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Managing resident to resident elder mistreatment (R-REM) in nursing homes: the SEARCH approach

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Abstract

This article describes an educational program to inform nursing and care staff in the management of resident-to-resident elder mistreatment (R-REM) in nursing homes, using the SEARCH approach. Although relatively little research has been conducted on this form of abuse, there is mounting interest in R-REM, as such aggression has been found to be extensive and can have both physical and psychological consequences for residents and staff. The aim of the SEARCH approach is to support staff in the identification and recognition of R-REM, and suggesting recommendations for management. The education program and the SEARCH approach are described. Three case studies from the research project are presented, illustrating how the SEARCH approach can be used by nurses and care staff to manage R-REM in nursing homes. Resident- and staff safety and well-being can be enhanced by the use of the evidence-based SEARCH approach.

INTRODUCTION

The aim of this paper is to describe an educational program to inform nursing and care staff in the management of resident-to-resident elder mistreatment (R-REM). The program: Support, Evaluate, Act, Report, Care plan, and Help to avoid (SEARCH) was conceived as part of a larger research effort aimed at developing a training program for R-REM (Teresi et al., 2013b).

Background to the development of the educational program on R-REM

There is a growing literature related to the mistreatment of older community-residents by family and paid caregivers (Daly, 2011; Lachs & Pillemer, 2004a). There is also a small body of literature on the mistreatment of elderly residents by staff of nursing homes (Cohen,

Halevy-Levin, Gagin, Priltuzky, & Friedman, 2010; Payne & Cikovic, 1994; Pillemer & Moore, 1989), and on aggressive behaviors experienced by family members and paid caregivers at the hands of older people with dementia (Finkel, Costa de Silva, Cohen, Miller, & Sartorius, 1997; Lachs et al., 2012).

Relatively little research has been conducted on a potentially prevalent form of abuse: resident-to-resident elder mistreatment (R-REM) in nursing homes. However, there is mounting interest in R-REM, as indicated by a number of recent articles (Castle, 2012; Lachs et al., 2012; Pillemer et al., 2011; Ramirez et al., 2013; Rosen et al., 2008; Shinoda-Tagawa, Leonard, Pontikas, McDonough, Allen, & Dreyer, 2004; Teresi et al., 2013a, Teresi et al., 2013b). Such aggression has been found to be extensive (Pillemer et al., 2011; Shinoda-Tagawa et al., 2004) and can have both physical and psychological consequences for residents and staff (Cohen – Mansfield, Marx and Rosenthal, 1989; Rosen et al., 2008).

Prevalence of R-REM

A prevalence rate of approximately 2–10% has been estimated in community surveys of elder abuse, depending on the type and definition of abuse, and on varying methodological approaches (Lachs & Pillemer, 2004b). There have been no epidemiological studies of R-REM, so its prevalence has not been established. However, evidence from supporting literature suggests that R-REM may be common in nursing homes (Castle, Ferguson-Rome, &Teresi, in press). A study of resident-to-resident violent behaviors in one nursing home conducted over a one year period found 294 cases of resident-to-resident abuse; lacerations, bruises and fractures were the common associated injuries (Shinoda-Tagawa et al., 2004). Castle (2012) conducted a survey with nurse aides from 249 nursing homes in ten states in the USA. He found extensive reports of R-REM, including verbal, physical, material, psychological and sexual abuses; the most common forms were verbal and physical. In a qualitative study, Pillemer and colleagues (2011) developed a typology of R-REM with the categories “invasion of privacy or personal integrity”, ”roommate issues”, “intentional verbal aggression”, “unprovoked actions” and “inappropriate sexual behavior”.

Indirect evidence supporting the argument that R-REM is a widespread problem in nursing homes comes from studies of: (a) dementia care, specifically behavioral disturbances, which include verbal and physical aggression, (b) elder abuse from relatives and staff and, (c) violence from residents towards nursing home staff. Several studies have identified and documented disruptive behaviors among individuals in congregate settings and among those with cognitive impairment (Burgio et al., 2002; Cohen-Mansfield, Marx, & Rosenthal, 1989). One study of 1152 residents (Teresi, Morris, Mattis, & Reisberg, 2000) found a prevalence of concomitant cognitive impairment as high as 90%. Another found that ‘co-mingling’ of residents with and without dementia resulted in those residents without dementia expressing dissatisfaction with their living arrangements due to agitated behaviors and noise caused by residents with dementia (Teresi, Holmes, & Monaco, 1993). Some investigators (Burgio et al., 1994) have examined actions of staff that are likely to produce residents’ aggressive or agitated behaviours, e.g., disruptive vocalizations, which can be a stimulus to commit R-REM.

