Introduction

Program Development
Disclosures
Instructions
Purpose
Learning Objectives/Outcomes
Program Development

Contributors
Denise R. Felsenstein, MSN, CRNP, WHNP-BC
Nurse Planner/CE Consultant
Alicia V. Aslami, BSN, MPH, RN
CE Consultant

Gary Elias, JD
Elder Law Practitioner/Consultant

Program Review and Approval
E-Learning Team, Wolters Kluwer Health/Lippincott Williams & Wilkins
Karen Innocent, DNP, CMSRN, ANP-BC, RN, CRNP
Executive Director, Continuing Education

Karen DuBois-Kahn, MSN, RN
CE Manager
E-learning

Richard Gonzalez
CE Coordinator
Creative and Production Support

Kathleen Felix, AA
CE Manager
Project Management and CE Coordination

Hector Ortiz, BFA
Consultant
Creative and Educational Design

Eli Gancias, MBA
CE Coordinator
Creative and Production Support

Maria Miller, MBA
Consultant
Creative and Production Support

Wolters Kluwer
Disclosures

The planners have no financial relationships related to this educational activity.
Instructions

To obtain a certificate of earned contact hours for this continuing education activity:

1. View the entire program.

2. Take the post-test. If you pass, you will be able to print your certificate of earned contact hours and an answer key. If you fail, you have the option of taking the test again. The passing grade is 70%.

3. Complete the evaluation form.
Purpose

To provide senior managers of long-term care facilities with information about angry residents and management strategies to reduce the risk of negative outcomes.
Learning Objectives/Outcomes

After viewing this presentation and taking the post-test, you should be able to:

1. Identify long-term care residents who are at risk for destructive angry behaviors.
2. Explain the consequences of ineffective anger management and the associated risk exposure to the long-term care facility.
3. Summarize risk reduction strategies for managing the anger of residents in long-term care facilities.
Angry statements made by residents. At one time or another staff hear accusatory or disgruntled words uttered in a sarcastic, belligerent, or loud manner. Why are they so angry?

That’s a good question. What are they really trying to express? What type of communication is occurring between the resident and the caregiver? Are they upset because this is the first time in their lives that they need the assistance of other? What is really going on, and how can we, as professional caregivers, recognize those factors and effectively diffuse the situation?
As a senior manager at a facility providing care to long-term care residents, you must ensure that everyone at your facility is able to recognize a resident who is at risk for becoming angry or agitated. Most residents newly placed in long-term care or assisted living are confronting the loss of their independence and are nervous in a new unfamiliar environment. Many are also experiencing mental status changes as a result of dementia or medication side effects. All of these things put residents at risk for angry behaviors.

Disrespect of the resident and inappropriate reactions to anger will put your facility at risk for malpractice, legal and criminal charges. The facility policy and procedure manual should outline appropriate actions to take as well as lines of supervisor communication available to and expected of all caregivers and support staff.
Anger is often misplaced, surfacing in situations remotely related to the underlying issue.

Moving into new long-term care facility is a major life change, the stress of which can easily lead to angry lashing out. Many new residents are experiencing the additional stressors like the death of spouse, loss of a child or caretaker, health problems, or financial difficulties. Many are losing the ability to care for themselves independently. This contributes to verbal and physical abuse among residents needing help with activities of daily living.

Older people experiencing difficulties with social interactions may not engage in activities which can lead to social isolation.

Medical conditions common to this population including neurological changes, memory deficits, and emotional liability due to stroke or brain injury can predispose residents to agitation and anger. Anger is symptomatic of several mental health issues, including depression, anxiety, and psychosis.
All people experience feelings like frustration and helplessness which can lead to aggression. There are socially acceptable outlets for those emotions like work, play, or sports. When life changes significantly, as in aging or entering long-term care, aggressive tendencies may be exacerbated. If an individual may no longer is unable to release frustration through work or leisure activities, aggressive behaviors might be released through socially unacceptable outlets.

Abusive behavior does not always follow anger or aggression. Several studies have found that abusive behavior by residents is almost always associated with impaired cognitive ability. Other risk factors in addition to confusion are pain, depression, and environmental factors.

Medications can also play a part in aggression and abuse. Residents who seem unusually angry, are acting irrationally or appear confused may be experiencing more than anger. They could be physically or mentally ill, or be experiencing side effects from medicine. If you encounter an irrational or confused resident, or if a resident you know has a sudden change in behavior, alert a nurse or a doctor. The resident might need a medical examination.
In order to respond appropriately and de-escalate an angry resident situation, you and your staff must first identify and optimize your own responses to the anger. The staff needs to be always be respectful to the resident and do not take it as a personal attack on them. Each recipient’s response is unique to him or her, and is shaped by past experiences, level of frustration, perceived threat, level of self-confidence, and the presence of other emotions.

Some things interfere with a caregiver’s ability to respond appropriately. These include feelings of fear and anxiety or feeling personally attacked. Assuming blame or taking personal responsibility for the resident’s anger can also interfere with an appropriate response. Caretakers may also feel powerless and unprepared to respond, or may have their own angry response to feeling unfairly treated, unjustly accused, or blocked from completing the task at hand (the bath, daily care, etc.). Remember, the caregiver’s duty is to give assistance to the resident and not to become personally involved with whatever is creating the anger in the resident.

