Resident to Resident Aggression in Residential Care in B.C.

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Background

- Increased public awareness of resident to resident aggression (RRA) incidents for seniors in care
- In 2013, regulations were changed to enable capture of these types of incidents
- This is the first systemic review of incidents looking for patterns or predictors

Objectives of Review

To examine incidents of aggression between residents that resulted in harm to one or both of the residents

To look at the facilities where incidents are occurring, as well as the circumstances of the incidents themselves

To identify where, or if, specific systemic patterns emerge when looking at incidents

Challenges in Conducting the Review

- Residential care governed by 2 separate regulatory frameworks – *Hospital Act* (HA) and *Community Care and Assisted Living Act* (CCALA)
- 204 facilities under CCALA, 100 under HA (includes both owned and operated and private)
- CCALA sites report their incidents to Licensing Office and it is mandatory
- *Hospital Act* sites report through different streams depending on Health Authority, including the Patient Safety and Learning System

Definitions Differ

- Under CCALA:
  - **Aggression between persons in care** that results in injury requiring first aid, emergency treatment, or hospitalization
- Under *Hospital Act:*
  - **Serious adverse event that l**eads to **severe harm** or the death of a resident
  - Severe harm is an injury that:
    - Causes permanent or long-term changes to a person's quality of life and functioning
    - Causes pain, requires major medical intervention, or leads to a shortened life expectancy
- Under PSLS:
  - Incidents resulting in minor, moderate, or severe harm; or death

Incidents Examined

- RRA incidents between April 1, 2014 and March 31, 2015
  - Analysis of incidents by facility characteristics
    - 331 reported incidents (excluding PSLS incidents)
    - 58% of facilities reported no incidents
  - Analysis of individual incident reports
    - 422 incidents including PSLS incidents
    - Anonymized data – not tied to individual facilities

Characteristics of People in Care

Less than 4% of BC seniors live in residential care
4% over 65 / 15% over 85

	Seniors in Residential Care
Over 85 years of age	56%
Female	65%
Diagnosis of Alzheimer's or other dementia	61%
Diagnosis of psychiatric condition or mood disorder	30%
Moderate to severe cognitive/memory impairment	62%
Combination of complex conditions indicating high or very high need for facility level care	82%
Exhibits aggressive behaviour	33%
Received 9 or more different medications in the last 7 days	51%

