SeneCura GRUPPE

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Elaboration
Violence in the Elderly Care
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Gender specific terms used here refer to men and women equally.

Introduction

Violence in the elderly care needs to be prevented. It is important to be mindful of the many faces of violence in everyday life. If we are aware of the possibility of violence in care, a first step against violence has already been taken. Only then will we be able to become sensitive to signs of violence and recognize it at an early stage. It is therefore necessary not only to know the forms and causes of violence in care, but also to know what options there are to act against occurring violence. This topic has to be recognized and addressed in all of its forms.

Definition of violence

The World Health Organization defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

In concrete terms, violence against elderly people means a one-off or repeated act or the failure to respond appropriately in the context of a trusting relationship, which causes harm or suffering to an elderly person.

Forms of violence

The following chapter is based on the forms of violence described by Staudhammer (2018, 7-14) and Andratsch and Osterbrink (2015, 43-53). In general, a distinction is made between direct and indirect violence. Furthermore, a distinction is made between physical and psychological violence as well as the restriction of free will, financial exploitation and neglect. Structural and cultural violence are named as external factors that encourage violence.

Direct (personal) violence: In this form of violence, perpetrators and victims face each other and there are always negative consequences for the victim. The will of the victim is being counteracted and there is a damage left behind. The violence is immediately recognizable as such.

Physical violence: All forms of abuse that deliberately inflict pain on the opponent, e.g. hitting or punching, detain somebody against their will, forcing someone to take psychotropic drugs, sexual abuse, force-feeding, insertion of catheters and tubes that are not needed.

Psychological violence: In contrast to physical violence, psychological violence is often invisible; however it is just as hurtful and damaging. The problem is that the person concerned is often unable to name the injuries to their soul. Psychological violence includes all forms of ignoring needs, mocking, not taking them seriously, insulting, threats and exposing them.

Restriction of free will: Examples from the hospital and care sector are: Regulation of the place of residence, mechanical restrictions on freedom such as bed rails, belts, etc., electronic restrictions on freedom and surveillance, restrictions on freedom through psychotropic drugs as well as the threat of one of these measures.

Vernachlässigung: Hierbei werden Handlungen unterlassen. Als passiv gelten unterlassene Handlungen, wobei es zu einer Fehleinschätzung der Bedürfnisse kommt und darauffolgend zu Schäden. Als aktiv werden unterlassene Maßnahmen bezeichnet, die willentlich von der betreuenden Person verweigert werden. Als Vernachlässigung gilt sowohl jede Verweigerung von Hilfen und Hilfsmitteln als auch der missbräuchliche oder falsche Einsatz von Hilfsmitteln. Auch die Verweigerung von Gesprächen, Kontakten und Zuwendung sind hier zu nennen.

Neglect: This means, for example, that shares in the assets of the person concerned are sold against their will. Retention of the retirement pension for one's own benefit, embezzlement of assets by the supervisor and an inappropriate classification of the care level can also be mentioned here. This form of violence occurs more frequently in the family or private environment of people in need of care. However, it can be assumed that financial exploitation is often used in connection with psychological and physical violence.

Sexual violence: This form of violence includes all actions against a person in need of care in which sexuality is used as a means of humiliation and harm. Forms of this are sexual harassment, sexual assault of any kind (e.g. inappropriate physical contact, forcing sexual acts, intimate contact that the victim does not agree on), rape and sexual abuse. Sexual violence can also be expressed in verbal, suggestive statements and looks.

Indirect violence: Indirect violence are the effects of the different forms of violence, which always take place in a multidimensional way. Physical violence is usually associated with psychological violence and psychological violence with neglect due to isolation.

Structural violence: This form of violence is based on external factors and circumstances and is not tied to a specific person. It is based on institutional and social structures which, in the way they are established and specified, influence people. These include all house and home regulations, staffing, tight day-to-day structures, spatial equipment and the resulting lack of privacy, a shorter stay in hospitals in order to save costs, hygiene regulations, standards and statutory requirements of long-term care and health insurance companies. This form of violence is seen by most employees as the main risk factor for violence in the medical sector.