Violence from residents towards staff has been identified in several studies. Pillemer and Moore (1989) identified that over three-quarters of nursing home staff reported resident aggression in the previous year. In more recent studies, Astrom et al. (2002), and Mandiracioglu and Cam (2006) found that 40% and 56% of the direct care staff, respectively, had been exposed to physical violence from residents during a care episode in the past twelve months. The latest study (Lachs et al., 2012) showed that 16% of residents engaged in abusive behaviors toward staff in a two-week period. Two indirectly related publications identified racial conflict in the form of name calling from a predominately white nursing home population, particularly those with dementia, directed toward ethnically diverse staff (Ramirez, Teresi, Holmes, & Fairchild, 1998), and documented the emotional impact on staff (Ramírez, Teresi, & Holmes, 2006). Similarly, a study from the extensive literature on staff turnover and burnout highlights physical and verbal assault from residents and other staff as one of the contributing factors to such outcomes (Evers, Tomic, Browuers, 2002).

Risk factors for R-REM

The study by Shinoda-Tagawa et al. (2004) focuses on victims of R-REM; they found that this group was more likely to be male, with cognitive impairment, moderate functional dependency and behavioral disturbances, in particular wandering. The community-based elder abuse literature identifies the profile of perpetrators as individuals with problems themselves, such as alcoholism, psychiatric illness and substance abuse (Muehbauer & Crane, 2006; Ramsey-Klawsnik, 2000; Selwood & Cooper, 2009). It is through indirect literature that a picture emerges of the resident perpetrators of R-REM. Because many people with psychiatric illnesses now live in nursing homes, this can be one of the risk factors for R-REM.

The literature on agitated behaviors of residents in nursing homes highlights an important situation that can lead to R-REM in susceptible residents. Behavioral disturbances that occur with residents with dementia (Cohen-Mansfield & Libin, 2005; Lachs, Williams, O'Brien, Hurst, & Horwitz, 1996) can be exacerbated by environmental changes and acute illness (Boockvaar & Lachs (2003), resulting in R-REM. Research on the actions of staff that may cause aggressive behaviors by residents (Burgio et al., 1994) could provide needed insights into the behaviors of both staff and residents that might contribute to resident-to-resident abuse. The results of another indirect study in a psychiatric facility found that the crowded environment was correlated with violent episodes (Nijman & Rector, 1999). This situation could be applied to the nursing home setting where older people who may have lived alone for many years are exposed to interactions among many individuals, both residents and staff in crowded spaces. Any hostile and aggressive interactions can create an environment where all participants are at increased risk of being an abuse victim (Akerstrom, 2002). Cognitive impairment of both victim and perpetrator has been identified as an important potential risk factor for R-REM in long term care. Given that Lachs et al., (1996) found a fivefold risk of abuse among community residing victims as their cognitive impairment worsened; arguably, in nursing homes, where the prevalence of dementia is high and residents with dementia are often congregated together, the opportunity arises for residents to be both victims and perpetrators of R-REM. Another potential precipitant for which there is no evidence extant

is the comingling of individuals with a previous psychiatric history who may bring with them to the nursing home associated psychiatric behaviors.

Consequences of R-REM

The outcomes of R-REM range from injuries such as falls, fractures, lacerations, abrasion and cuts to depression, anxiety, functional decline and decreased quality of life. It is likely that minor injuries in marginally compensated older people may result in greater physical and psychological distress than in younger people. In a recent incident witnessed by one author (JE), eight residents with different levels of cognitive decline were participating in a group activity. A man and a woman started to verbally abuse each other and a third resident (with dementia) stood up and walked away. The distress experienced by the resident resulting from the incident was evident as JE walked along with her and she stated that she did not like to be near such behavior.