Source: CIHI RAI MDS-2.0 Assessment

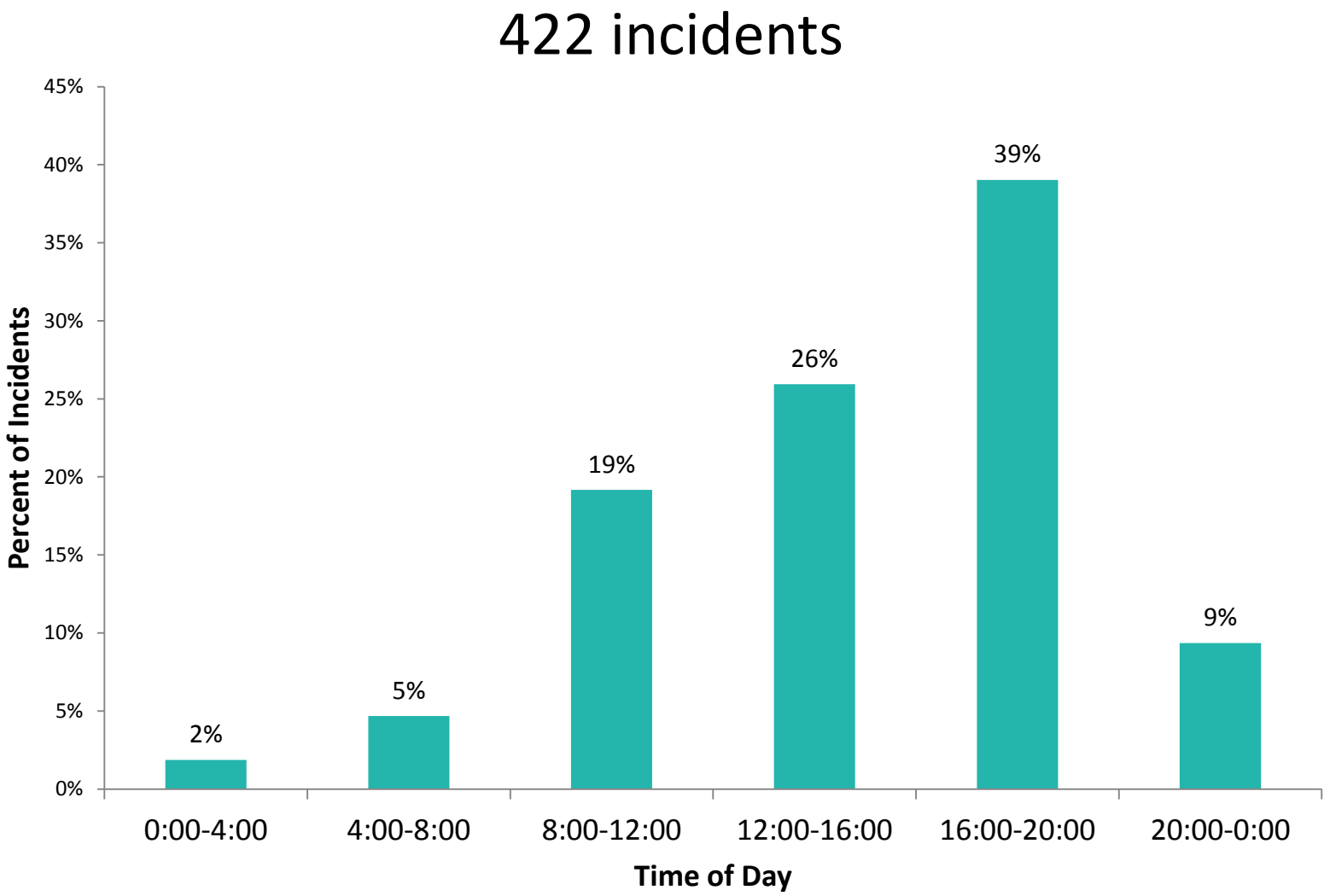
Facility-level Findings

331 incidents

Facilities with reports of RRA incidents tended to have resident populations with:

- More psychiatric diagnoses and more diagnosed aggression problems
- Higher instances of physical and verbal abuse
- Higher rates of anti-psychotic use
- Higher mobility
- Higher rates of independent walking