Cultural violence: Cultural violence is defined as the violence that results from prejudices that prevail within a culture and determine ones actions. This refers to the values of a society. Old age, illness and addiction are often associated with inefficient and expenses. In society, being old or suffering from chronic illnesses means that you are worth less and cannot make any contribution to society.

Causes of violence in the elderly care

The causes of violence in care relationships are as complex as their forms. Violent incidents rarely occur suddenly and without any signs - rather, violence and aggression in most cases have a longer history. This chapter first explains seven causes of violence in care, followed by a list of further backgrounds.

1. Nursing staff are unsure about how to speak to colleagues about violence they have observed.
2. Either the facilities have no standards for dealing with problematic situations or the nursing staff do not know the content of such standards.
3. The general conditions of care - lack of staff, time pressure, unequal power structures and long periods of work - favor violence.
4. Aggressive or disruptive behavior on the part of those in need of care provokes violence on the part of the nursing staff.
5. Excessive demands, low qualifications, the carers' own experiences of violence and a lack of identification with the profession of care for the elderly encourage the use of violence.
6. There is too little training on violence prevention.
7. There is no generally binding definition of the term violence and the carers do not know where and when violence begins.

(Hieber 2017, 62)

- Bad working environment, conflicts within the staff
- High and unmanageable workload
- Lack of staff
- Lack of time for the patient / resident
- Burnout, thoughtlessness, carelessness, ignorance
- Financial, social or health problems, disgust
- Physical attacks by the person being cared for
- Accusations, distrust, behavioral disorders of the patient
- Enormous documentation effort
- Lack of training
- Inconvenient working hours
- High responsibility
- Too little recognition
- Difficult patients / residents with challenging behavior
- No support from supervisors
- Private problems
- Pressure from loved ones
- Insufficient payment
- Insufficient suitability for the job / personal problems of individual employees
- Little sense of achievement
- Rigid guidelines, rigid hierarchies

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- No right to have a say
- No support in difficult situations
- Lack of transparency
- No professional lobby

(Staudhammer 2018, 21)

Identifying features of potential violence

The risk of abuse of power and the associated use of violence against patients and residents is increased,

- if individual living habits are not taken into account or are denied.
- when individual needs are ignored.
- when personal property is reserved.
- when structural procedures are placed before self-determination.
- when personal needs are put before patient and resident needs.
- when communication skills are not taken into account.
- when regulations and standards are placed before human dignity.
- when predominantly physical symptoms are considered.
- when staff are overwhelmed.
- when problems are not addressed.
- when the service handover includes more than 70% somatic and basic care concerns.
- if psychosocial measures are not taken into account in care planning.
- if staff members do not know which measures are planned in the nursing documentation.
- if there are conflicts and disagreements in the nursing team.
- when the mood of the staff depends on who is on duty with whom.
- if more than 40% of the residents in long-term care have been prescribed psychotropic drugs.
- if measures that deprive or restrict freedom are taken due to structural or staffing conditions.
- if the daily routine is dominated by basic nursing activities.
- when there is no laughter.
- when residents in the nursing home lie in bed after dinner.
- when the individual's well-being is put before the general well-being.
- when the wishes of relatives are put before the needs of patients and residents.
- when there is no or disturbed interdisciplinary communication.

- when duty rosters are staff-oriented instead of resident-oriented.
- when meal plans and meal times are based on the kitchen staff.
- when there are more controls instead of discussions.
- when staff turnover and sick leave accumulate.
- when staff complain more than they propose solutions.
- when mistakes are not allowed.

In order to make care and support as low-violence as possible, it is necessary to recognise and quickly reduce the potential for danger (Staudhammer 2018, 29-30).

Perception of violence

Significant changes in the person in need of care, but also in the general conditions and/or the tone of interaction can be indications of acts of violence. Observations of the care relationship can contribute to the perception of violence. Particular attention should be paid to:
Signs of dehydration (dry skin, skin folds, etc.), possible signs of injuries (bruises in places not typical for falls), injuries of a bony nature, bleeding in the rectal and genital area (sexual assaults), skin under-bleeding of a special form that could indicate an object that has had an impact, abrasions and redness on wrists and/or ankles, i.e. injuries that can be caused by rough holding or by fixations, bedsores, etc., signs of depression, isolation, particularly aggressive behaviour on the part of the patient.