A study by Smith and Hart (1994) found that nurses who showed their own reactive anger made situations worse for themselves because of subsequent shame and guilt for losing control. This led to further erosion of self-esteem, as well as fear, anxiety and more anger.
Review Question

Please click on the correct answer.

When a resident becomes angry with a caregiver it is a personal attack.

a. True
b. False
Caretakers and other staff, including managers, feel especially threatened when they perceive an attack to their own competency or personal integrity. This is intensified if they were already in a situation that was not going well and were already feeling anxious or inadequate. A resident’s anger causes emotional arousal in the caretaker and interferes with the caretaker’s cognitive ability to process the resident’s message and respond in a professional manner. As difficult as it may be, the caregiver has to stay indifferent to any personal attack aimed at them by the resident, and as a manager, this concept has to be reinforced to the caregiver.

If the perceived threat level is high, and the staff member may disconnect using defensive protective strategies. These strategies shield the staff member from the situation but impede communication. They include taking a time out or leaving the for a brief time to compose him or herself or to seek emotional support. Anger can be suppressed by transferring blame onto the doctor, the institution, or back to the resident.

Self-efficacy of the caretaker within the given situation lowers the perceived threat to the caretaker and allows him or her to connect with the angry resident. It allows him or her to move toward helping the angry resident and resolving the situation.
When anger is not managed appropriately, residents often feel anxious, fearing loss of control, or guilty for lashing out at caretakers. Staff may be frightened and hesitant to care for the resident, compounding the stress and resulting in less than optimal care. Demonstrations of anger are distressing to other residents and disruptive to the daily routine of the community.

All staff should be offered an opportunity for training to manage difficult residents.

Unresolved anger with or without sub-optimal care can lead to accusations of misconduct or abuse, staff termination or attrition, loss of residents to other facilities, and liability to the organization and its members.
Anger and aggression are interactional events influenced by the characteristics of both the individual and the environment. Interventions to reduce anger and aggression should be individualized and specific, taking circumstances and resident needs and abilities into account. There is no “one size fits all” or “cookie cutter” approach to this problem.

Programs that reduce conflict may be useful for verbal aggression that resembles bullying. Verbal aggression due to unmet needs or frustration (like poorly managed pain or inability to ambulate) requires direct resolution with specific caregiver assistance. Chronic verbal altercations among roommates require solutions specific to that situation. Understanding context of anger is very important.

Interventions appropriate for residents with cognitive impairment may not be appropriate for residents without cognitive impairment. Standardized interventions like routinely separating residents who fight with each other could conceivably have negative effects. For example, social interaction is crucial in the long-term care setting. Careful consideration should be given before separating residents who sometimes quarrel, but also provide each other social support.

The individualized resident care plan should be used to communicate between staff members. The plan needs to be communicated in a detailed manner and consistent, so there are no deviations when there is a shift in personnel.
One study of resident to resident aggression identified several triggers of aggressive behavior in nursing homes. The most common triggers included:

- Invasion of personal space, which feels threatening to the resident, who then lashes out;
- Invasion of room privacy, when others enter the resident’s room uninvited, especially if touching the resident’s belongings. This could be an uninvited guest or a “wanderer” or confused resident;
- Congestion and crowding in common areas and hallways can push frustration to its limit, especially for those with disabilities or limitations ambulating;
- Others interfering with care, whether they are legitimately attempting to help or just interfering;
- Arguments with roommates over typical roommate issues, like the room temperature or noise; and
- Dealing with an aggressive or belligerent roommate (who might be confused).

Environmental modifications to address these issues include measures to reduce crowding in common areas and passageways with special attention to the effect of congestion on wheelchair users, and the use of non-restraining barriers to prevent unwanted entries into residents’ rooms.

Long-term care staff should be aware of all of these common triggers and be empowered to address them before situations escalate. Be sure that staff are familiar with policies and procedures that address these situations.
Long-term care employees should be taught basic strategies for handling acutely angry residents. As the resident escalates, the staff must be aware of their own emotional reactions and work to stay calm. The staff must remember this is not a personal attack on them.

Teach staff to recognize warning signs related anger and agitation such as body language like pacing, clenched fists, tense posture, or any behavior unusual for the individual. Staff should avoid the temptation to avoid the resident who is becoming angry. They should avoid touching the resident, as touch can be easily misinterpreted. Communication should be in a calm steady tone. Resident concerns should be addressed directly and honestly. Empathetic responses and honest attempts to resolve problems may prevent the anger from escalating into a crisis.

Firm limit setting on disruptive or aggressive behavior is needed to reinforce boundaries and maintain control of the environment. A resident who is bored and restless might benefit from engagement in an activity. Conversely, someone who is escalating probably needs decreased stimulation to regain control of their behavior.

If an angry resident is behaving irrationally, acknowledge his or her feelings without responding to the irrational content. Reassurance, ensuring safety, and decreasing stimulation is usually the best course of action.
Review Question

Please click on the correct answer.)

