

Exploring peer-to-peer abuse in residential care

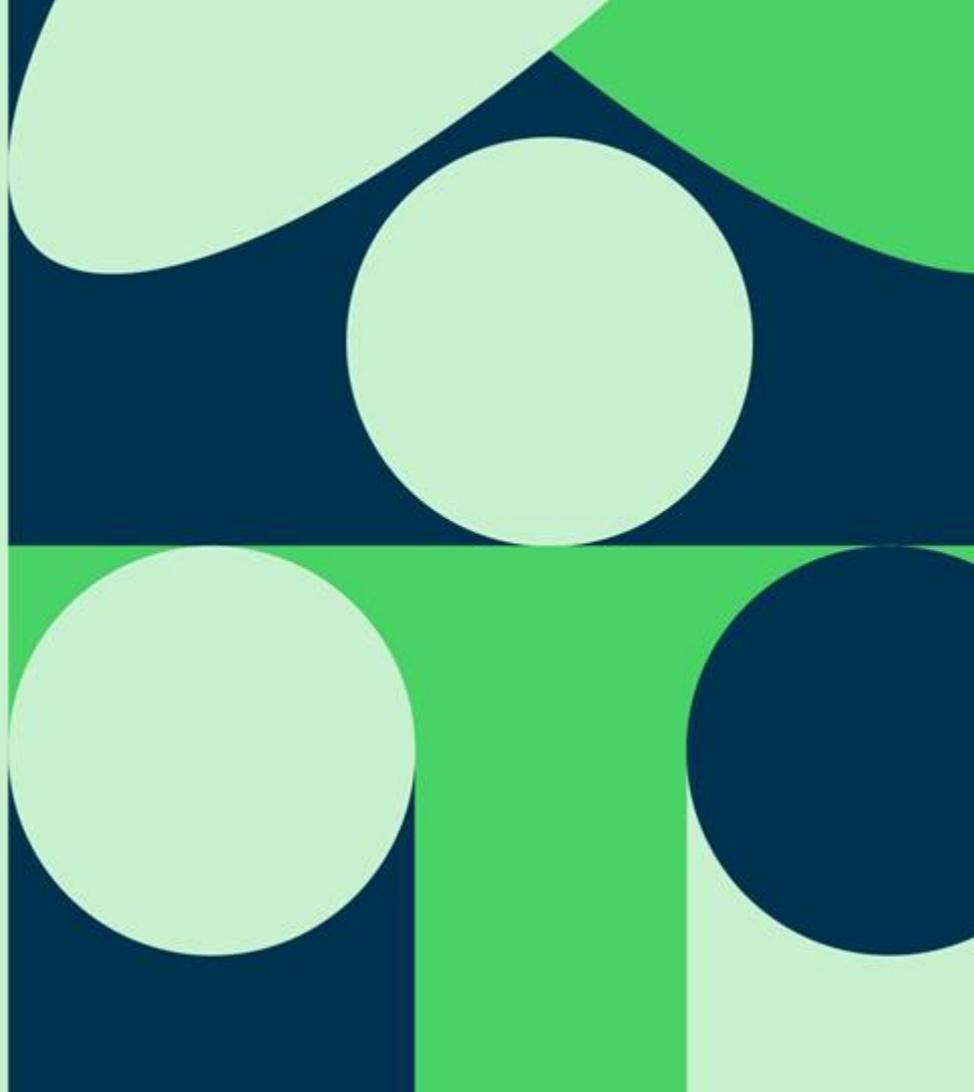
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95-year-old woman charged with murder in death of elderly nursing home roommate

18 Sept 2025

The family of victim Nina Kravtsov, 89, said she was a Holocaust survivor.



B B C

'Risks not assessed' in fatal beating care

October 2024



abc 7 EYEWITNESS NEWS

24/7 Live

November 2023

Joliet nursing home resident charged with murder of fellow resident over washing machine

Peer to Peer abuse AKA Resident to resident aggression/resident to resident harm

Resident-to-resident aggression is defined 'in long-term care facilities as negative and aggressive physical, sexual, or verbal interactions between long-term care residents, that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.'

(Rosen *et al.*, 2008:78)

Contextually different from abuse in the community but has the same spectrum of abuse types.

Underreported and under-researched.

A patient safety issue (Myhre *et al.*, 2020)

Abuse occurs within relationships where there is the expectation of trust. **That expectation cannot be applied to the relationship between residents.** (SCIE, 2023)

How Common?

