LIABILITY
landscape

BY LINDA WILLIAMS, RN

When residents attack residents

Most nursing homes and assisted living facilities (ALFs) have measures in place to prevent resident abuse by staff. But what happens when another resident *causes* the abuse?

According to data collected by the Centers for Medicare & Medicaid Services (CMS), approximately 88,000 nursing home residents in the United States have exhibited aggressive behavior in the week prior to their assessment with the Minimum Data Set (MDS). Last spring, the *Journal of the American Medical Association* published a shocking study that found more than 1,000 Massachusetts nursing home residents are attacked by other residents each year.

Assisted living facilities (ALFs) may face similar problems. Preliminary research suggests that as many as one in five ALF residents with dementia is physically violent each year, reports an official from the Massachusetts Alzheimer's Association. The state's health department reported two recent instances of ALF residents suffering dementia who died from injuries resulting from alleged attacks by other residents.

A confused resident with violent tendencies creates a liability exposure for healthcare providers in every state, not just Massachusetts. In addition to the mental anguish experienced by residents, families, and healthcare staff, the courts can be quite harsh on facilities in ruling that they are derelict in their duty to provide a safe environment for residents. The following is a summary of such a case.

The Situation

When the doors opened at a newly built ALF, a wealthy 78-year-old woman became the first resident in its Alzheimer's unit. During the admission process, while the nurse attempted to take her blood pressure reading, the woman suddenly hit her and began swearing. As the day continued, the staff discovered that the woman could be very loving and nice one minute, and then become violently aggressive toward others the next, for no apparent reason. During the following months, as other vulnerable and confused residents were admitted to the Alzheimer's unit, the woman's aggressive behaviors began to affect them. Staff had to intervene on several occasions when the woman would take other residents' food and drinks during meals or wander in and out of their rooms uninvited. She developed a habit of roaming the halls, at times yelling and striking at other residents as they passed. During these episodes, the woman would often lose her balance and fall, never injuring herself seriously. Staff members were directed to constantly monitor the woman and administer a dose of Ativan when her aggressive behaviors escalated.

Three months after this woman's admission, a 90-year-old woman was admitted to the same unit. The new resident was mildly confused but able to ambulate independently, and she was cordial with staff and other residents. One day, as the new resident was walking down the hall, a personal care attendant (PCA) noticed that she was not using her walker and was instead holding on to the wall for support. The PCA promptly went to the new resident's room to retrieve her walker. When she returned to the hallway, she saw the new resident on the floor and the 78-year-old woman standing near her. The new resident was crying out in pain and told the PCA that the woman had pushed her down. (This incident happened early in the morning when there wasn't yet a nurse on duty.) The PCA assisted the new resident to her bed until she felt better, and then helped transfer her to a wheelchair and took her to breakfast.

However, the new resident was unable to eat and complained of pain in her left leg. She was brought back to her bed. When a nurse arrived on duty almost two hours later, she examined the resident. She determined that the resident had good range of motion in her left leg, but noted that she winced with movement. An hour later, the nurse reexamined the resident and noticed that her left leg was shorter than the right and the toes on her left foot were pointed outward. The nurse notified the resident's son, and a family member transferred her to the hospital within the hour.

Two days later, the resident underwent left hip replacement surgery, but tragically had to remain on a life-support system following surgery. She died the following day, with cause of death listed as a stroke.

Meanwhile and thereafter, the 78-year old woman's aggressive behavior and instability continued to escalate until a decision was made to send her to a geriatric-psychiatric unit at the local hospital for evaluation. During this visit, the physician discontinued her use of Ativan and instead ordered Risperdol to control her behaviors. A month later, the woman returned to the original Alzheimer's unit, where she continued to be combative with staff. Plans were initiated to transfer her to a local nursing home as soon as a bed was available.