Although there is no epidemiological evidence regarding the incidence of resident-to-resident elder mistreatment in nursing homes, there is adequate indirect evidence that this problem is a serious issue for residents living in nursing homes and for staff management. Consequently, the education program using the SEARCH approach to R-REM management represents the potential for improvement in the quality of long-term care.

Staff education as an intervention for aggression management

Non-pharmacologic approaches to address disruptive behaviours in older adults with dementia have been documented, including behavioural interventions (Cohen Mansfield, 2004). The antecedents, behaviours and consequences (ABC) approach has been identified as a practical applied framework for the development of appropriate interventions for disruptive behaviours (Cohen-Mansfield, 2000; Douglas, James, & Ballard, 2004; Teri, Huda, Gibbons, Young, & van Leynseele, 2005). This method supports the behavioural mapping technique, i.e., describing the behaviour(s) (including the existing environmental factors) in a specific measurable way, in order to establish the etiology of the behaviour(s) and its ramifications. Appropriate interventions can then be developed, taking into account the detailed assessment of the behaviour(s), as well as the individual's preferences. Some of these approaches and techniques have been integrated into staff education programs (Teresi, Abrams, Holmes, Ramírez, Shapiro, & Eimicke, 2002).

Several studies in the nursing literature evaluate the impact of education programs addressing aggressive behaviours in nursing homes. Generally, the focus has been on resident to staff aggression (Chrzescijanski, Moyle, & Creedy, 2007; Gates, Fitzwater, & Succop, 2005; Hagen & Sayers, 1995; Maxfield, Lewis, & Cannon, 1996; Mentes & Ferrano, 1989; Narevic, Giles, Rajadhyax, Managuelod, Monis, & Diamond, 2011), although in one study (Pillemer & Hudson, 1993), both resident to staff and staff to resident aggression were examined. All studies used a pre-post-test design, and timeframe for the documentation of incidents of aggression were varied: they ranged from: 8 days (Hagen & Sayers, 1995), 2 weeks (Gates, Fitzwater & Succop, 2005), one month (Pillemer & Hudson, 1993; Maxfield, Lewis, & Cannon, 1996), and three months (Mentes & Ferrano, 1989; Narevic, Giles, Rajadhyax, Managuelod, Monis, & Diamond, 2011). In the study by

Chrzescijanski, Moyle, & Creedy (2007) data were collected for 14 days, and aggressive behaviours documented hourly on non-consecutive days. The education programs consisted of information for staff on how to develop skills to prevent and manage aggressive behaviours.

Overall, there was a decrease in the number of aggressive incidents. For example, Mentes & Ferrano (1989) identified a slight decrease in the number of aggressive incidents; Pillemer & Hudson (1993) reported that conflict items were significantly lower on the post test. There were lower numbers of acts of resident aggression towards staff, and staff abuse towards residents also declined. There was a decrease of 50% in incidents of aggressive behaviours following one education program (Hagen & Sayers, 1995), and a decrease of 77% in another study (Narevic, Giles, Rajadhyax, Managuelod, Monis, & Diamond, 2011). Aggressive incidents decreased from 41 before the training to 19 following the training in the study conducted by Maxfield, Lewis, & Cannon (1996). Although Chrzescijanski, Moyle, & Creedy (2007) identified a drop in the number of aggressive behaviours following an education program, the difference was not statistically significant; and Gates, Fitzwater, & Succop (2005) found that their education program of 9 one-hour sessions had no significant effect on the number of assaults that occurred.

As documented by these studies, it is possible to reduce resident aggression toward staff. However, to our knowledge, no evidence-based training programs for resident-to resident aggression, besides ours, have been developed and evaluated.

THE RESIDENT-TO-RESIDENT EDUCATIONAL PROGRAM

The educational program consists of three modules designed to be conducted in three sessions. Module 1 consists of (1) types of R-REM, (2) risk factors for R-REM, (3) the extent and prevalence of the problem and (4) the consequences of R-REM. In the second module, the SEARCH approach to the management of R-REM is introduced and supported by a 25 minute video that highlights three types of R-REM: physical assault, verbal assault and psychological abuse. Experts from four perspectives: psycho-social, medical, nursing and administrative/legal discuss how to manage incidents of R-REM in the nursing home setting and these are then summarized by the presenter of the video. Module 3 provides instructions and guidelines for staff on how to use the resident-to-resident elder mistreatment behavior recognition and documentation sheets (R-REM-BRDS). The BRDS are forms designed as prescription pads to be carried in the pockets of nursing staff used to capture real time R-REM events that occur during practice. For a more detailed description of the educational program, see Teresi et al. (2013b). The current paper focuses on one aspect of the training program: the SEARCH intervention. The aim of this program is to decrease the incidence of R-REM by supporting staff in their identification and recognition of this problem, and suggesting recommendations for management.