Person Allegedly Causing Concern	18-64		65+		65-79		80+		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Other Service User/Peer	6856	62%	1636	33%	1096	39%	540	26%	8492	53%
Immediate family member	1607	15%	1852	37%	962	34%	890	42%	3459	22%
Staff	1958	18%	978	20%	504	18%	474	22%	2936	18%
Other Relative	173	2%	271	5%	150	5%	121	6%	444	3%
Neighbour/Friend	188	2%	162	3%	93	3%	69	3%	350	2%
Stranger	239	2%	48	1%	30	1%	18	1%	287	2%
Total	11021	100%	4947	100%	2835	100%	2112	100%	15968	100%

Prevalence

Resident-to-resident aggression equates to 22.22% of all types of abuse in nursing homes (Touza, 2019).

*Resident data of 6,848 US residents: 7.6% of assisted living residents engaged in physical aggression or abuse toward other residents or staff in the past month, 9.5% of residents had exhibited verbal aggression or abuse, and 2.0% of resident engaged in sexual aggression or abuse toward other residents or staff. Dementia & MH issues common contributory factors. (Grimm *et al.*, 2018)*

15.2% in assisted living-verbal abuse most common (Pillemer *er al.*, 2024)

RRA: 0.5% (1/207) of nursing home deaths reported to the medical examiner (Ferrah *et al.*, 2015)



3.4 incidents per 1,000 beds per year (Jogerst *et al.*, 2005)



23% (79/339) of residents (Brazil *et al.*, 2013)



United States 20.2% (Lacks *et al.*, 2016)



28 deaths from RRA over a 14-year study period (0.004 per 100,000 bed days). Most exhibitors of aggression were male (n = 24, 85.7%), and risk of death from RRA was twice as high for male as females (dementia 90%, ¾ history of behaviour problems, often younger and recently admitted) (Murphy, 2017)

deBois et al., 2020

- Multistate National Violent Death Reporting System (NVDRS) related to fatal RRA incidents between years' 2003 and 2016
- “Push-fall” incidents as the most common incident type, and head injuries, followed by hip fractures, as the most common injury location.
- Physical strength is a factor in RRA, particularly fatal RRA
- **Fatalities:** difference of 17 days between injury and death data with Only 11 residents of 101 dying on the same day the injury occurred.
- Suggests they are more common as not immediate to event.

Caspi 2010

- **Residents:** limited capacity to tolerate disruptive behaviour or noise from other residents (questioning, shouting, burping, sneezing, coughing etc.)
- Crowded rooms could lead to irritation.
- Three-quarters of resident to resident abuse took place when there was no activity; 1/3 during mealtimes.
- Modifiable



Intent

- Difficult as ? Perpetrator is conscious, voluntary and intended to result in harm to the target of aggression.
- May be reciprocal.
- Cognitive impairment.

Table 1. Major Forms of RRA Events (Count of Events)

Category 1: invasion of privacy or personal integrity	
Incursion on personal space (7)	A resident reacts verbally or physically because of perceived physical threat, either real or exaggerated, from another resident, usually the invasion of personal space.
Invasion of room privacy (16)	A resident enters another's room without invitation, sometimes touching his or her belongings and making him or her feel threatened or uncomfortable.
Clearing a way through congestion (8)	Verbal or physical aggression prompted by the aggressor's desire or attempt to move through a space; collisions or scuffling that occurs between proximate residents trying to move about.
Inappropriate caregiving (2)	Suggestions or instructions from one resident to another in an attempt to take on the role of a caregiver.
Category 2: roommate problems	
Roommate disagreements (12)	Annoying or disruptive behavior of a roommate, sometimes leading to arguments about behavior in the room, such as, music being played too loudly or temperature.
Belligerent roommate (11)	Repetitious aggressive or antagonistic behavior from one roommate to another, seemingly without cause.
Category 3: hostile interpersonal interactions	
Angry attempts at social control (13)	Imperative statements made with the intent of changing another resident's behavior, most often to prevent another resident from being disruptive or to conform to a normative standard for the setting.
Arguments (7)	Aggressive verbal exchanges in which two residents engage in an angry dispute about a topic.
Disproportionate response to normal interaction (7)	Insults or mean-spirited responses or statements made during a typical interaction with another resident; often the result of a disproportionate anger response.
Teasing or joking (6)	Sarcasm, jeering, or making fun of a resident that was perceived as hurtful.
Accusations (5)	In a threatening manner, a resident (inaccurately) accuses another resident of having stolen something or invaded his or her privacy.
Category 4: unprovoked actions	
Unprovoked actions (21)	Unprovoked and unanticipated aggression.
Category 5: inappropriate sexual behavior	
Inappropriate sexual behavior (7)	Unwanted sexual advances and intentional nudity or exposure in the presence of other residents.