Two years after the incident, a lawsuit was filed by the deceased resident's family members against the ALF, alleging the wrongful death of their mother. They stated that the aggressive resident's behavior and tendencies were common knowledge to the staff and that the facility had failed to protect their mother from harm. Their initial demand was for $2.2 million, but they settled two years later for $500,000.

Risk-Management Practices

Whether you are an employee of a licensed nursing home or of an ALF, you can minimize the risks of resident aggression, particularly in an Alzheimer's care setting, by implementing the following risk-management practices:

1. Establish a clear, person-centered philosophy for the type of care that your facility is able to provide, and focus all interventions, interactions, and programming around it.

2. Identify the resident acuity level for which your facility can safely provide care and services. Set admission criteria and policies that enable staff to address behaviors.

3. If possible, have a nurse and social worker each personally assess all potential residents in their existing home environments. Each professional will see things uniquely but both should assess for odors, safety interventions by the family, the potential resident's anxiety level and orientation within a familiar setting (it will be much worse in a new setting), etc. They should ask for any history and physical information for facility staff to review prior to admission.

4. Require a new physical examination before admission, and ask the physician to declare the appropriate level of care for the resident. If the resident is on the border between two levels, first offer admission to the higher level of care. Then if the resident makes the adjustment/transition, reevaluate him/her for a lesser level. Be consistent, and accept only those individuals whose needs can be met by your staff.

5. Establish a monitoring system to determine if a resident no longer qualifies for the level of care and services that your facility is able to provide. From the start, have a plan in place to move him/her to a higher level of care if needed. Admissions personnel should clearly explain to the resident and responsible party the facility's admission criteria, monitoring system, and potential transfer plan.

6. Educate the resident and responsible party about diagnosed disease processes and what to expect when transitioning to a new environment.

7. Provide interdisciplinary training to staff to equip them to work with individuals with dementia. Make sure staff understands the following:

- What dementia is and how it affects individual functions and behaviors;
- How to effectively approach residents with dementia and use calming communication techniques (such as validation therapy, distraction, redirection, etc.);
- How to provide cognitive assistance with daily activities (such as breaking large tasks down into small manageable steps, etc.);
- How to keep the residents' environment as simple as possible (void of clutter, distracting mirrors, etc.), and promote lots of easy-to-negotiate redundancy;
- How to identify and manage resident pain and other stressors; and
- How to employ techniques to manage difficult behaviors and know how to avoid situations that trigger these behaviors.

8. Assess each resident's ability and develop a plan of care that will meet his/her needs, and communicate the resident's personalized care plan to the resident, responsible parties, and staff. Review the plan routinely and record any changes in behavior or condition that require modification of the plan.

9. Assess and modify the resident's environment to eliminate potential stressors (particularly extremes such as bright/dim lighting, loud noise, warm/cold temperatures, etc.).

10. Ensure that programming and activities meet the needs and current abilities of each resident. Provide a wide range of purposeful activities (such as providing towels to fold or socks to match, etc.).

11. Report acute changes in behaviors possibly signifying a medical problem immediately to the resident's physician and arrange for the resident to be seen as soon as possible. Also, obtain orders for lab work (including urinalysis) that can be performed within the facility.

12. Develop a system to monitor difficult behaviors and keep open lines of communication with the responsible parties, physicians, and interdisciplinary staff.

13. Deploy sufficient staff on each shift to meet the needs of residents and ensure that the staff assigned on all shifts has knowledge of the resident's care needs. In particular, anticipate sundowning problems and provide increased staffing during these peak times as needed.

14. Thoroughly investigate all abuse allegations immediately. Report outcomes of the investigation to responsible parties, physicians, and state agencies, as required.

Difficult resident behavior can dramatically impact the quality of life and safety of both residents and caregivers. Protect your residents and staff by making proactive and effective risk-management changes in your facility. It is crucial that your facility be able to manage these behaviors and not accept residents for whom this might be problematic. Contact your state's Alzheimer's Association for additional information about what your facility can do with its current capabilities to manage this issue. ■

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