Staff should treat all angry residents in a manner that conveys
a.  disappointment.
b.  respect.
c.  friendship.
Staff should always be reminded that resident and employee safety is the first priority. If a situation escalates out of control or there is any fear of physical harm, employees should know how to call for immediate help. If a resident becomes physically abusive, staff needs to know to call for assistance immediately to reduce the likelihood of the resident injuring him or herself or the staff. Fall prevention is a high priority in these situations.

Supervisors must respond quickly, prioritize and make fast decisions. Know the chain of communication and follow well-documented procedures per the institution’s policies.

Outbursts and resident complaints should be documented in the medical record and on an incident report and then shared within the organization and to outside agencies as necessary. Appropriate responses to anger and proper documentation can help prevent litigation and limit employee and facility liability. Make sure that the report is filled out in a timely manner as soon after the incident as possible. Review the report with the caregiver. Senior management should contact the Ombudsman when necessary.
Residents experiencing ongoing or recurrent episodes of anger and agitation warrant medical and psychiatric evaluation in order to assess for and address any causative factors. Ongoing psychiatric care with a psychiatrist, therapist, psychiatric social worker, or nurse practitioner may be advised.

Longer term interventions are necessary and may include one-to-one time with staff members, increased socialization, or engagement in activities the resident finds soothing, perhaps doing artwork or listening to music.

Mindfulness-based stress reduction (MBSR) programs have been shown to improve coping and reduce depression and anger in older adults and one study showed that nursing home residents receiving weekly “humor therapy” experienced less agitation.

Agitation is frequently seen in residents with dementia. Studies have shown that activities, exercise, walking programs, 1:1 socialization, recreational activities, music therapy or daily music, white noise, and behavior modification therapy all decrease agitation in residents with dementia.

Residents with agitation related to dementia or psychiatric comorbidities may benefit from antipsychotics, antidepressants, mood stabilizers, or benzodiazepines. Any of these medications must be used cautiously with older adults. Make sure the medication prescribed is administered exactly as per the doctor’s instructions.
Staff training and education on how to deal with angry residents should be part of your facility’s ongoing continuing education program. It should include practical instruction in dealing with agitation and de-escalation techniques as well as verbal and non-verbal communication skills.

Staff should be consistently reminded to listen to resident complaints, respond with appropriate concern, and address the resident’s fear and anxiety.

Work with unit managers to conduct post-event conferences for staff to deconstruct situations. Analyze what worked well and what did not. These communications can improve staff’s understanding of the team dynamic, review techniques, and prepare for the next event.

Staff responses to angry or agitated residents should be empathic. They should be trained to identify signs of escalating behaviors and have the knowledge and skills to de-escalate the resident and the environment to maintain safety.
It bears repeating that the first and most effective thing an employee can do when encountering an angry resident or family member is to take charge of his or her own angry response. Threat is minimized when the employee is able to connect with the individual without allowing the anger to threaten one’s own self-esteem. If the caregiver loses control, the situation will remain out of control.

Teach staff to avoid personalizing other people’s anger, even if it is misdirected at them. Educate them to recognize the underlying cause of the anger, rather than taking it personally. Help them to understand that a personal attack is more likely an expression of fear or anxiety.

The productive approach is to gain a holistic understanding of the resident or family member’s situation by detecting early signs of anger, exploring feelings, responding empathetically, and keeping lines of communication open. Suggest that the middle manager hold a team meeting or meetings with family to better manage the resident.
Senior managers should know what type of leadership style they are most comfortable with. When staff have encounters with angry or agitated residents, senior management needs to be made aware of the situation as soon as possible. Think about this scenario.

You are the senior manager of a long-term care facility. Mrs. Jones is having difficulty transitioning from her home of 50 years to living as a resident in your facility. She has berated staff at every attempt to help her with activities of daily living. She is not physically abusive but at times she has insulted staff and become belligerent. The staff are finding it hard to approach Mrs. Jones with empathy. They would like to avoid her.

The unit manager has met with you and at your suggestion she met with the family to explore alternate care plans for Mrs. Jones.

During the weekend the resident was resisting treatment and fell. An incident report was completed and put on your desk Friday evening. You found the report on Monday morning. More than 24 hours has passed. While staff followed procedure, they should have called you and so that the incident could have been addressed within 24 hours.
Review Question

(Please click on the correct answer.)

What is the most productive thing a staff member can do when encountering an angry resident in order to decrease the risk of repercussions?

a. Find out who is to blame for the problem.

b. Convince the resident that the problem is minor.

c. Manage his or her own emotional response.
References


References


References


Disclaimer

This publication is intended to inform Affinity Insurance Services, Inc., customers of potential liability in their practice. It reflects general principles only. It is not intended to offer legal advice or to establish appropriate or acceptable standards of professional conduct. Readers should consult with a lawyer if they have specific concerns. Affinity Insurance Services, Inc. does not assume any liability for how this information is applied in practice or for the accuracy of this information. Aon Quality Institute is a registered trade name for the brokerage and program administration operations of Affinity Insurance Services, Inc. (TX 13695); (AR 244489); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc. (CA 0G94493); Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency. © 2016 Affinity Insurance Services, Inc.