Myhre et al., 2020

Sub- Categories	Code	Meaning unit
Common	Resident-to resident aggression are common	<i>We have very often residents that are both physically and psychological aggressive towards other residents.</i>
Resident - to resident aggression as normalized	Difficult to do something with resident- to resident aggression	<i>I think it is due to the cognitive failure, so then it is not an abuse, because it doesn't help to just talk to the resident.</i>
	Resident-to-resident aggression a big part of everyday life in nursing homes	<i>We may have a little thick skin in relation to where the limit goes for what we accept. Because it is such a big part of our everyday life that it became normal in a way.</i>
	Normal behaviour from people with dementia	<i>When we have focus on dementia, it becomes normal for us to see such behaviour.</i>
Hitting	Physical abuse – hitting when trespassing a resident rom	<i>We had a patient who was hit and beaten by the same resident several times. The resident walks into his room and simply knocked him down, and that is a despair.</i>
Verbal abuse	Psychological abuse – verbal abuse normal behaviour for people with dementia	<i>Then we have residents with frontotemporal dementia who just acts in that way, they just verbally offending others, but it is their way of behaving.</i>
Violation of resident's privacy	Psychological abuse – violation of resident's privacy when trespassing into another resident's room	<i>Trespassing into another residents' room that happens a lot, but it's a violation of their privacy, and if the resident can't speak or is cognitive impaired, they may be unable to tell if something is happening.</i>
Stealing things	Financial abuse – stealing things	<i>They steal things from each other's room, yeas that happened.</i>
Sexual assault	Sexual abuse – sexual assault and an ethical dilemma	<i>We see sexual approaches or that they forgot that they are married and find each other instead. But that is more a dilemma than an assault or maybe it can be an assault... well I don't know.</i>

- RRA events are determined by multiple factors, including victim and offender characteristics, situational cues, and organisational attributes.
- Connections between physical health and functional capacity are complex. Dementia may be a background factor of aggressive behaviour but needs to be seen in a comprehensive perspective and in its interaction with variables such as pain and depression.
- Situational features such as noise, crowding, and invasion of personal space may be relevant. Currently, little is known about the influence of organisational characteristics such as unit size, staffing, institutional climate and policies. (Goergen 2017)

Triggers

Calling Out / Making Noise

Territoriality / Challenges with Communal Living

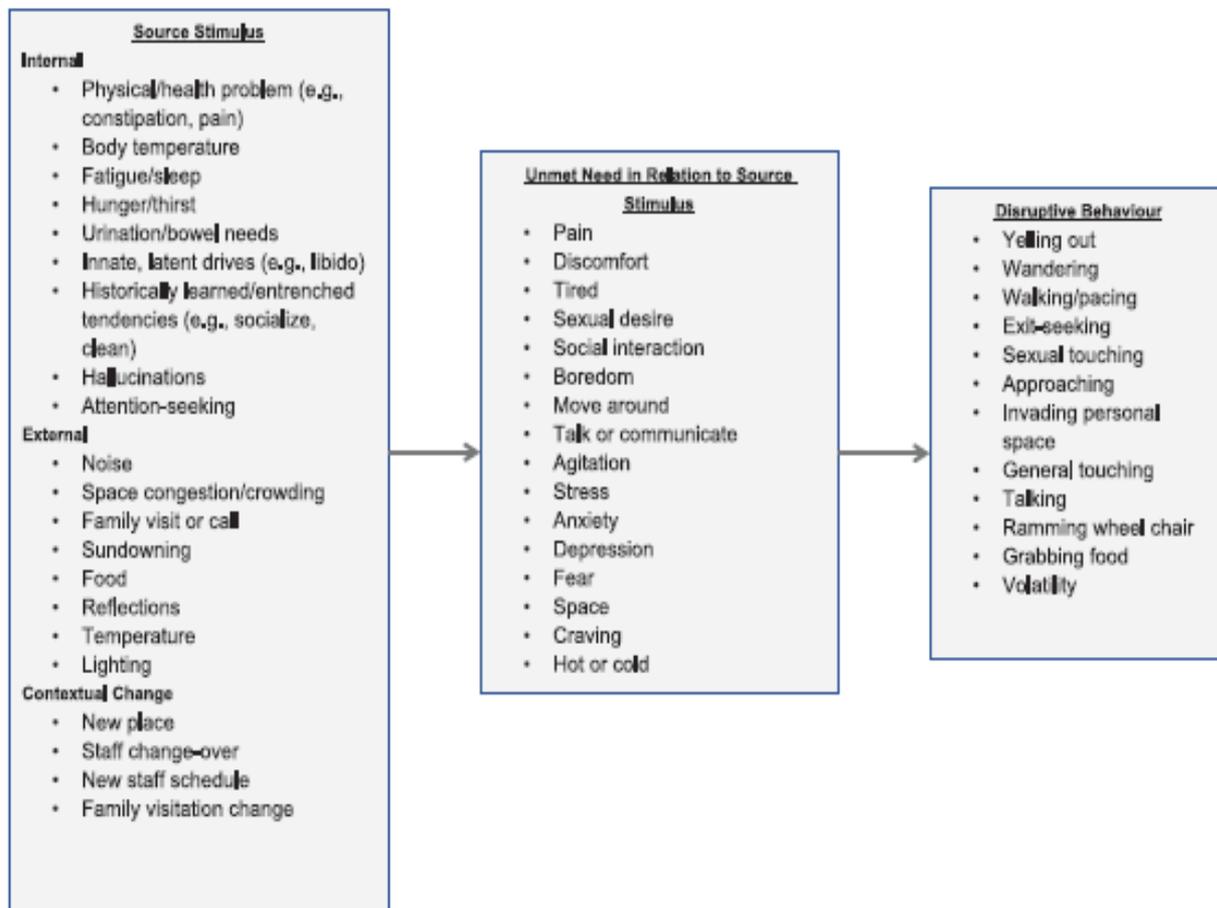
Roommate inability to compromise preferences