THE SEARCH APPROACH TO MANAGING R-REM

The SEARCH approach (Support, Evaluate, Act, Report, Care plan & Help to avoid) to the management of R-REM provides clear guidelines for nurses and care staff (certified nursing

assistants –CNAs) on how to react to and manage and prevent R-REM in long term care settings (See Table 1). The steps are as follows:

Support all residents involved in the incident. This support will depend on the type of abuse and the outcomes of the abuse. Physical injuries take precedence and must be attended to immediately. For example, a bleeding wound should have pressure applied to stop the blood flow, and a resident who has fallen onto the floor should be checked for signs of head injuries or fractures. Depending on the type of injury it may not be advisable to move the person. If the person is able to move, and the event occurs in a common area, it may be advisable to move the person to a quiet, unoccupied space. Head injuries must be taken seriously. Even a seemingly small injury could result in an aneurism. Thus, a resident with a head injury should be monitored after the incident. Both the victim and the perpetrator may be physically injured, so both would need to be checked for physical injuries. In addition to supporting the physical injuries, all residents involved in the incident may need psychological support. This can be provided by listening to each resident's interpretation of the events, without blame or condemnation. The victim may be very distressed by what has occurred and the support should include allowing the residents to discuss how they feel. The perpetrator may also be distressed and may require psychological support. Validate the resident's perceptions of a situation: "*You have just told me that you are feeling… In these circumstances, I can see why you feel this way*". In the case of a cognitively impaired person, it is not constructive to say "*you did a bad thing*". However, it is important to negatively reinforce the behavior. For example, "*I know you don't always get along with ____, but it is better to talk or move away than hit*". In some cases it is not possible to reason with a person because of more severe cognitive behavior. In that case non-verbal support may be best. Provide support for all residents involved in and/or who have witnessed an event because violence can be upsetting for others as well.

Evaluate the situation and the environment to identify those who were directly or indirectly involved in the incident as well as risk factors or precipitating events. The initial evaluation is to identify what immediate actions are required: residents may need to be separated or an injured resident may need immediate assessment of injuries. There may need to be an evaluation of the behaviors of both the victim and the perpetrator. Potential precipitating factors at the individual level such as pain or physical discomfort should be considered. In evaluating the situation and the environment, it is important to identify aspects that can be changed. For example, the layout of rooms may provide little space for residents to move about freely, particularly residents with walkers and wheelchairs. Seating arrangements at meal times are another modifiable environmental intervention; residents who are known to argue should not be seated in close proximity to each other. Evaluate also the impact of the incident on other residents who may be in close proximity, but not necessarily involved in the incident.

Act immediately. The actions taken will depend on the type of incident and the environment where the incident occurred. If the incident is occurring, then the first act would be to verbally attempt to stop the incident; however, conflicts must be confronted constructively. This can be achieved by using non-threatening body language, using physical gestures carefully and a calm, firm tone of voice to separate the residents involved in the incident.

The next act would be to physically separate the residents involved, and assess the residents for physical harm and call for other staff to help. Medical help would then be sought as indicated. After the residents are no longer in any physical or medical danger, the next act would be to discuss with the residents involved what had occurred and why. At this stage it is important to act in a manner that is conveying concern and empathy with appropriate facial expression and language. Do not use patronizing or humiliating confrontational language and avoid placing blame. Do not display a strong emotional reaction of shock, disgust or embarrassment and do not tell residents that they are wrong to behave or feel the way they do or trivialize a resident's problems, worries or concerns. This set of behaviors on the part of staff indicates that the incident has been taken seriously. However, do not assume the crisis has passed and always be on the alert for early signs of impending aggression. In the case of missing personal items, assure the resident that in order to locate them, a room-by- room search will be conducted. Ensure this happens promptly.