In order to become aware of violence, it is also important to have the ability as a carer to listen well to the person in need of care (Andratsch und Osterbrink 2015, 54-57).

Preventing violence in care

First of all, it is of great importance to be aware of the danger of violence. The danger of abuse of power and violence exists in all human relationships and is increased in relationships of dependency.

It is also important to mention that every individual has the responsibility for his or her "doing" and "not doing". Even though the challenges are constantly increasing and everyone can give many reasons and causes for the emergence of violence, the responsibility for how and what

we are doing at any given moment always lies with the individual. The more caregivers and carers address the issues of human behaviour and individual needs, as well as the issues of power and violence, the more opportunities for prevention there are (Staudhammer 2018, 25).

Violence prevention measures can be divided into primary, secondary and tertiary prevention measures (Andratsch and Osterbrink 2015, 186-187):

Primary prevention measures aim to prevent violence and aggressive behaviour from occurring in the first place. For the field of care, primary prevention includes recognising risk factors and taking action against them. The sources of violence and aggressive behaviour are to be minimised as far as possible through a good culture of discussion, smooth communication, professional handling of feelings, sufficient knowledge about violence and a pleasant working environment.

Secondary prevention measures aim at de-escalation in acute violent situations, i.e. in emergencies. The aim is to react immediately to current cases of violence. Signs of violence should be recognised and stopped, as violence does not stop by itself. Recognising violence extends not only to physical symptoms such as bruises, but also to psychological signs, such as exposing or belittling another person. Crisis plans that have already been drawn up in advance or procedures that have been discussed in the team can be used to help all those involved to act calmly and in a considered manner in order to defuse the situation in the best possible way.

Tertiary prevention measures deal with the reprocessing of violence that has happened, with the aim of preventing future incidents. The aggressive or violent behaviour is being analysed. In the course of a subsequent confrontation, the victim as well as the perpetrator must be given the opportunity to process and reflect on what has happened. This includes case discussions, training, etc. This also includes consequences for the offender.

Selection of violence prevention measures

(Andratsch und Osterbrink 2015, 188-192)

In the following subchapter, three selected violence prevention measures are described in more detail, followed by possible solutions at the organisational level and a list of important aspects regarding prevention among professional caregivers.

Support through supervisions and Balint groups:

Supervisions are discussions between nurses and a trained supervisor, a kind of counselling for the staff. It is important that the supervisor is a neutral outsider who is not involved in the respective institution. Supervision helps nurses to reflect on their professional actions and to relate them to the structures and tasks of the respective organisation - problems, unanswered questions and case studies from everyday professional life and the direct work environment are discussed. Stressful feelings and difficulties in everyday care can be addressed and expressed. Supervision should be offered to carers more than it has been until now, and it should also be possible to make use of supervision during working hours. They should be integrated into training and everyday work as a support offer and not only used in emergencies.

Balint groups are basically a reflection group for doctors in which their relationship with patients is discussed with the help and support of a psychotherapist. The aim is to improve the relationship between doctor and patient and thereby also the treatment of the specific patient. This concept has evolved and is now also relevant for other professional groups such as nurses. At a regular meeting of the respective group, usually every 14 days, individual cases from everyday professional life are discussed and worked on together.

Prevention of violence through professional care:

Professional care, i.e. care of a high quality, is able to fight violence with its own means. Caring for people requires certain key qualifications of the carer. A certain degree of social competence as well as empathy play an important role. In addition, sufficient professional competence is required, which is imparted through training. Expertise also includes knowledge

of how violence arises and which constellations are conducive to the development of violence. In the course of training and later in practice, nurses must be sensitised to the possibility of violence within nursing care. Continuing education and training has to be a matter, as well as an interest on the part of nurses in current literature. Highlighting violence and providing knowledge and education is definitely a violence prevention approach.

Professional nursing also includes self-competence. This is understood as the ability and willingness of nurses to reflect on their own actions, to expand their knowledge and to develop personally. Personal aptitude must already be checked when selecting applicants for the nursing profession. In this context, particular attention should be paid to the personal resilience of applicants, for example how they react to stressful situations, but also how they cope with given structures and the working environment.

