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Editorial

Deaths as a Result of Resident-to-Resident Altercations in Dementia in Long-Term Care Homes: A Need for Research, Policy, and Prevention

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"This is a matter of serious concern. It happens very often and will be fatal."— Resident in early-stage Alzheimer disease

"He is going to kill someone one day."— Certified Nursing Assistant

"I am just afraid that he will hurt someone when we don't see it…especially someone frail whom he can take down with one blow."— Certified Nursing Assistant

"I want to know that someone will be there for me if something happens to me."— Resident in mid-stage Alzheimer disease

The preceding quotations are from a study by the author of this editorial.[1]

A growing number of studies in the past decade examined the public health problem of resident-to-resident altercations (RRA) in long-term care (LTC) homes.[1–14] These studies identified key characteristics/typologies and causes and triggers of this form of behavioral expression as well as staff-reported strategies to address it. One groundbreaking study examined physical injuries due to episodes of RRA.[4] The vast majority of these studies have been conducted in nursing homes, whereas 2 studies were conducted in assisted living residences, 1 among cognitively intact residents[15] and 1 among older residents with dementia.[1]

The prevalence of episodes of RRA has recently been identified in a rigorous study among 2011 residents (average age 84 years) in 10 nursing homes.[16] Two other encouraging developments pertaining to this underrecognized behavioral phenomenon include the development and evaluation of the first instrument for measuring episodes of RRA[17] and the first staff training program in recognition and prevention of these behaviors (this training program demonstrated fivefold increase in staff recognition of these episodes after the training).[18]

In addition, at least 3 reviews of the literature have been recently published on RRA in LTC homes.[19–21] Furthermore, the first Blog dedicated to prevention of episodes of RRA in dementia was launched in April 2012 and consists of hundreds of free resources on this form of behavior.[22]

One of the major gaps in research on episodes of RRA in dementia in LTC homes is the fact that virtually no studies examined deaths as the primary outcome of these episodes as well as the circumstances surrounding these fatal episodes. One study examined 1296 deaths due to external causes in nursing homes in Victoria, Australia (deaths reported to the Coroners Court). The study found that 7 (0.5%) of these deaths were due to episodes of RRA.[23] The actual proportion of deaths due to episodes of RRA is likely higher given the fact that a substantial number of these fatal episodes are not reported to coroners.[24]

Judy Berry, founder and former CEO of Lakeview Ranch Minnesota, currently president of Dementia Specialist Consulting, asserts,

> "I know from being a provider for 16 years that many providers would never admit to a death that might be eventually attributed to severe understaffing. Most of these kinds of deaths are truly preventable with appropriate staff-resident ratios and ongoing staff training and support. Higher ratios of appropriately trained staff are critical to proactive care management and prevention of these types of incidents! I just wish more places would be willing to make the commitment to change from barely getting by to the staff ratios necessary for prevention! Although it raises upfront cost initially, it lowers long-term costs, significantly, in the long haul, by specifically cutting the huge costs of staff burnout, which leads to excessive turnover and in addition contributes to an overwhelming reduction in liability. This is truly what is needed to prevent resident-to-resident aggression!" (J. Berry, personal communication, August 30, 2015).

The possibility that deaths due to episodes of RRA in dementia are underreported is consistent with the underreporting of verbal, physical, and sexual RRA episodes. As stated by Professor Jeanne Teresi et al,[18] "It is most likely that at the present time the majority of resident-to-resident mistreatment incidents are not reported in most nursing homes."

The cumulative effects of a series of persisting barriers contribute to the lack of research on deaths due to RRA in dementia. Selected examples of these barriers are described in Table 1.

In light of the paucity of research studies on deaths due to episodes of RRA in dementia, I conducted a review of 40 deaths reported in the general media that occurred as a result of such episodes (ie, episodes in which at least one of the residents involved, the exhibitor or the target, had been reported to have dementia or cognitive impairment). This comprehensive Internet search was conducted during September 2015, building on 3.5 years of ongoing collection of these episodes on

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Table 1
Barriers for Research on Deaths due to RRAs in Dementia

The strong disincentive of LTC homes to report on episodes of RRAs (ie, care providers' concerns for liability and damage for reputation).
Staff reluctance/fear of reporting, which could negatively reflect on their job performance (ie, their duty to protect residents from injury/harm) or end up in disciplinary action against them.
Staff are often understaffed and completing behavioral expressions logs or incident reports can be difficult given their heavy workloads and lack of adequate training in filling out these reports.
The normalization of behavioral expressions in older residents with dementia as reflected in and shaped by commonly used labels such as "aggressive" "violent" and "abusive (e.g., the perceptions by which these behaviors are inevitable part of dementia, represent an expected and natural part of the job of caring for people with dementia, that not much can be done to prevent them, and that older adults with dementia are physically incapable of injuring each other).
Lack of clinically useful instruments for measuring RRA (except for the recently published Resident-to-Resident Elder Mistreatment Instrument[17]).
Memory loss of residents with dementia may limit their ability to report reliably on episodes they were involved in or witnessed. Certain target residents who are cognitively capable of reporting may avoid doing so due to fear of reprisals, and certain exhibiting residents may be unreliable reporters due to guilt, embarrassment, or fear of punishment.
Substantial portion of episodes of RRA are not witnessed by staff.[25,26]
Only a small proportion of these deaths are being examined by coroners/medical examiners.
Significant number of death certificates do not explicitly acknowledge episodes of RRA as contributing factors or direct causes of deaths.
A relatively small number of fatal RRA episodes end up in lawsuits, convictions, inquests, or make their way to the general media.
Lack of effective collaboration and timely information transfer between external agencies (eg, law enforcement, medical emergency personnel, Ombudsman, state regulatory agencies, adult protective services, coroners/medical examiners, hospitals) related to serious episodes of RRA.
The MDS 3.0 (Behavior E Section) does not differentiate the targets of aggressive behaviors (ie, whether the behaviors are directed toward staff or other residents).[27]
A significant number of falls in LTC homes take place during altercations between residents[28] ("push-fall" episodes) but it is not uncommon for these episodes to be reported merely as falls without explicitly attributing these to the altercations.
The tragic episode that led to severe injuries and subsequent death of 76 year old Dwayne E. Walls, a Korean War Veteran with Alzheimer's disease, is an example of this problem.[29]

