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Resident-to-resident harm in care homes and other residential settings: a scoping review

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Key findings

- There is very little UK literature on resident-to-resident abuse or harm, with most being from the US. Of the UK literature that is available, much of it is policy or practice documents rather than empirical research.
- The focus of literature on resident-to-resident harm has been on older adults, with less available about people with learning disabilities and other groups.
- Types of resident-to-resident abuse included: verbal (yelling, screaming), physical (hitting, kicking, pushing, throwing things), sexual (inappropriate touch, exposing themselves), violation of privacy and taking/damaging another's belongings. Linked to this was bullying, mainly highlighted in 'senior living facilities'.
- Abusive behaviour was rarely documented or reported in some settings, with evidence that some care managers consider it an inevitable or predictable part of living in a residential setting. Some services allow harmful behaviours to be accepted and unchallenged.
- Research regarding the prevalence of resident-to-resident abuse is limited, yet information from a variety of sources suggests it occurs fairly frequently. Prevalence data is hard to compare across studies and settings due to very different methods being used.
- Resident characteristics that are a risk factor for resident-to-resident abuse include dementia, mental illness, behavioural symptoms that may disrupt others and a history of aggressive or negative interactions with others.
- Environmental characteristics that are risk factors for resident-to-resident harm include a crowded environment, inadequate staffing levels, lack of staff training, high numbers of residents with dementia, a lack of meaningful activities, crowded common areas and excessive noise.
- Many incidents of resident-to-resident harm are not witnessed by staff.
- There is significant overlap between interventions to prevent staff-to-resident abuse as for resident-to-resident harm. These include professional training, development of person-centred care practices, and the use of a multidisciplinary approach.
- Interventions to reduce resident-to-resident harm include both environmental considerations (such as reducing crowding, noise and clutter, and prompting meaningful activities) and care practices (including care plans, staff training, identifying risk factors, consistent staffing to build relationships)
- There is a paucity of research into resident-to-resident harm, including prevalence data, detailed identification of perpetrator and victim characteristic, developing/assessing environmental interventions, developing/assessing staff training interventions

1. Introduction

This report from Social Care Institute for Excellence (SCIE) aims to explore resident-to-resident harm in care homes, also referred to as resident-to-resident abuse. However, there is an important distinction to be made between harm and abuse as abuse occurs within relationships where there is the expectation of trust. That expectation cannot be applied to the relationship between residents. Having highlighted this key distinction, this report reflects the literature and so refers to resident-to-resident abuse (RRA) throughout.

SCIE provides adult safeguarding training to a wide range of organisations across sectors. When working with care home providers, including those providing care in secure accommodation for people sectioned under the Mental Health Act, the issue of resident-to-resident harm is frequently raised as an issue of concern. Staff have highlighted the difficulties of managing residents with high-level needs and behaviours that may cause risk to others that are often caused by cognitive impairment. These issues are exacerbated where many such people are housed in the same service. Staff working with these challenging issues have reported the difficulties it causes for them as social care practitioners, causing anxiety and stress for individuals who are expected to manage sometimes volatile situations. This led SCIE to look at the research evidence to establish what techniques and practices might be considered best practice in this area of work. Unfortunately, the research review found little in the way of evidence to support good practice in this area.

Specifically, this report aims to identify current research, policy and practice about resident-to-resident abuse in care homes. The report explores:

- Definitions and types of resident-to-resident abuse
- Prevalence of resident-to-resident abuse
- Risk factors for resident-to-resident abuse
- Prevention of and interventions for resident-to-resident abuse
- Research gaps
- Potential case studies

Whilst this report focuses on care homes, we recognise that harm can occur between people who use services in other settings such as day services.

1.1 Search strategy

A combination of the search terms presented in the table below were used to search the following databases: Social Care Online, Google Scholar, Google and Epistemonikos (systematic reviews database). Snowballing was used to identify additional references from key studies. This identified 67 papers to review, a large number of which are mentioned in the body or this report.

Population	Setting	Phenomena of interest
residents	nursing home	abuse
resident at risk	residential care	neglect
'other residents'	care home	violence
co-resident	assisted living	harassment
peer	group homes	harm
resident-to-resident		physical abuse
resident perpetrators		emotional abuse
client on client		sexual abuse
resident-to-resident aggression (RRA)		financial abuse
resident-to-resident violence (RRV)		psychological abuse
resident-to-resident elder mistreatment (R-REM)		adult abuse
assault OR physical abuse between residents		elder abuse
autism		elder bullying
challenging behaviour		senior bullying
dementia		
intellectual disabilities		
learning disabilities		

1.2 Overview of the included literature

Most of the literature reviewed about resident-to-resident abuse comes from the USA (n=37) followed by UK (n=12), Australia (n=9), Canada (n=5), Netherlands (n=2), Norway (n=1) and Germany (n=1). There has hardly been any research about the issue in the UK, with most of the UK literature, practice or policy documents, rather than empirical research.

Most of the research is about the prevalence of resident-to-resident abuse or indicators or risk factors for abuse of older people. There is less research about resident-to-resident abuse of people with learning disabilities. Where there is research about this groups, it is mainly about prevalence.

There has been some research about tools or instruments to measure resident-to-resident abuse in residential care (Ramirez et al, 2013; Teresi et al, 2014; Berry et al, 2017):

- **SEARCH Approach** – identification and management of resident-to-resident elder mistreatment (R-REM) in nursing homes (Ellis et al, 2014 and 2019)
- **Guardians in residential care** (Cox, 2008)

- **Resident-to-resident elder mistreatment training intervention** (Teresi et al, 2013 and 2020)
- **Staff strategies** (Rosen et al, 2008 & 2015; Snellgrove et al, 2015)

Some of the research addresses what good care might look like in care homes, when it comes to safeguarding residents from the abuse from other residents. The dominant theme identified in the literature was providing person-centred care.

There is some existing UK guidance or good practice about how to manage resident-to-resident abuse in nursing homes. This includes the new NICE guideline on safeguarding adults in care homes (NICE, 2021) and SCIE guide on common safeguarding challenges in care homes (SCIE, 2012).