Impatience

Loneliness / Abandonment / Frustration with Institutionalization

Jealousy

Dementia / Cognitive Impairment / Dis-inhibition



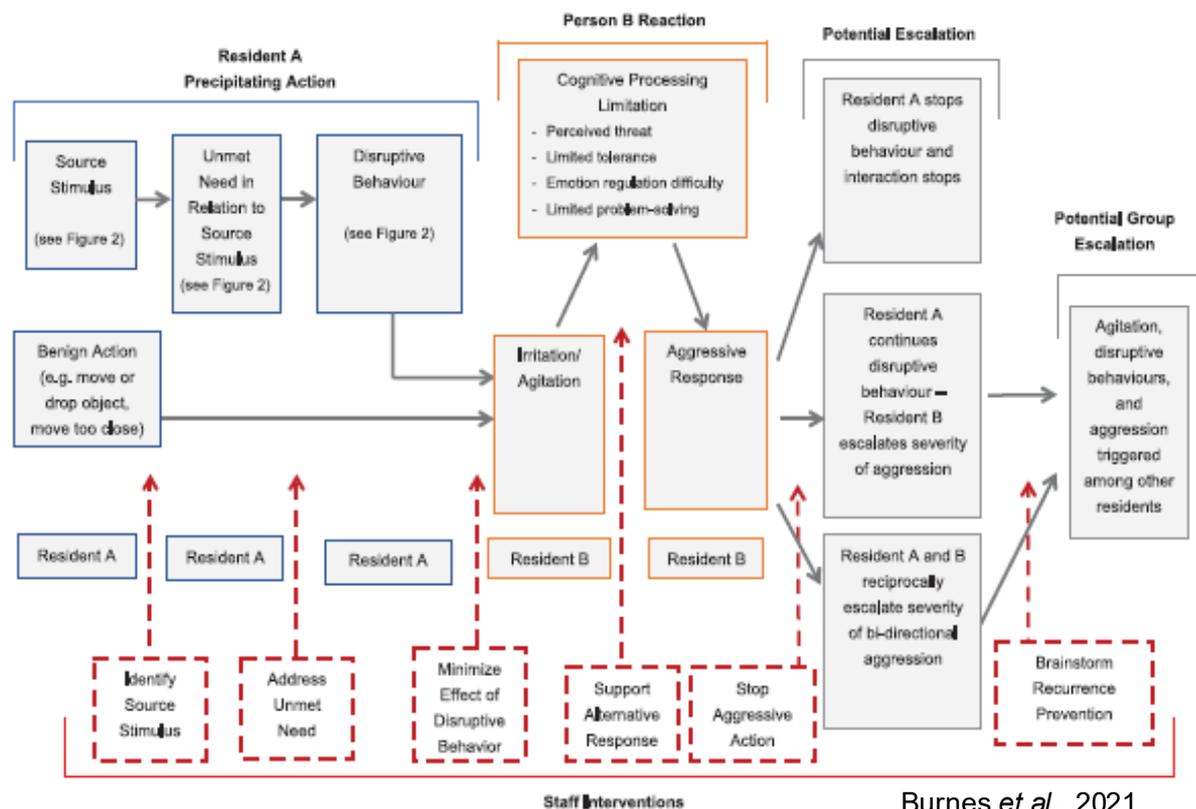


Figure 1. Model I—Interactive RRA process driven by disruptive behaviors of one resident and cognitive processing limitations of another resident.