Report all incidents of R-REM and document the incidents, depending on the protocols of each nursing home. There are many incidents of R-REM that are currently not reported. In the study conducted by Teresi et al. (2013b), many incidents (discussed in the next section) were ignored by the staff. Very few incidents reported independently by staff or observed by research assistants to occur in the presence of staff were documented in the medical records. In fact, even incidents involving physical altercations were not recorded in either incident/ accident reports or the medical record. The reporting of incidents must be encouraged by all levels of management. A negative response to a staff member reporting an incident of R-REM is likely to discourage staff from reporting these incidents further. It is only through reporting and documenting of incidents that a process of discussion of appropriate strategies and relevant issues can occur. It is through such discussions that appropriate interventions can be implemented and documented in the Nursing Care Plans.

Care plans are to be used to document interventions or strategies that can be used to attempt to manage the incidents of R-REM; to avoid or minimize incidents of R-REM and to ensure the safety of all residents. An interdisciplinary team approach to care planning is advisable in order to meet the physical, emotional and psychological needs of the victim and/ or perpetrator. An assessment of all incidents of R-REM should occur so that clear, specific documented interventions are available for all staff to implement; in this way a consistent approach will be used and has greater chance of success.

Help to avoid incidents of R-REM is the role of all staff, who need to be actively involved in the discussion and development of management strategies, and care plan. (See Table 1 for examples.) Many incidents of R-REM involve either verbal abuse between residents or rough physical actions between residents, such as pushing and hitting or knocking into residents with walkers or wheel chairs. Consequently, an acute awareness of the physical environment and the interactions between residents is important for all care staff. Management should ensure that there are adequate staff numbers in congregate settings, reinforce resident safety as a nursing home priority, and take inventories of personal belongings. Care staff must avoid crowding people and their equipment into small spaces; recognize risk factors for R-REM e.g., wandering, memory disorders, noisy and/or threatening behaviors and separate residents who are known to have negative interactions

with one another. They should also be responsible to remind residents and staff that residents with dementia are often unaware that their behavior may be disturbing to others. Additionally, identifying residents who have a history of aggression is extremely important.

Example of the SEARCH approach

Incidents reported by any of the study sources, i.e., residents, staff, and/or research observers were investigated and reconstructed retrospectively as case studies, in a narrative style. In order to create these narratives, the victim(s), the perpetrator(s) and the care staff present were interviewed. Medical records were reviewed for medications, and for other relevant health and mental health information. Any previous documentation of incidents of abuse were searched and recorded as part of the background information in case reconstructions. These incidents occurred and were documented by the research assistant (RA) before the SEARCH education program was implemented.

Case Study One – Mary

During a three week period when one RA observer was stationed in a corner of the lounge room, she identified five separate incidents involving Mary. Mary has dementia, is confined to a wheelchair, and suffers physical pain from a wound on her back, which causes her to scream out ‘ow! ow!”. On several occasions there were verbal altercations between Mary and other female residents who tell her to “shut-up”; these responses led to Mary responding in an abusive manner. One incident involved wheeling herself very close to where a resident was sitting, resulting in verbal abuse between the two residents. In another incident, Mary and another female resident started to hit and push each other, while continually verbally abusing each other. The second resident picked up a fork and repeatedly stabbed Mary in the arm. The RA spoke to the CNA (who was in the room, ignoring the altercation), who then moved Mary in her wheelchair to a distant corner of the room. When Mary was interviewed about the incidents, she said that she hated the facility, had no friends there and wanted to leave.

Using the SEARCH approach, the CNA should have provided **S**upport: checked the arm that had been injured and have a discussion with the other residents involved, to validate their frustrations and make sure they were not distressed by the event. An Evaluation of Mary’s physical and mental health, including pain management should be undertaken. The CNA Acted by moving Mary to another area in the room; however, she only did this after the RA called the incident to her attention. Because Mary was involved in many R-REM incidents, more drastic action is required: Assessment of her back wound and appropriate pain management should be implemented. Depending on whether the incidents decrease after pain management, she may have to be moved away from other residents or even to another unit that accommodates better behavioral disorders. Each incident should be Reported and documented in the Care plan and she should be monitored closely. Because Mary seems to be involved in diverse incidents as a victim as well as a perpetrator, and because of her complex clinical profile, an interdisciplinary approach might be warranted for the development of a comprehensive care plan. By documenting each incident of R-REM in which Mary was involved, her patterns of behavior can be identified. Moreover, the fact that she repeatedly calls out “ow, ow” and complains of back pain (later shown to be caused by a

wound on her sacrum) indicates the need for a physical intervention and pain medication. This documentation becomes instrumental for care planning and for behavioral management, which together with staff awareness and education about abuse among residents, will help to avoid further incidences of R-REM.