2. Definitions and types of resident-to-resident abuse

2.1 Terminology and definitions

The most common term used in the literature for resident-to-resident abuse is resident-to-resident aggression (RRA). This is defined as:

> *'negative and aggressive physical, sexual, or verbal interactions between long-term care residents that (as in a community setting) would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.' (*Teresi et al 2013; Rosen et al, 2008; McDonald et al, 2015)

Other common terms used in the literature reviewed include: resident-to-resident violence (RRV); resident-to-resident elder mistreatment (R-REM) or resident-to-resident abuse.

Relational aggression is defined as a manipulative, non-physical form of aggression using rumour or gossip. (Benson and Beckmeyer, 2013)

2.2 Types of abuse

The most common types of resident-to-resident abuse identified by Rosen et al, (2008) in a series of focus group with nursing home residents and staff were:

- verbal abuse − with screaming or yelling being the most common. Mentioned in 100 per cent of focus groups
- physical abuse. Mentioned in 94 per cent of focus groups
- sexual abuse − inappropriate touching. Mentioned in 38 per cent of focus groups.

Similarly, Myhre et al (2020), in their study of nursing homes in Norway found the main types of co-resident abuse were:

- hitting, kicking, pushing and throwing things
- verbal abuse
- violation of resident's privacy
- stealing or destroying a resident's assets
- sexual assault.

Resident-to-resident aggression (RRA) was described as the biggest issue related to abuse in this study and a daily challenge for the participants These findings are illustrated in more depth in Table 1.

Table 1: Elder abuse and neglect: An overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect

	Co-residents **'A normal part of nursing life'**	**Relatives** **'A private affair'**	**Direct care staff** **'An unthinkable event'**
Physical abuse - Hitting, kicking, pushing and throwing things	X		X
- Rough handling		X	X
- Use of force or restraint		X	X
Psychological abuse - Verbal abuse	X	X	X
- Violation of resident's privacy	X		X
Financial abuse - Steeling or destroying a resident's assets	X	X	X
Sexual abuse - Sexual assault	X		X
Neglect - Neglect of user participation		X	X
- Health care neglect			X

Source: Myhre et al, 2020

A large study conducted in the US in 249 nursing homes found similar levels of the different types of abuse, as reported by nurse aides (Castle, 2012). The percentage of nursing aides reporting each form of abuse was as follows:

- High levels of residents yelling at each other: 67 per cent
- Residents yelling at each other in the three months prior: 97 per cent
- Residents pushing, pinching or grabbing each other: 94 per cent

- Aggressive 'psychological behaviour' towards each other: 91 per cent
- Residents exposing body parts to other residents: 77 per cent
- Taking another resident's belongings: 69 per cent

Finally, a few other studies conducted in the US also found similar findings. For example, Magruder et al (2019) reported that in their study that verbal/psychological abuse was the most reported type of abuse and sexual abuse was the least reported. Moreover, assisted living residents had disproportionately high rates of financial exploitation. A study by Pillemer et al (2012) identified five major forms of resident-to-resident abuse that occur in nursing homes:

- invasion of privacy or personal integrity
- room-mate issues
- intentional verbal aggression
- unprovoked actions
- inappropriate sexual behaviour.

Rosen et al (2016) demonstrated that participant nurses rarely documented abusive behaviour or informed supervisors or colleagues from other sectors. The results also demonstrated that the professionals did not act in almost 25 per cent of the cases of RRA, suggesting that many workers consider this type of aggression normal and inevitable and do not take actions in these cases. This was also the view of Myhre et al (2020) that found that some care managers stated that the risk of harm caused by resident-to-resident aggression was something residents must accept when living in a nursing home: *'There is a predictable risk, when living in nursing homes, [of] such incidents; there is a foreseeable risk that this will happen'.* This demonstrates that resident-to-resident abuse is normalised.

2.2.1 Sexual abuse and sexual assault

A systematic review of sexual assaults in nursing homes (Smith et al, 2018) found that in one study using 15 focus groups, sexual assault was discussed by 18 per cent of the participants in 38 per cent of focus groups. Inappropriate touching as a component of sexual assault was discussed more than any of the physical assault components, with the exception of punching and fighting (38 per cent and 44 per cent, respectively) (Castle, 2012b).

A Care Quality Commission (CQC) report (2020) about sexual safety found that sexual incidents happen in all types of adult social services. Types of sexual incidents reported to the CQC (March to May 2018) were:

- 48 per cent sexual assault
- 11 per cent exposure and nudity
- 8 per cent sexual harassment
- 5 per cent allegations of rape
- 8 per cent 'Undefined or other', included grooming and giving intimate care without appropriate respect and dignity

A concerning picture from some of the most harmful sexual incidents reviewed as part of the CQC report show some services have allowed harmful behaviours to be accepted and unchallenged. People who use services are not protected from harm where a lack of respect or knowledge becomes a normalised part of working practice. The report found that sex is often treated as a taboo subject, with providers, staff and families sometimes reluctant to raise issues. This means predatory behaviour can be missed or normalised. The report concludes that a lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm. It recommends that cultures are developed where people and staff feel empowered to talk about sexuality and raise concerns.

Other reports also raised concerns and issues about residents who show a sexual interest in others. Myhre et al (2020) reported that care managers viewed this sexual interest as an ethical dilemma for them. On the one hand, they want residents to have a healthy sex life in the nursing home, but on the other hand, this is difficult when a resident has dementia and may not be competent to give consent. Several care managers reported that what seemed to be voluntary sexual interest between residents could not be that, after all.

2.2.2 Bullying

Research associated with resident-to-resident bullying in senior living facilities (i.e., senior bullying), has been growing in recent years due to anecdotal stories in the popular press. In a small study (n=19) set in a senior living facility in the US, 52.9 per cent of residents had observed senior bullying at least once. Verbal and social bullying were equally observed by participants, with the majority of bullying being observed in common areas. Perpetrators and victims were reported to be mostly female. However, only 10.5 per cent of the sample felt that bullying was a problem at their facility (Ira, 2018)

Another study conducted in the US in one facility (n=98) also found that 25 per cent of residents had seen or heard another resident being bullied at some point. Social bullying was reported as the main form of bullying. (Jeffries et al 2018)

Finally, care managers (Myhre et al, 2020) described psychological abuse as acts of ‘everyday bullying’ and threats made among residents. They interpreted these situations as a normal consequence of the dementia disease in the individual resident. One care manager noted, ‘*What I think is the challenge is the everyday bullying. It is seen as normal behaviour for that group of residents’*.