Note. RRA = resident-to-resident aggression.

Resident to resident abuse

Consequences can include:

- A reduction in life satisfaction
- Increased risk of depression, anxiety,
- Loneliness
- Low self-esteem
- Overall negative mood
- A higher likelihood of experiencing neglect by caregivers and non-receipt of care after suffering sexual abuse (McDonald et al., 2015).
- Death, post traumatic stress disorder, reduced QoL, falls, health deterioration, moved from facility (Bonifas, 2015)
- Morbid and mortal (Pillemer et al., 2024)

Socioecological model (Pillemer *et al.*, 2011)

- The social–ecological approach highlights the interconnection of human interactions with physical and sociocultural surroundings.
- Specific behaviors are thus treated as interactions between individuals and the physical and social environment rather than taking a linear, sequential view of causality and focusing solely on individual-level behaviors and risk factors (Pillemer *et al.*, 2011:25)
- Thus, examination requires a consideration of needs, person–environment fit, and antecedents or consequences for both members of the RRA dyad

For nursing staff, encountering aggressive behaviour by residents has some degree of ordinariness; their coping strategies mainly develop against this background of everyday professional experience.

Approaches include staff training, such as the SEARCH strategy (for Support, Evaluate, Act, Report, Care plan, Help to avoid)

(Goergen, 2017)

- **Prevent**-assessment and reevaluation, rights-based approaches (Grigoroich *et al.*, 2019).
- Accurate and comprehensive pain management (Hyochol et al. 2015)
- Antipsychotic medications have traditionally been used to manage agitation and aggression, but antipsychotics have limited efficacy, result in poorer quality of life, and are associated with a high risk of adverse effects, including mortality (Jutkowitz *et al.*, 2016)
- Non-pharmacological interventions
- Person-centred care (Slone *et al.*, 2004)
- Relational citizenship (Grigorovich *et al.*, 2019)

Management

- **Prevention:** Assessment, right match of facility to need, environment of recognition, non-punitive, care fits around the person, not around the system, matching residents, staff training, skill mix, workload.
- **Managing:** intervene, staff training, place of safety, counselling, reassurance, recognise deterioration of responsive behaviours, and family discussions.
- **Size:** Larger units have higher levels of agitation (Calkins, 2011; Benbow 2018).

- Rights-based responses for both victim and perpetrator (FREDA, PANEL)
- Searching for reasons explaining aggressive behaviour. Triggers (organic, social, environmental, psychological)-unmet need? i.e infection, constipation, boredom, loneliness.
- Performing interdisciplinary case reviews focusing on aggressive behaviour (Bonifas, 2015)
- Integrating person-centred biographical information, for example, preferences, habits or dislikes.
- Setting limits for residents, for example, non-acceptance of aggressive behaviour
- Describing aggressive behaviour in the nursing report or in an 'aggression protocol'.

Intervention

- Applying measures for validation, for example, asking supplementary questions, mirroring behaviour verbally or by body language, confirming residents' emotions.
- Distracting residents by social interactions, for example, singing.
- Carrying out activities for memory stabilisation, for example, talking about residents' life themes, associated with positive or negative feelings
- Introducing methods of basic stimulation, (therapeutic) touch, massage, aromatherapy.
- Enhancing mobilisation and physical activities of residents, if possible (walks, passive exercises, dancing, art).
- Adapting the daily structure to residents' needs
- Changing the environment, room interior, etc.
- Exercising calm.
- Use a standardised assessment- Cohen-Mansfield Agitation Inventory and Aggressive Behaviour Scale

ABC model

http://www.dementiamanagementstrategy.com/pages/abc_of_behaviour_management.aspx

▶ A = Activating Event

Joe wanders into co-resident's room.
Co-resident orders Joe out.

▶ B = Behaviour

Joe responds with verbal aggression.

▶ C = Consequence

Staff assess the situation and talk to Joe in a warm and friendly manner that is respectful and maintains dignity. Staff use communication techniques aimed at diffusing the aggressive situation.

D = Decide & Debrief

Joe's aggression de-escalates and staff and others undergo debriefing.

By not confronting Joe in his anger and by using appropriate communication techniques, the (C) moves to (D) rather than (A), allowing staff to distract him with an activity rather than an (A) activating event.