Individual Incidents – Time of Day



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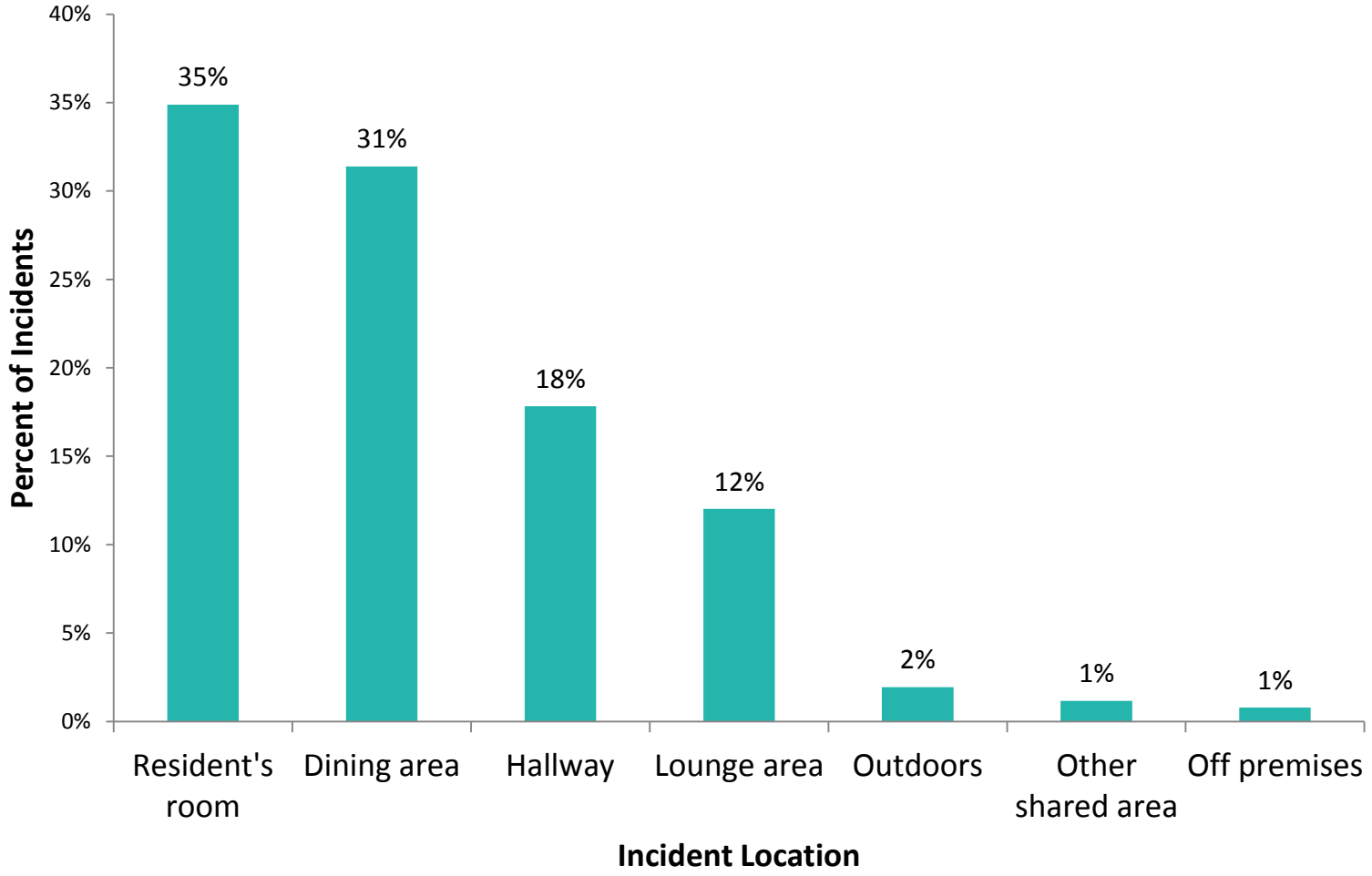
Facility-level Findings

Incidents and Direct Care Hours

- Facilities with incidents tended to have residents with more complex care needs while having slightly fewer direct care hours (3.08) than those with no incidents (3.13)
- While this is equivalent to only three minutes per resident per day, in an 80 bed facility, this represents a deficit of four hours of direct care (182 fewer eight hour shifts per year)
- May suggest that facilities where residents have more complex care needs (and more incidents) are not getting enough care hours to adequately handle the complexity of their residents