3. Prevalence of resident-to-resident abuse

Research regarding the prevalence of resident-to-resident abuse is limited, yet information from a variety of sources suggests it occurs fairly frequently. Some studies (Castle, 2012; McDonald, Sheppard et al, 2015; McDonald, Sheppard et al, 2015; Rosen, Pillemer, & Lachs, 2008) showed that the prevalence of this abuse is higher than that of staff-to-resident abuse and represents a third of the complaints filed in nursing homes (McDonald et al, 2015). Another study found that resident-to-resident aggression made up 22.22 per cent of all types of abuse in nursing homes (Touza, 2019)

Similarly, Lachs et al (2016) revealed that 407 of 2,011 residents from ten facilities had experienced at least one resident-to-resident event over one-month observation, showing a prevalence of 20.2 per cent, and the most common form was verbal abuse. Trompetter et al 2011, in the Netherlands, examined resident-to-resident relational aggression and subjective wellbeing in assisted living facilities and found that 19 per cent of residents reported prevalence, compared to 41 per cent of nurses reporting prevalence. Finally, Gimm et al (2018), in a large nationwide US study, found 7.6 per cent of assisted living residents engaged in physical aggression or abuse toward other residents or staff in the past month, 9.5 per cent of residents had exhibited verbal aggression or abuse, and 2.0 per cent of resident engaged in sexual aggression or abuse toward other residents or staff.

On the other hand, a recent Australian study (Joyce, 2019) found that resident-to-resident abuse in aged care facilities lower than in other reports, with only 7.6 per cent of residents reported as targets, and 6.9 per cent exhibited aggression.

Some studies (McDonald et al, 2015; Ellis et al, 2014; Tromopetter et al, 2011). also reported on the impact and consequences of resident-to-resident abuse. They reported that it has been associated with:

- a reduction in life satisfaction and increased risk of depression, anxiety, and loneliness
- low self-esteem and overall negative mood
- injuries such as falls, fractures, lacerations and cuts
- a higher likelihood of experiencing neglect by caregivers and non-receipt of care after suffering sexual abuse.

Finally, one study examined 1,296 deaths due to external causes in nursing homes in Victoria, Australia (deaths reported to the Coroners Court). The study found that seven (0.5 per cent) of these deaths were due to episodes of RRA (Ibrahim et al, 2015) 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.

4. Risk factors for resident-to-resident abuse

An overview of the risk factors for resident-to-resident abuse are highlighted in Table 2 that were identified in the literature reviewed. Some of these are discussed in more detail in the following sections.

Table 2: Overview of risk factors for resident-to-resident abuse

Resident characteristics	Family characteristics (environmental and care)
Residents with significant cognitive impairments such as dementia and mental illness	Inadequate number of staff
Residents with behaviour symptoms related to dementia or other cognitive impairment that may be disruptive to others (e.g. yelling, repetitive behaviours, calling for help, entering others' rooms)	Lack of staff training about individualised care in order to support residents' needs, capabilities and rights (e.g. resident-centred care, abuse prevention, care for those with limited capacity, dementia and mental health needs)
Residents with a history of aggressive behaviour and/or negative interactions with others	High number of residents with dementia
	Lack of meaningful activities and engagement
	Crowded common areas (e.g. too many residents in one room, equipment/obstacles in common areas)
	Excessive noise

Source: Long-Term Care Ombudsman advocacy: resident-to-resident aggression

Ellis et al (2014) cited a number of studies and highlighted the following risk factors:

- Crowded environment
- High number of residents with dementia
- Cognitive impairment of both victim and perpetrator
- Behavioural disturbances that occur with residents with dementia
- Comingling of individuals with psychiatric illness or a previous psychiatric history who may bring with them to the home associated psychiatric behaviours.

4.1 Characteristics and vulnerabilities of resident perpetrators and victims

A number of studies reported that in the majority of incidents, the resident perpetrator had a cognitive impairment (89.9 per cent in Joyce, 2019; 90 per cent Murphy et al, 2017; Rosen et al, 2008). In fact, one study found that '*cognitive impairment, and worsening cognitive impairment in particular, conferred a five-fold risk of mistreatment in victims'.* Similarly, the main cause of resident-to-resident aggression reported by care managers in a study in nursing homes in Norway was symptoms of dementia, especially in the initiator, but also in the victim (Myhre et al, 2020). Another study found that perpetrators of resident-to-resident sexual assault often suffered from dementia, cognitive impairment, and disinhibition (Rosen et al, 2008).

Ferrah et al (2015) conducted a systematic review to identify contributing factors and outcomes of RRA in nursing homes. They found that RRA commonly occurred between exhibitors with higher levels of cognitive awareness and physical functionality and a history of aggressive behaviours, and female targets who were cognitively impaired with a history of behavioural issues including wandering.

A large study in the US, using data from 2000 (Shinoda-Tagawa et al 2004), found that in resident-to-resident violent incidents, the injured residents were more likely to be cognitively impaired, exhibit symptoms of wandering, be verbally abusive, and have socially inappropriate behaviour than the controls. Residents who were classified as needing extensive assistance and being severely dependent had a significant reduction in being injured. Residents in an Alzheimer's disease unit were almost three times as likely to be injured than those living in other units. Injured residents were more likely, perhaps unknowingly, to 'put themselves in harm's way', be verbally aggressive, and be cognitively impaired. The study findings suggest that interventions to prevent these incidents should focus on the behaviour of the injured persons.

Another study (Murphy et al, 2017) explored the frequency and nature of deaths from resident-to-resident aggression (RRA) in nursing homes in Australia. This research identified 28 deaths from RRA over a 14-year study period. Most exhibitors of aggression were male (85.7 per cent), and risk of death from RRA was twice as high for male as for female nursing home residents. Almost 90 per cent of residents involved in RRA had a diagnosis of dementia, and three-quarters had a history of behavioural problems, including wandering and aggression. RRA incidents commonly occurred in communal areas and during the afternoon and involved a 'push and fall'. Seven (25 per cent) RRA deaths had a coronial inquest; criminal charges were rarely filed.