Case Study Two – Bill

A CNA was in a resident's room with the resident when Bill walked into the room, pulled down his pants and started playing with himself. The resident told the CNA that this incident had happened to him several times in the last week. The CNA told Bill to stop what he was doing, and he responded by cursing at her and walking out of the room. The CNA reported this incident to the RA, but did not file a report as she explained that the incident was resolved. Bill is confused but is able to communicate his needs. He is usually sociable and friendly, and was described as "fun-loving, chatty and charismatic" by an RA. However, he has another side, and he can be mean, verbally abusive, and sexually harassing.

This incident required follow up as per the SEARCH approach. Both residents required Support through active listening and supportive communication. Bill needs support to help identify what he needs: Behaviors like this will not go away without some appropriate interventions. An Evaluation and assessment would help identify the frequency of these behaviors; Acting in Bill's best interest might include providing him with sexual magazines or even allowing a visit from a sex worker, if consistent with the particular organization's policy and practice. Reporting the incident raises the awareness of all staff that older people are still sexual beings and that sexual expression is an important aspect of their residents' care and well-being. Details in the Care plan should document how this incident is to be managed. Providing appropriate sexual expression for Bill may Help to avoid his involvement of other residents in his need for sexual expression (Bouru, Reingold, & Holmes, 1999; Holmes, Reingold & Bouru, 1999; Holmes, Reingold & Teresi, 1997; and Sexual Expression Guidelines-Hebrew Home at Riverdale).

Case Study Three – Alice and Betty

Two women were sitting next to each other in the lounge, watching TV. Alice was in a wheelchair and Betty had her walker in front of her. There were other residents sitting in chairs, also watching TV. Alice screamed, "stop it!" She started shaking her walker back and forth. The observer turned to see what was happening. Betty had her hand on Alice's walker. Alice started hitting Betty's hand. Betty started hitting back. Alice screamed, "stop it," again. Another resident snapped her fingers in the air and called for the nurse. "Nurse, nurse!" She also said to Alice and Betty, "Come on guys, we don't need this. Settle down." The hitting back and forth continued. A CNA ran through the lounge at this point, raising her voice, saying something that the observer could not make out. Another CNA approached from the kitchen, yelling, "Stop it!" She broke it up by wheeling Betty away from Alice to a table at the other side of the room. There were verbal reports that these women were previously involved in 'tiffs and fights'.

This is an example of when it is hard to identify the perpetrator and victim, as both women were hitting each other. From the SEARCH approach, the CNAs should not have run or

shouted at the two residents. However, the Act of moving Betty was appropriate, as she was in a wheelchair, which made it easier and quicker to move her. Following the incident, using the SEARCH approach, both Alice and Betty and the other women should have been provided with some Support by giving them the opportunity to discuss the incident, to validate their frustrations and make sure they were not distressed by the event. An Evaluation of the incident and the environment would have identified that these women were previously involved in abusive incidents and consequently should not be seated near each other in the lounge room. The previous incidents should have been Reported and documented in the Care plan, and the appropriate strategy would be for the two women to be kept away from each other. Again, this incident should also be documented, and discussed at change of shift as a reminder to staff to Help in avoiding further incidences of R-REM involving these two residents.

DISCUSSION

Although frequently observed in long term care facilities, resident-to-resident elder mistreatment has not received significant attention from the scientific, clinical or administrative community. In most cases R-REM is ignored by staff in nursing homes as it is not identified as abuse, and often even perceived as normative. In fact, incidents of yelling and insulting remarks by residents to each other were not seen as forms of abuse by nurse aides in a study by Castle (2012). Consequently, these incidents were not reported, leaving residents at potential risk (Hirst, 2002). CNAs are not experienced in managing aggressive residents who often require individualized intervention such as cognitive-behavioral therapy, validation therapy and/or time out (Gates et al., 2005). Shown in the case studies described above, nurse assistants' interventions were well intended but most likely ineffective as preventive strategies for future R-REM. There was no evidence of a systematic approach to addressing R-REM incidents, neither for follow-up and/or documentation. These responses most likely represent normative staff behavior and response to these types of events, in the absence of institutional training and guidelines. Not surprisingly, there is a call by the front-line direct care nursing staff for further education and training on how to recognize and to manage elder abuse incidents in different settings (Trevitt & Gallagher, 1996).

