victim. Document the event without specifically identifying of the other party. This fulfills the HIPAA, the United States' Health Information Privacy requirement. *"Minimum Necessary. A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request".* (Health Information Privacy, 2011) However, in the incident report, record both parties and the events completely. The incident report if done thoroughly and competently can be very effective as a risk management document.

9.2 Prevention

Documentation can be used in RRA prevention in several ways.

Documentation prevention involves the use of a Preadmission Behavioral Review. This form consists of a list of the behavioral concerns for a new admission. It offers staff insights into residents who are about to be joining their unit. This is particularly useful since the entrance for the new resident to any unit can be both stressful to the unit and the resident. One specific interesting aspect of this form has been the place for staff to initial that they have read it. Staff by initialing the form, helps to assure effective transmission resident care information. This form provides an excellent place to put in information about the resident's life such as birth order and profession.

A companion piece to the Preadmission Behavioral Review is the Individual Treatment Plan. This form not only outlines specific behavior concerns but also should contain information about emergency management techniques if the resident becomes aggressive. Here again the Treatment Plan offers an excellent place for information about the resident's life such as birth order and profession.

There is one other useful way to record RRA events. This is one master list of all RRA incidents in the facility by time and place. By documenting each RRA event, clinical staff and administration have an important method to track and see patterns of resident aggression. If they identify certain times and units of high RRA events, they use that information to deploy staff to forestall violence episodes.

10. Conclusion the impact of RRA

The impact of resident-to-resident violence is both profound and pervasive. It affects both the actual residents involved, their families, the witnessing residents, the clinical staff and

the administration. RRA plays a significant role in the quality of life in the nursing home. Incidents of RRA can lead to residents feeling unsafe and anxious. It can result increased staff turn-over.

There are a number of identifiable causes of RRA. An appreciation of the roots of residents' aggression can lead to ways of preventing RRA. RRA must be dealt with swiftly and decisively. And after the RRA episode, it must be reviewed. Finally, each RRA event must be thoroughly documented.

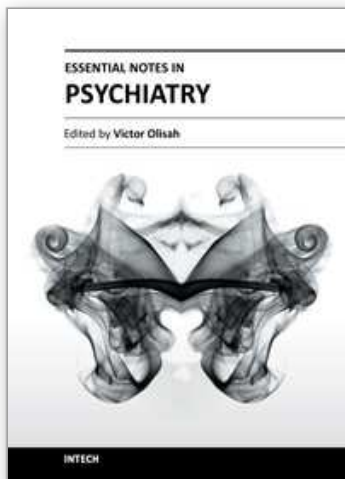
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