What are possible solutions?

In health and social care facilities, team culture is of great importance. If descriptions of incidents of violence are not dismissed as misunderstandings or false assessments, violent situations can be addressed more easily. This makes it possible to sensitise the staff and promotes the search for the causes. This persuasion leads to criticism not being perceived as a disloyal approach against the team. Dealing with this issue in a professional manner is a component of care quality.

The management level has the task of setting clear objectives, setting an example of appreciative interaction and showing that there is room for the needs of the elderly and the concerns of the staff. If the procedures and guidelines are oriented towards the needs of the elderly and adapt to their physical and mental capacities, time pressure, constraint, incapacitation and overprotection are reduced.

During discussions in team meetings, strategies for needs-oriented care and for preventing or solving violence can be developed. Further education and training can also provide concepts for action and ideas for dealing with incidents of violence in a constructive and solution-oriented manner, as they enable an exchange with other institutions (BMASK 2012, 30).

Prevention among caregivers

- Organisational framework conditions that counteract excessive demands on caregivers (sufficient personnel resources, duty scheduling, ...)
- Possibilities for retreat and breaks
- Suitable personality profile for care
- Goodwill, tolerance, patience, friendliness
- Good training and further education, in which "non-violent care" is also an issue
- Creation of a relaxed departmental climate (space and time for conversations) / strengthening team spirit
- Conscious situation assessment (nursing diagnostics)
- Transparent and participatory decision-making processes
- Reflection, team talks, nursing case discussions, supervision
- Continuity and stability of care relationships / replace caregiver if necessary
- Use of technical aids

(Kapl 2012, 14)

Measures against violence

1. formulation of a common concept of violence
2. standards for dealing with difficult situations
3. further training on the topic of violence

(Hieber 2017, 62)

Exemplary introduction of non-violent care and support into an organisation

- Awareness and will building in the leadership team
- Collecting cases in practice / defining non-violent procedures adapted to the culture, including the obligation to report misconduct (small group)
- Identifying and changing organisational framework conditions or rules that promote violence
- Training of all staff members (incl. management) (goal: awareness raising = distinguish between constructive aggression and violence; get to know non-violent procedures; gain confidence for aggressive situations)
- Periodic reflection at team meetings and in the leadership team ("Staying on the topic")
- If necessary, follow-up events for staff members

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- If necessary, family members' evening on the topic of "Aggression in care relationships" (Kapl 2012, 15).

(Kapl 2012, 15)

Right of residence in homes (Heimaufenthaltsrecht)

The "Federal Act on the Protection of Personal Freedom during Residence in Homes and Other Nursing and Care Facilities", which entered into force on 1 July 2005, aims to protect and safeguard the personal freedom and dignity of people who require nursing or care due to old age, a disability or an illness. The Residential Homes Residence Act (Heimaufenthaltsgesetz, HeimAufG) regulates the prerequisites and review of restrictions on freedom in old people's and nursing homes, homes for the disabled and other facilities in which at least three mentally ill or mentally disabled people can be permanently cared for or looked after (Halmich 2020, 102).

Bibliography

Andratsch, Franziska und Jürgen Osterbrink. 2015. *Gewalt in der Pflege: Wie es dazu kommt. Wie man sich erkennt. Was wir dagegen tun können.* München: C.H.Beck.

Bundesministerium für Arbeit, Soziales und Konsumentenschutz. 2012. *Gewalt erkennen: Ältere Menschen in Institutionen.* Wien.

Halmich, Michael. 2020. *Gewaltschutzrecht für Gesundheitsberufe*. 1. Aufl. Wien: Educa.

Hieber, Markus. 2017. „Was dämmt die Gewalt in der Pflege?" *Pflegezeitschrift* 7, 62.

Kapl, Gerhard. 2012. „Gewaltprävention in der Pflege und Betreuung". Referentenmanuskript. Linz.

Staudhammer, Martina. 2018. *Prävention von Machtmissbrauch und Gewalt in der Pflege.* Deutschland: Springer.

Weltgesundheitsorganisation. 2003. *„Weltbericht Gewalt und Gesundheit: Zusammenfassung*". 1-73.