Finally, a US study (Sifford-Snellgrove et al, 2012) that explored nursing assistants' perceptions of the characteristics of both the victims and initiators of resident-to-resident violence (RRV) found that:

- initiators of RRV are perceived 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
- victims of RRV were described using phrases such as, 'they don't know', 'can't communicate', and 'gets around good'.

4.2 Situational characteristics of resident-to-resident abuse

Two studies reported that RRA was most frequent in dining and residents' rooms, and in the afternoon, although it occurred regularly throughout the facility at all times (Rosen et al, 2008; Ferrah et al, 2015).

Caspi's small study (2016) about episodes of fatalities from RRA found that most of the reviewed episodes were not witnessed by staff (70 per cent; 19 of 27) and took place inside bedrooms (68 per cent). 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 per cent of episodes of physical RRA were not witnessed by staff. More than one-third of the episodes (37 per cent) were between room-mates, which may indicate serious problems in room-mates' assignment and/or ongoing monitoring (Caspi, 2016). Most episodes (for which there was a report on the time of the episode) took place during the evening/late evening hours (81 per cent; 13 of 16 episodes; two other episodes took place during the night), whereas close to two thirds of the episodes (62 per cent; 18 of 29) took place on weekends (Caspi, 2016).

Another study by Caspi (2015) that studied aggressive behaviour between residents with dementia in long-term care residences in the US found that the majority of incidents were situational-reactive (circumstance-driven) and therefore potentially modifiable, for example, problematic seating arrangement.

4.3 Triggers and other risk factors for abuse

Snellgrove (2013) suggested two types of triggers for resident-to-resident abuse:

- **Active triggers**: involved the actions of other residents that were intrusive in nature, such as wandering into a resident's personal space, taking a resident's belongings, and so forth
- **Passive triggers:** did not involve the actions of residents but related to the internal and external environment of the residents. Examples were factors such as boredom, competition for attention and communication difficulties.

Rosen et al (2008) also listed a number of triggers or other risk factors for abuse:

- Calling out or making noise
- Territoriality or challenges with communal living
- Room-mate inability to compromise preferences
- Impatience
- Loneliness, abandonment, or frustration with institutionalisation
- Jealousy

Another study (Jain et al, 2018) found that the potential causes of RRA included:

- Maladaptation to nursing home life
- Transfer of pre-existing issues into the nursing home environment
- Physical environment
- Staffing-related issues.

Resident-to-resident aggression was commonly viewed by participants as dangerous and unpredictable or, conversely, as expected behaviour in a nursing home setting.

Five themes of RRA events are shown below (Long-Term Care Ombudsman, 2015).

Five themes of RRA events

- **Hostile interpersonal interactions** (angry attempts at social control, arguments, disproportionate response to normal interaction, sarcasm or jeering, accusations)
- **Invasion of privacy or personal integrity** (incursion on personal space, invasion of room privacy, clearing a way through congestion, inappropriate caregiving)
- **Room-mate problems** (room-mate disagreements, belligerent room-mate)
- **Unprovoked actions** (verbal or physical assault without cause or warning)
- **Inappropriate sexual behaviour** (unwanted sexual advances and intentional nudity or exposure in the presence of other residents)

(Listed in order of frequency (from highest to lowest) reported in Pillemer et al, 2011)

5. Prevention of and interventions for resident-to-resident abuse

5.1 A multi-factorial and multidisciplinary approach to prevention

Touza (2019) reviewed the evidence about interventions used to prevent elder abuse in long-term care facilities and found that measures to prevent RRA, to a large extent, are the same as those used to prevent cases of staff-to-resident abuse, including professional training, development of person-centred care practices, and the use of a multidisciplinary approach. The analysis of the reviewed articles in Touza (2019) demonstrated the need for a comprehensive approach, which considered the interactions between individual and contextual factors, and creation of relevant social policies in developing effective preventive strategies that target institutional neglect (Schiamberg et al, 2011).

This was also echoed by Bonifas et al (2015) in their US study that identified three assessment and intervention strategies social workers use to address RRA:

- **Assessment approaches** include gathering information, applying knowledge of causal factors, and determining psychosocial impact
- **Intervention approaches** comprise determining appropriate interventions, applying preventive approaches, and delivering psychosocial interventions
- **Collaborative strategies** include mutual assessment consultations, joint intervention planning, tandem intervention delivery, and maximising professional strengths

The findings illustrate social workers' extensive involvement in responding to RRA incidents and the importance of social worker-nurse collaboration, especially with direct care workers.

Finally, the Long-Term Care Ombudsman, in its research review (2018) also identified the changes needed to both care practices and environmental conditions to help prevent incidents of RRA. See Table 3.

Table 3: Recommendations to prevent and reduce incidents of RRA

Environmental considerations	Care practices
Clear common areas of clutter, reduce noise and overcrowding	Develop comprehensive care plans. Provide individualised, resident-centred care and implement best practices fir supporting residents with behavioural symptoms related to cognitive impairment
Provide areas for supervised, unrestricted, safe movement	LTC facility staff training (including training on person-centred care, dementia and mental illness) and facility policies regarding how to prevent, recognise, respond, report and document RRA

Identify environmental influences on behaviour and adjust accordingly (e.g. temperature, lighting)	Identify residents with risk factors for RRA, and a history of RRA, and develop care plan to address their needs and monitor closely
Promote meaningful activities and opportunities for engagement for all residents based on individual needs, interests and abilities	Identify root causes of behavioural symptoms and reduce or eliminate those causes (e.g. pain, boredom, loneliness
	Implement consistent staffing assignments so staff and residents are more comfortable with each other and staff are more familiar with resident needs and changes in behaviour
	Ensure adequate staffing levels in order to meet resident needs and provide supervision

Long Term Care Ombudsman, research review, 2018

5.2 Staff education and training interventions

The literature has stressed that staff should play a vital role in identifying and managing aggressive interactions between residents. This will help avoid serious consequences for residents living in aged care facilities (Ellis et al, 2014). However, many staff may not recognise these behaviours as forms of abuse, and instead think of them as normal behaviours which cannot be changed. This indicates the need to develop educational programmes to assist staff engaged in the management of resident-to resident abuse in care facilities.