Location of Incidents



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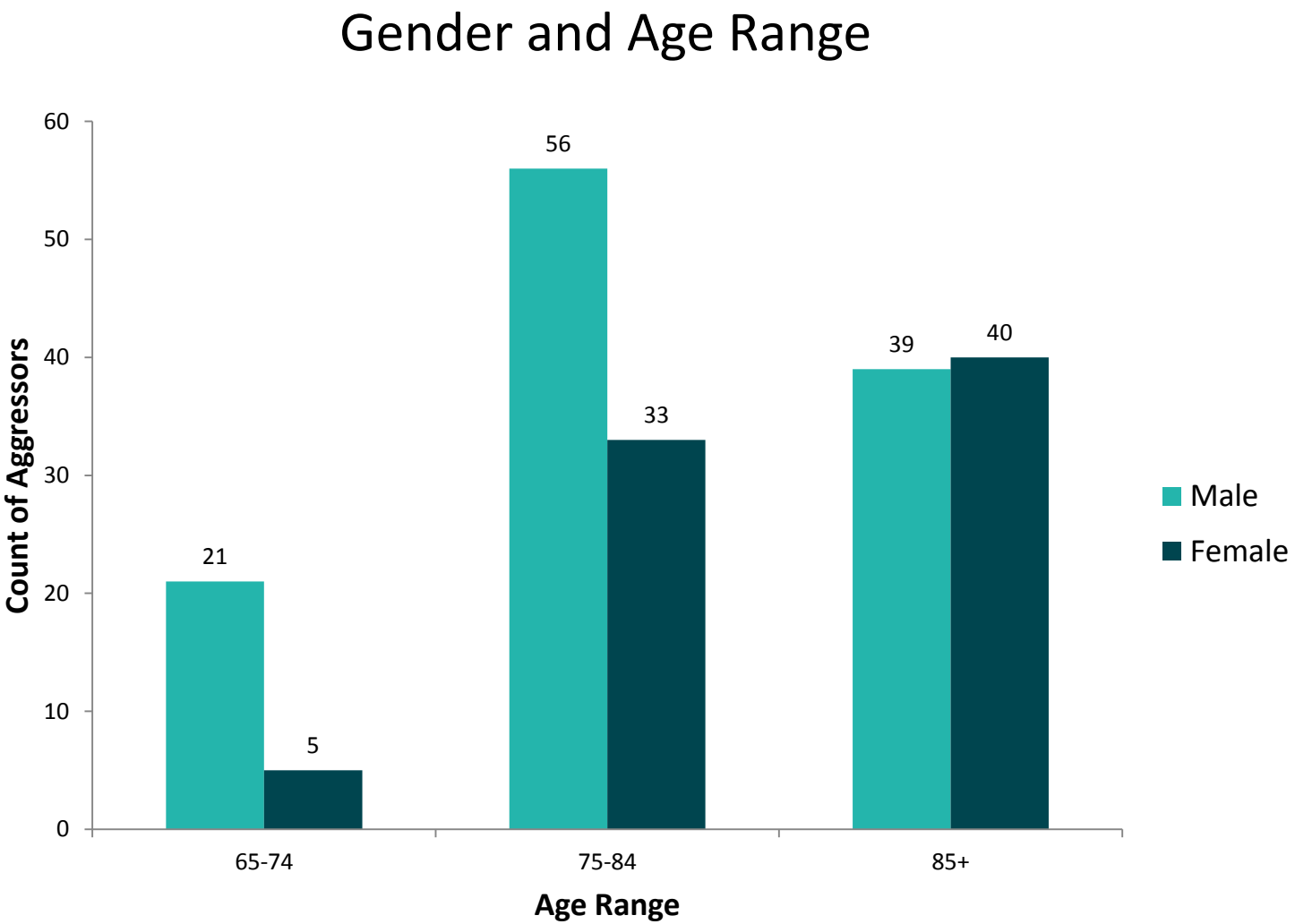
Characteristics of Aggressors