With the diversity of types of resident-to-resident mistreatment, a person-centered approach to the management and prevention of these incidents is crucial. It is through identifying incidents and documenting them that patterns of residents' behaviors can be identified and individual strategies planned, implemented and assessed.

Adequately managing R-REM is important as it has implications for both resident and staff in long term care. Adequate management of R-REM is a key factor in maintaining resident quality of life, staff and resident safety, and staff job satisfaction and morale. Nursing homes and other long-term care congregate living facilities have both an ethical and legal responsibility and obligation to protect all residents in their care, as well as all employees. Environmental factors as well as resident characteristics specific to long-term care settings and to the nature of shared living can lead to opportunities for conflicting dynamics. Thus, R-REM can no longer be ignored, and all forms of R-REM must be recognized and addressed. In order to ensure the safety and well-being of residents and staff in the context

of R-REM, it is recommended that staff of nursing homes and other long-term care settings learn and use the evidence-based **SEARCH** approach: Support, Evaluate, Act, Report, Care plan and Help to avoid. A longitudinal evaluation of this R-REM training intervention for nursing staff demonstrated that it was effective in enhancing knowledge; recognition and reporting of R-REM in nursing homes (Teresi, Ramirez, Ellis, Silver, Boratgis, Kong, et al., 2013b).

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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KEY POINTS

1. Environmental factors as well as residents' characteristics specific to long-term care settings and to the nature of shared living can lead to opportunities for conflicting dynamics.
2. Administrators of nursing homes and other long-term care congregate living facilities have both an ethical and legal responsibility and obligation to protect all residents in their care, as well as all employees.
3. Adequate management of R-REM is a key factor to maintaining all residents' quality of life, both staff and residents' safety, and staff job satisfaction and morale.
4. R-REM can no longer be ignored, and all forms of R-REM must be recognized and addressed.

TABLE 1

SEARCH - (**S**upport, **E**valuate, **A**ct, **R**eport, **C**are Plan, **H**elp to Avoid) approach to R-REM management.

Support	Support injured residents until help arrives Listen to all involved residents' perspectives on the situation Validate resident fears and frustrations.
Evaluate	Evaluate what actions are needed Monitor resident behavior Evaluate and support all residents involved in and/or who have witnessed an event, because violence can be upsetting for others also.
Act	Seek medical treatment when indicated Verbally try to stop the incident Support the initiator's feelings instead of criticizing this person, as this will intensify the incident Call for other staff or security to help Move/separate residents who do not get along. In the case of missing personal items, assure the resident that in order to locate them, a room-by- room search will be conducted. Ensure this happens promptly. Evaluate and support residents involved in and/or who have witnessed the event, because violence can be upsetting for all. Follow-up with residents after upsetting incidences to make sure they are ok. Acknowledge resident's grievances and concerns.
Report	Initiate investigation of serious incidents when warranted Notify the nursing supervisor and administrator Contact families if appropriate Document the event in the resident care plan Initiate the facility protocol and procedures for reporting R-REM.
Care Plan	Plan for both the initiator and the victim Talk with the care team about best ways of intervening and avoiding R-REM Document threatening behaviors Recognize and document residents' preferences for privacy/routines In severe cases, seek medical and/or psychiatric evaluation Monitor residents to potentially avoid future incidents.
Help to Avoid	Have adequate staff in congregate settings Avoid crowding people and their equipment into small spaces Reinforce resident safety as a nursing home priority Educate residents about dementia-specific behaviors, e.g. rummaging Remind residents that residents with dementia are often unaware that their behavior may be disturbing to others Take inventories of personal belongings Recognize risk factors for R-REM e.g., wandering, memory disorders, noisy and/or threatening behaviors Separate residents who are known to have negative interactions with one another.