A key educational programme to inform nursing and care staff of the management of resident-to-resident elder mistreatment (R-REM) in nursing homes that was identified in the literature is the **SEARCH** programme (Support, Evaluate, Act, Report, Care plan, and Help to avoid).

The goal of the SEARCH approach is to support staff in the identification and recognition of R-REM as well as to suggest recommendations for management. Ellis et al (2019) conducted a randomised control trial of the approach in aged care facilities in Australia. (Ellis et al, 2019)

The key parts of the framework included:

- **Support** all residents involved in the incident
- **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
- **Act** immediately. The actions taken will depend on the type of incident and the environment where the incident occurred
- **Report** and document all incidents of R-REM according to the nursing home protocol. Many incidents of R-REM are not reported

- **Care plans** should be used to document interventions or strategies to attempt to manage incidents of R-REM, avoid or minimise incidents of R-REM, and ensure the safety of all residents
- **Help to avoid** incidents of R-REM, which is the role of all staff who need to be actively involved in the discussion and development of management strategies and care plans

Table 4 outlines this approach in more detail.

Table 4: The SEARCH approach to R-REM management

Support	Support injured residents until help arrives: • Listen to perspectives of all involved residents • Validate resident fears and frustrations
Evaluate	Evaluate what actions are needed: • Monitor resident behaviour • Evaluate and support all residents who were involved in or witnessed an event because violence can be upsetting for others too
Act	Seek medical treatment when indicated: • Verbally try to stop the incident. Support the initiator's feelings instead of criticising this person because criticism will intensify the incident • Call for other staff or security to help move or separate residents who do not get along • If personal items are missing, assure the resident that a room-by-room search will be conducted to locate the items • Ensure that this search is conducted prompted • Evaluate and support residents who were involved in or witness the event because violence can be upsetting for all • Follow up with residents after upsetting incidents to make sure that they are ok • Acknowledge resident grievances any 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	Formulate a plan for both the initiator and victim: • Talk with the care team • About the best way to intervene and avoid R-REM • Document threatening behaviours • Recognise and document residents' preferences for privacy and routines • In severe cases, seek medical 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 behaviours, such as rummaging • Remind residents that people with dementia are often unaware that their behaviour may be disturbing to others • Take inventories of personal belongings • Recognise risk factors for R-REM (e.g. wandering, memory disorders, noisy or threatening behaviours) • Separate residents who are known to have negative interactions with one another

Source: Ellis et al, 2014, p117

Another resident-to-resident elder mistreatment training intervention was reported by Teresi et al (2013) which worked with direct care staff to enhance knowledge of R-REM and increase reporting and resident safety by reducing falls and associated injuries. It consisted of three modules. Teresi et al (2020) are conducting a large randomised controlled trial to evaluate this intervention (underway). Results from the testing so far showed significant

increases in staff knowledge post training. Additionally, falls, accidents, and injuries were reduced (Teresi et al, 2013 & 2020).

As discussed above, a number of educational interventions have been proposed to prevent RRA. However, very few studies have evaluated the effectiveness of these interventions, and larger reviews on this topic are necessary (McDonald et al, 2015).

5.3 Staff prevention strategies and practices

Caspi (2015) identified 12 effective staff prevention strategies for dealing with aggressive behaviour between residents with dementia. These are:

- Being alert
- Being proactive (vs. being reactive)
- Being informed about previous incidents in which a certain resident was involved in an aggressive behaviour or about a history of confrontations between two residents
- Redirecting a resident from an area where the aggressive behaviour took place
- Offering the person to take a walk
- Separating
- Positioning, repositioning, or changing seating arrangement
- Refocusing or switching the topic or subject
- Distracting the person to a more pleasurable activity, diverting to a different activity or changing activity
- Staying calm
- Never arguing with a resident involved in the aggressive behaviour
- Seeking help from other staff members

Rosen (2015) also identified some common staff responses to resident-to-resident elder mistreatment (R-REM) in nursing homes in the US. These are:

- Physically intervening/separating residents
- Talking calmly to settle residents down
- No intervention
- Verbally intervening to defuse the situation

Less common staff responses were notifying a nurse or documenting in behaviour log.

5.4 Person-centred care

A person-centred care approach was considered most effective for managing and responding to RRA (Jain et al, 2018.) A movement towards person-centred care that promotes understanding of individual care needs is favoured as an approach to reducing RRA. Increased reporting of both minor and major incidents of RRA will help to identify

patterns and inform appropriate responses. However, a cultural shift is first required to recognise RRA as a manageable and preventable health care and adult safeguarding issue.

A US study (Pillemer et al, 2012) that sought to identify the major forms of RRA that occur in nursing homes found that there is diversity in the types of RRA, which suggests the importance of considering personal, environmental, and triggering factors, and the potential for emotional and physical harm to residents. The findings from (Pillemer, 2012) suggested the need for person-centred and environmental interventions to reduce RRA.

Moreover, Snellgrove et al (2015), in their study that explored strategies developed by nurses' assistants in the US to prevent and manage resident-to-resident violence in nursing homes identified one overriding theme, 'Putting residents first', which the staff described as a conscious effort to put themselves or a beloved family member in the place of the resident while administering care. Within this theme, there were three related subthemes:

- Knowing the residents
- Keeping residents safe
- Spending quality time

5.5 Other approaches and interventions

Grigorovich et al (2019), in their Canadian study that explored the ethics of resident-to-resident aggression suggested that a more ethical approach requires attention to the structural conditions of long-term care that both foster aggression and constrain prevention efforts. Grigorovich advocated using a model of relational citizenship that offers a theory of embodied self-hood and relationality as essential to human dignity, thus entailing human rights protections. The application of an ethic based on this model offers a more holistic prevention strategy for resident-to-resident aggression by drawing attention to the critical need and obligation to promote human flourishing through system-level efforts.