my archival blog[22] (since April 2012). All the information identified and reported in Table 2 is based on publicly available sources (primarily newspaper articles). For a large number of episodes, a few articles had to be consulted and cross-checked to gather as much detail as possible detail about them.

The 40 episodes took place between 1994 and 2015 in these locations: Canada (20), United States (18) (Tennessee [3], New York [2], Massachusetts [2], New Jersey [2], Connecticut [1], Minnesota [1], South Carolina [1], Illinois [1], Indiana [1], California [1]; Pennsylvania [1]; Wisconsin [1], Colorado [1]), Ireland (1), and New Zealand (1).

The report is intended to raise awareness to injurious and fatal episodes of RRA in dementia in LTC homes among the following stakeholders: cognitively able residents, family members, care staff members, interdisciplinary teams, physicians, administrators, care advocates, Ombudsman, care providers' associations, the Alzheimer's Association, Adult Protective Services, law enforcement agencies, medical emergency personnel, coroners/medical examiners, regulatory agencies, policy makers, and legislators.

Discussion

This editorial represents a small first step toward bridging the major gap in understanding the circumstances surrounding fatal RRA in dementia in LTC homes. It reveals serious problems related to staff ability to supervise residents effectively and keep them safe. For example, most of the reviewed episodes were not witnessed by staff (70%; 19 of 27) and took place inside bedrooms (68%). The findings add to a previous pilot study using video cameras 24/7 in the public spaces of a dementia care home showing that nearly 40% of episodes of physical RRA were not witnessed by staff.[25,26]

In addition, more than one-third of the episodes (37%) were between roommates, which may indicate serious problems in roommates' assignment and/or ongoing monitoring. This finding supports recent culture change practices and enlightened models of care (eg, Green Houses of the Eden Alternative; English Rose Suites) committed to provision of private bedrooms as the standard of care. In the words of Professor Mark Lachs, "If every resident had their own room, you'd probably see 50% reduction in resident-to-resident elder mistreatment."[30]

Furthermore, most episodes (for which there was a report on the time of the episode) took place during the evening/late evening hours (81%; 13 of 16 episodes; 2 other episodes took place during the night), whereas close to two-thirds of the episodes (62%; 18 of 29) took place on weekends. These 2 latter findings may suggest vulnerability periods requiring enhanced clinical attention and allocation of care resources (such as staffing and activity programming). The finding in which 7 of the residents engaged in the altercations (17%) were newly admitted residents may suggest a need for improved preadmission behavioral assessment procedures and enhanced supervision of residents exhibiting aggressive behaviors in the weeks and months after admission. Support for this possibility was received in a study in 3 LTC homes among 339 residents showing that during the 3 months after admission, 79 (23%) of the residents were documented to be involved in an aggressive incident toward another resident (incidents causing physical injury or psychological or emotional harm in which a resident was made fearful). Residents involved in an aggressive incident were more likely to have a diagnosis of dementia than residents not involved in incidents.[11]

The findings reported in this editorial must be interpreted with caution given the inherent limitations posed by varying quality and level of detail about the episodes as reported in the newspaper articles used for the review. In addition, the small number of episodes reported in this editorial should not be considered representative of the full spectrum of fatal RRA episodes in dementia. The preliminary findings cannot be generalized to all long-term care homes. There is a need for research in view of the lack of datasets and research studies on fatal episodes of RRA in LTC homes.

Directions for Future Research

1. Conduct *analyses and integration of existing datasets* on injurious and fatal episodes of RRA in LTC homes (eg, nursing homes and assisted living residences) *to identify prevalence, characteristics, causes, risk factors, and protective factors.* Data sources may include Centers for Medicare and Medicaid Services data, Nursing Home Compare and Nursing Home Inspect (ProPublica), state inspection reports, Ombudsman data, APS (Adult Protective Services) (in states in which APS has authority to investigate these episodes), Medicaid Fraud Control Units, death certificates, coroners/medical examiners, hospitals, and police reports.
2. Encourage the *US Inspector General* and states' Inspector Generals to conduct examination of serious episodes of RRA in LTC homes (at the very least, episodes leading to falls, injuries, and deaths).
3. Develop, test, and add questions to the *Minimum Data Set 3.0* that will enable the distinction to be made between aggressive behaviors directed toward staff versus other residents.[27]
4. Examine the scope of *fatal episodes caused by falls* during altercations between residents (eg, "push-fall episodes"). One