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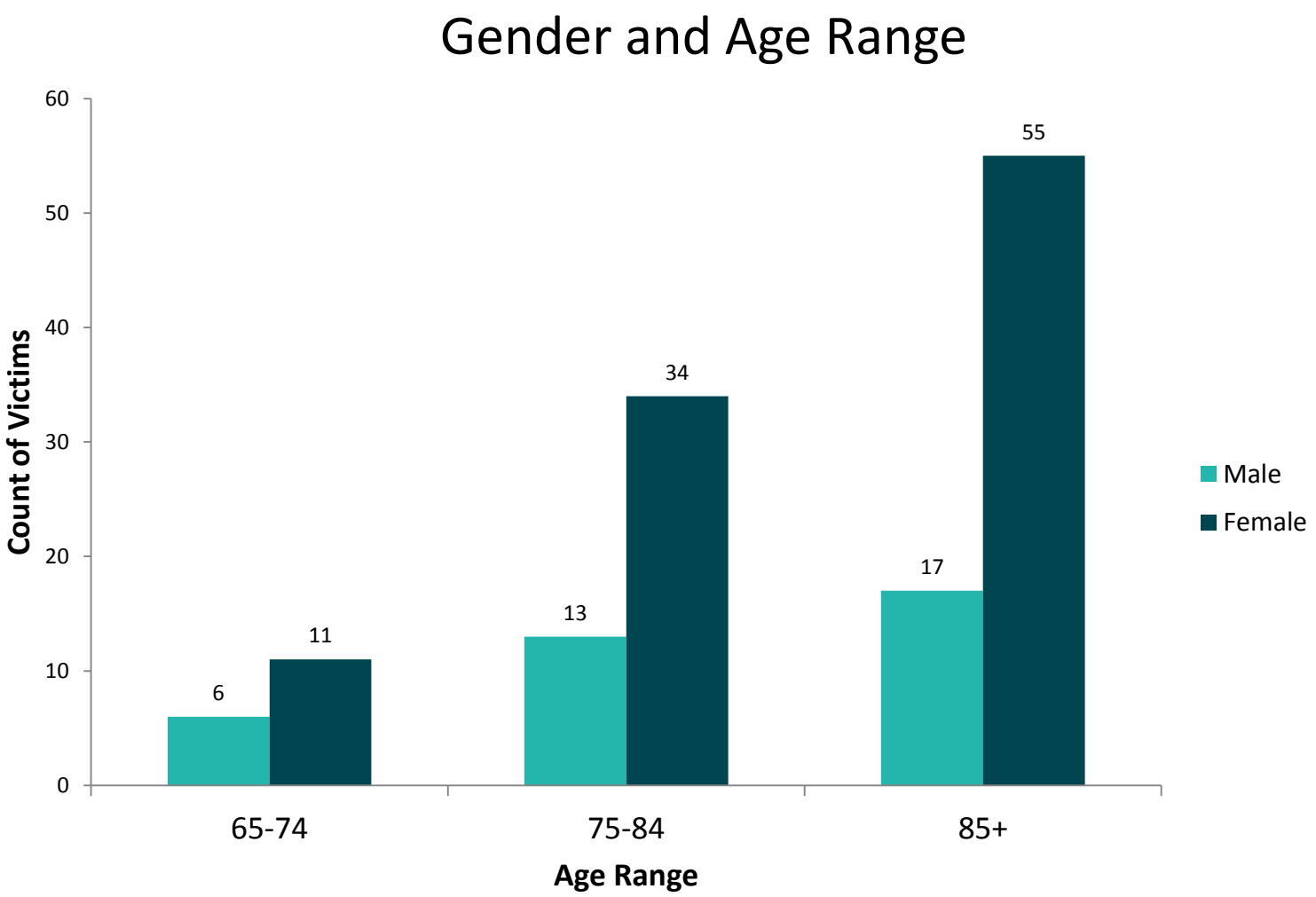
Characteristics of Victims



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Mitigation Strategies

The majority of facilities have put in place strategies to reduce aggressive behaviours and wandering

- Secure units and alarm systems
- Technology to monitor resident movements
- Secured indoor/outdoor walking circuits
- Low stimulant rooms
- P.I.E.C.E.S Training (for dementia)

Recommendations from Study

- The OSA recommends the implementation of:
  - A consistent definition of RRA incidents across Health Authorities
  - Province-wide processes to track both RRA incidents and their follow up
  - A review of the adequacy of staffing for residents with more complex needs, specifically during busy times like dinner hours
    - Ministry of Health called for a review of care hours in April 2016
  - More education for staff and management to ensure that staff report and address RRA incidents comprehensively
  - Facility design features that are known to be effective in mitigating aggressive behaviours including the use of locking systems for private rooms to mitigate wandering behaviours

Thanks and Acknowledgement

- Special thanks to:
  - Health Authorities
  - PSLS Team
  - Residential care facilities that took the time to respond to our survey
  - Ministry of Health staff

Questions?

Questions and suggestions on further analysis are welcome

Contact

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