Cox (2008) proposed that a reformulated and strengthened role for guardians that would help to combat elder abuse be introduced in the UK. Cox (2008) argued that it has been shown within the residential care context that guardians would bring in a quality control dimension that is both 'outside the system' and fully 'on the side' of the individual resident. No one is presently able to speak up for these persons in this way (Cox, 2008).

There is also some evidence in the literature about the potential benefits of using assessment tools to help prevent abuse. For example, the Aggressive Behaviour Risk Assessment Tool (ABRAT) may help identify potentially aggressive residents in long-term care homes (Berry, et al. 2017). Additionally, the Resident-to-Resident Elder Mistreatment (R-REM) measure is another potential tool that could be used (Ramirez et al 2013; Teresi et al 2014).

5.6 Recommendations from professional guidance and good practice guides

There are a few published guides that offer advice relating to preventing resident-to-resident abuse.

For example, SCIE's Commissioning care homes: common safeguarding challenges (SCIE, 2012) includes a section about physical abuse between residents, and presents a prevention checklist:

- All residents are assessed in terms of their risk of being abused or of abusing others.
- Physical screening takes place to rule out infections which could alter behaviour.
- Staff are trained to identify the causes of challenging behaviour and understand that it may be used as a method of communication.
- Where risks are identified, plans are in place to support individuals and to prevent and reduce the risk of abuse.
- Care home staff are trained and competent in the management of challenging behaviour and supported by community health care professionals.
- Medication is reviewed regularly, whenever behaviour changes and at least every six months.
- Investigations are carried out to assess for medical or other reasons which may be causing behaviour that is difficult to manage.
- Where there are ongoing issues between individuals, the care home takes a multi-agency approach to long-term resolution.
- All incidents of abuse between residents are recorded and reported under local safeguarding procedures. Close family or friends should be informed unless there is a legitimate reason for not doing so.

In addition, whilst the NICE guide on safeguarding adults in care homes covers all types of abuse in care homes, not just resident-to-resident abuse, it does provide some relevant guidance and suggests what 'good should look like' in relation to providing training and support to the alleged abuser during and an enquiry or investigation. i.e.

> *1.8.21 Be aware that when the alleged abuser is another resident, they may also need support (including advocacy). Manage the risks between residents while any enquiry takes place and work with relevant commissioners.*

There are also a few authors and public bodies that highlight good practice in preventing resident-to-resident abuse. For example, Hirst (2015) suggested that aged care facilities need to:

- educate staff on resident-to-resident abuse to facilitate recognition of it when it occurs
- provide guidelines for staff to follow when resident-to-resident abuse occurs
- ensure accurate and complete documentation to facilitate reporting, managing, and preventing resident-to-resident abuse
- use a person-centred approach versus a provider focus, tailored to meet the needs of the unique individual resident
- assess for triggers that may contribute to abuse by one resident to another (e.g., pain, hunger, delirium).

Additionally, the CQC (2020) recommended the following relevant good practice in relation to sexual incidents:

- Staff should feel confident to speak up if they have concerns about harmful behaviour of people who use services or other staff.
- Providers should work with relevant community groups to give staff and people who use services support and access to information on sexual safety and sexuality.
- Guidance should include: how to recognise the changes in physical appearance, feelings and behaviours that indicate sexual abuse and harassment of people who use services and how to raise issues, whilst remaining vigilant with those who are unable to articulate their concerns.

6. Research gaps

Many authors have argued that resident-to-resident elder mistreatment (R-REM) has become a global issue of concern. However, it is still an understudied research area and the occurrence of R-REM in aged care facilities has not received adequate attention, even though R-REM is a potentially serious issue for older people living in aged care facilities (Ferrah et al, 2015; Lachs et al, 2016; Lindner et al, 2007; Murphy et al, 2017; Ellis et al 2019).

Whilst research evidence relating specifically to the abuse of people with learning disabilities in residential care settings is limited (Fyson & Patterson, 2020), there is even less research specifically about resident-to-resident abuse in residential settings for people with learning disabilities. There is also a paucity of research about the use of positive behaviour support for people with dementia and or its use in residential settings. A recent systematic review (Hayward et al, 2021) about introducing positive behaviour support into disability services for successful adoption found that there needs to be further research on the application of PBS in specific disability contexts and to broaden the application of PBS beyond challenging behaviour.

Similarly, resident-to-resident aggression (RRA) is a serious issue that has a significant negative impact on all residents involved, but incidents are often not reported and investigated (Long Term Care Ombudsman). Ferrah et al (2015) conducted a systematic review to identify contributing factors and outcomes of RRA in nursing homes and found that limited information exists on organisational factors contributing to RRA and the outcomes for targets of aggression. Moreover, very little evidence-based literature currently exists on intervening to reduce or eliminate RRA (Rosen et al, 2008). Specifically, there is a paucity of studies concerning educational programmes in nursing aimed at managing and reducing resident-to-resident elder mistreatment in aged care facilities. However, the work by Ellis developing the SEARCH approach is promising (Ellis et al 2019).

Finally, McDonald et al (2015) identified the top five research priorities as:

- Developing/assessing RRA environmental interventions
- Identification of the environmental factors triggering RRA
- Incidence/prevalence of RRA
- Developing/assessing staff RRA education interventions
- Identification of RRA perpetrator and victim characteristics

7. Potential case studies

Included below are a list of potential case studies for further review and consideration.

- **Allan Wallace**, 86, died three weeks after an altercation with a fellow resident at Mapleford Nursing Home in Huncoat. **Source**: LancsLive. (2016). Dementia sufferer died after suffering injuries in care home row. Available at: **https://www.lancs.live/news/local-news/dementia-sufferer-died-after-suffering-11544905**
- **May Miller**, 95, was assaulted by a fellow resident just four days after moving into Beech House care home in Halesworth. Source: Nixon Matthew. (17 February 2020). Woman, 95, dies after care home assault. Eastern Daily Press. Available at: **https://www.edp24.co.uk/news/crime/95-year-old-woman-dies-after-tragic-care-home-assault-1-6517963**
- An incident occurred between two residents (one male and one female) in a care home. As a consequence of this the female resident (FR) fell and hit her head. Despite emergency treatment, she subsequently died from a subdural bleed which occurred as a direct result of falling and hitting her head. (Consequence UK, 2016)
- The SEARCH intervention programme described earlier also includes some case studies:
  - Mary: verbal altercations between two women, one with dementia
  - Bill: masturbating in front of another resident
  - Alice and Betty: hitting and screaming in the TV room

Finally, a useful source for keeping up to date or for case studies is a US blog dedicated to prevention of episodes of RRA in dementia was launched in April 2012 and consists of news and free resources on this form of behaviour. It is called **Prevention of Harmful Interactions Between Residents in Dementia blog** and can be accessed at**:** **https://eiloncaspiabbr.tumblr.com/**

References

Abner E. et al. (2019). Victim, allegation, and investigation characteristics associated with substantiated reports of sexual abuse of adults in residential care settings. Journal of Interpersonal Violence, 34(19), pp.3995−4019.

Baumbusch J., Puurveen G., Phinney A., et al (2018). Family members' experiences and management of resident-to-resident abuse in long-term residential care. Journal of Elder Abuse & Neglect, 30(5), pp.385−401.

Beaton MD. (2018). Stories of resident-to-resident aggression: Fears and experiences in long-term residential care. Arts & Social Sciences: Department of Gerontology. Available at: https://summit.sfu.ca/item/18060.

Benson JJ, Beckmeyer JJ. Aggression and subjective well-being in independent senior living communities. Paper Presentation: Gerontological Society of America Annual Meeting 2013; Saturday November 23, 2013. Page 182 in Conference Program.

Berry B., Young L., and Kim SC. (2017). Utility of the Aggressive Behavior Risk Assessment Tool in long-term care homes. Geriatric nursing, 38(5), pp.417−422.

Bonifas RP. (2015). Resident-to-resident aggression in nursing homes: social worker involvement and collaboration with nursing colleagues. Health and Social Work, 40(3), pp.e101−e109.

Care Quality Commission. (2020). Promoting sexual safety through empowerment. Newcastle upon Tyne: Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf.

Caspi E. (2015). Aggressive behaviors between residents with dementia in an assisted living residence. Dementia, 14(4), pp.528−546.

Caspi E. (2016). Deaths as a result of resident-to-resident altercations in dementia in long-term care homes: A need for research, policy, and prevention. Journal of the American Medical Directors Association, 17(1), pp.7−11.

Caspi E. (2018). The circumstances surrounding the death of 105 elders as a result of resident-to-resident incidents in dementia in long-term care homes. Journal of elder abuse & neglect, 30(4), pp.284−308.

Castle N. (2012). Resident-to-resident abuse in nursing homes as reported by nurse aides. Journal of Elder Abuse and Neglect, 24(4), pp.340−356.

Castle N. (2013). Examination of resident abuse in assisted living facilities. National Institute of Justice (NIJ). Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/241611.pdf.

Cox BE. (2008). Combating elder abuse: the role of guardians for older people in residential care. Journal of Adult Protection, 10(2), pp.33−38.

Ellis JM., Teresi JA., Ramirez M. et al (2014) Managing resident-to-resident elder mistreatment in nursing homes: The SEARCH approach. The Journal of Continuing Education in Nursing, 45(3), pp.112−121.

Ellis JM., Ayala Q., Beatriz P. et al (2018). A systematic review protocol of educational programs for nursing staff on management of resident-to-resident elder mistreatment in residential aged care homes. Journal of advanced nursing, 74(8), pp.1975−1983.

Ellis JM., Ayala Q., Beatriz P. et al (2019). Implementation and evaluation of an education programme for nursing staff on recognising, reporting and managing resident-to-resident elder mistreatment in aged care facilities. Journal of advanced nursing, 75(1), pp.187−196.

Ferrah N. et al (2015). Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. Age and Ageing, 44(3), pp.356−364.

Fyson R. and Patterson A. (2020). Staff understandings of abuse and poor practice in residential settings for adults with intellectual disabilities. Journal of Applied Research in Intellectual Disabilities, 33(3), pp.354−363.

Gimm G., Chowdhury S., and Castle N. (2018). Resident aggression and abuse in assisted living. Journal of applied gerontology, 37(8), pp.947−964.

Grigorovich A., Kontos P., and Kontos AP. (2019). The ‘violent resident’: a critical exploration of the ethics of resident-to-resident aggression. Journal of bioethical inquiry, 16(2), pp.173−183.

Hirst SP. (2015). Resident-to-resident abuse. Journal of gerontological nursing, 41(12), pp.3−4.

Ibrahim JE, Murphy BJ, Bugeja L, et al (2015). Nature and extent of external-cause deaths of nursing home residents in Victoria, Australia. J Am Geriatr Soc 2015; 63:954e962.

Ira K. (2018). Bullying in Senior Living Facilities: Resident Perspectives. Available at: https://cornerstone.lib.mnsu.edu/etds/806/.

Jain B., Willoughby M., Winbolt M., et al (2018). Stakeholder perceptions on resident-to-resident aggression: implications for prevention. Australian Health Review, 42(6), pp.680−688.

Jeffries H., Slovak K., and Huston S. (2018). Measuring and Addressing Elderly Bullying in a Senior Residential Community. J. Soc. & Soc. Welfare, 45, pp.141.

Joyce CM. (2019). Prevalence and nature of resident-to-resident abuse incidents in Australian residential aged care. Australasian journal on ageing.

Lachs M. Teresi JA., Ramirez M. et al (2016). The prevalence of resident-to-resident elder mistreatment in nursing homes. Annals of internal medicine, 165(4), pp.229−236.

Lachs M. (2016). Documentation of Resident to Resident Elder Mistreatment in Residential Care Facilities, New York City, 2009-2013. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/246429.pdf.

Long Term Care Ombudsman. (2016). Long-Term Care Ombudsman advocacy: resident-to-resident aggression. Available at: https://ltcombudsman.org/uploads/files/issues/TA_Brief-LTCO_and_RRA-FINAL.pdf.

Long term Care Ombudsman. (undated). Long-Term Care Ombudsman advocacy: Resident-to-resident mistreatment Available at: https://ltcombudsman.org/uploads/files/support/resident-to-resident-mistreatment-ref-guide-final.pdf.

Long Term Care Ombudsman. (2015). Resident-to-resident aggression in long-term care settings: research to practice. Available at: https://ltcombudsman.org/uploads/files/issues/rr-aggression-research-practice.pdf.

Magruder KJ., Fields NL., and Xu L. (2019). Abuse, neglect and exploitation in assisted living: an examination of long-term care ombudsman complaint data. Journal of Elder Abuse and Neglect, 31(3), pp.209−224.

McDonald L., Sheppard C., Hitzig SL., et al. (2015). Resident-to-resident abuse: A scoping review. Canadian Journal on Aging/La Revue canadienne du vieillissement, 34(2), pp.215−236.

McDonald L., Hitzig SL., Pillemer KA. et al (2015). Developing a research agenda on resident-to-resident aggression: recommendations from a consensus conference. Journal of Elder Abuse & Neglect, 27(2), pp.146−167.

Murphy B., Bugeja L., Pilgrim J., et al (2017). Deaths from resident-to-resident aggression in Australian nursing homes. Journal of the American Geriatrics Society, 65(12), pp.2603−2609.

Myhre J., Saga S, and Malmedal W. et al (2020). Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect. BMC Health Serv Res, 20(1), pp.119.

National Center on Elder Abuse. (undated). Resident-to-resident aggression in long-term care settings: research brief. Available at: https://ltcombudsman.org/uploads/files/issues/rr-aggression-research-brief.pdf.

National Institute for Health and Care Excellence. (2021). Safeguarding adults in care homes: NG189. London: NICE. Available at: **https://www.nice.org.uk/guidance/NG189**

O'Connor C.M., Mioshi E., Kaizik C. et al (2020). Positive behaviour support in frontotemporal dementia: a pilot study. Neuropsychological rehabilitation, 1−24.

Pillemer K., and et al. (2012). Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study. Gerontologist, 52(1), pp.24−33.

Radermacher H., Toh YL., Western D. et al (2018). Staff conceptualisations of elder abuse in residential aged care: A rapid review. Australasian journal on Ageing, 37(4), pp.254−267.

Ramirez M., Watkins B., Teresi JA. et al (2013). Using qualitative methods to develop a measure of resident-to-resident elder mistreatment in nursing homes. International psychogeriatrics/IPA, 25(8), pp.1245.

Rosen T., Lachs MS., Bharucha AJ. et al (2008). Resident-to-resident aggression in long-term care facilities: Insights from focus groups of nursing home residents and staff. Journal of the American Geriatrics Society, 56(8), pp.1398−1408.

Rosen T., Pillemer T., and Lachs M. (2008). Resident-to-resident aggression in long-term care facilities: an understudied problem. Aggression and Violent Behavior, 13(2), pp.77−87.

Rosen T., Lachs MS., Teresi J. et al (2016). Staff-reported strategies for prevention and management of resident-to-resident elder mistreatment in long-term care facilities. Journal of elder abuse & neglect, 28(1), pp.1−13.

Consequence UK. (2016). Independent investigation report Care and management of MR September 2013 to June 2014. Available at: https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2016/11/invest-rep-bm-28-11-2016.pdf.

Long Term Care Ombudsman. (2018). Ending nursing home violence between residents: Prevention, intervention, and advocacy webinar. Available at: https://ltcombudsman.org/uploads/files/support/rrm-webinar-june-26-2018.pdf.

CITRA. (undated). Resident-to-resident elder mistreatment (R-REM). Available at: http://citra.human.cornell.edu/r-remp.

LancsLive. (2016). Dementia sufferer died after suffering injuries in care home row. LancsLive. Available at: https://www.lancs.live/news/local-news/dementia-sufferer-died-after-suffering-11544905.

Nixon Matthew. (17 February 2020). Woman, 95, dies after care home assault. Eastern Daily Press. Available at: https://www.edp24.co.uk/news/crime/95-year-old-woman-dies-after-tragic-care-home-assault-1-6517963.

Shinoda-Tagawa T., Leonard R., Pontikas J. et al (2004). Resident-to-resident violent incidents in nursing homes. JAMA, 291(5), pp.591−598.

Sifford-Snellgrove KS., Beck C., Green A. et al (2012). Victim or Initiator?: Certified nursing assistants' perceptions of resident characteristics that contribute to resident-to-resident violence in nursing homes. Research in gerontological nursing, 5(1), pp.55−63.

Smith D., and et al. (2018). A systematic review of sexual assaults in nursing homes. Gerontologist, 58(6), pp.e369-e383.

Snellgrove S., Beck C., Green A., et al (2013). Resident-to-resident violence triggers in nursing homes. Clinical nursing research, 22(4), pp.461−474.

Snellgrove S., and et al (2015). Putting residents first: strategies developed by CNAs to prevent and manage resident-to-resident violence in nursing homes. Gerontologist, 55, pp.S99-S107.

Social Care Institute for Excellence. (2012). Commissioning care homes: common safeguarding challenges. London: Social Care Institute for Excellence. Available at: https://www.scie.org.uk/publications/guides/guide46/.

Teresi JA., Ramirez M., Ellis J. et al (2013). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial. International Journal of Nursing Studies, 50(5), pp.644−656.

Teresi JA., Ocepek-Welikson K., Ramirez M., et al (2014). Development of an instrument to measure staff-reported resident-to-resident elder mistreatment (R-REM) using item response theory and other latent variable models. The Gerontologist, 54(3), pp.460−472.

Teresi JA,, Silver S., Ramirez M., et al. (2020). Resident-to-resident elder mistreatment (R-REM) intervention for direct care staff in assisted living residences: study protocol for a cluster randomized controlled trial. Trials, 21(1), pp.1−16.

Touza C., and Prado C. (2019). Prevention of elder abuse in long-term care facilities. Educational Gerontology, 45(8), pp.530−546.

Trompetter H., Scholte R., and Westerhof G. (2011). Resident-to-resident relational aggression and subjective well-being in assisted living facilities. Aging & Mental Health, 15(1), pp.59−67.

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