Module 1 Training Materials

BASIC MODULE ON VIOLENCE AGAINST ELDERLY PEOPLE

Against violence in elderly care (AVEC)
2020-1-CZ01-KA2020-0783321

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Content

1. Module 1: Framework conditions regarding violence against elderly people

1.1. Module description

- Introduction
- Getting to know each other and getting into the mood for the topic
- How much does the issue itself affect me?
- Key figures, sources of potential violence, ethics, national programmes and stakeholders
- Presentation of the programme (content, benefits)

1.2. Description of the initial situation

Trainers and participants enter together into a learning process lasting several days on the topic of "Violence in Care".
The participants have had to deal with different aggressive situations more or less frequently in their professional reality and have had positive and negative experiences. They have developed coping strategies that work more or less well and that are more or less okay from a professional point of view. They have received more or less good support from the organisation or leadership in situations of violence in which they themselves have reached their limits.

1.3. Description of the needs of the target group

The participants need a basic understanding that "violence in care" is more than ever a current and important individual and societal issue and what overarching approaches there are to prevent violence. In addition to a good personal and thematic introduction, participants need an overview of the entire training programme (topics, time structure).

1.4. Topics of the module

- Introduction (clarification of the framework conditions / introduction of the trainer)
- Getting to know each other and getting into the mood for the topic (getting to know the participants personally)
- How much does the topic itself affect me? (List of participants on some questions)
- Key figures, sources of potential violence, ethics, national programmes and stakeholders

- Presentation of the programme (content, benefits)

1.5. Learning Outcomes of the Module

- The participants have settled well into the group and the learning programme.
- It is clear to them why addressing the issue of violence in care relationships and building the relevant competences is important.
- They have a knowledge of national prevention programmes, important actors and basic ethical attitudes
- They have an overview of the training programme (topics, time structure) and the benefits.

1.6. Workshop Design

Abbreviations in the workshop design

FC	Flipchart	**CG**	Carer	**Col**	Colleague
Part	Participant	**Exe**	Executive	**Rel**	Relative
Res	Resident				

Duration: 2 hours

Topic	Content and brief description	Time	Material	Methodology
Get started and become employable	**Introduction**: - Clarification of the framework conditions / introduction of the trainer - Some typical examples from practice ...	10	Welcome FC Name cards	Trainer input
Get started and become employable	**Get to know each other and get in the mood for the topic:** - Some info about me ... - What is the beauty of my work? What is the challenging or stressful part? - What goes through my head and stomach about this programme? - What would have to come out of it for it to be time well spent for me? - What is not supposed to happen here?	15 20	Ppt with questions	Exchange in triads or groups of two (15 min) Short presentation in plenary (20 min)
Take a personal perspective on the topic	**How much does the topic itself affect me? ... Part 1** Some scaling questions, the participants line up on an 8-10m line (= scale of 1-100%; 1 = never / not at all, 100 = all the time / several times a day) according to their personal assessment: - As a CG, how often am I verbally attacked (insulted, insulted, threatened) by Res? - How often am I physically attacked by Res as a CG? - How often am I exposed to verbal violence by Rel? - How often do I observe violence between Res? - How often do I observe violence by Rel towards Res? - How often do I have to take actions towards Res that I perceive as violence? - How often do I observe actions by Coll towards Res that I perceive as violence?	10	Rope or line with adhesive tape Ppt with questions	Sociometry Self-assessment
Take a personal perspective on the topic	**How much does the topic itself affect me? ... Part 2** When I think about the pictures in this list ... what are my conclusions from it? What does it do to me emotionally?	10		Plenary discussion: reflection on the previous constellation

Topic	Content and brief description	Time	Material	Methodology
Key figures	**Key figures** Presentation of figures on (1) violence against elderly people and (2) violence against carers Details can be found in the appendix under: "M1 Key figures" Short reflection in plenary: What are the consequences in the homes and at home? Conclusion: Dealing professionally with violence in the care of the elderly is an important issue!	10	Ppt with info	Trainer input Short reflection in plenary
Sources of this potential for violence	**What is the source of this potential for violence?** Presentation of the backgrounds Details can be found in the appendix under: "M1 Sources of potential violence in the care of elderly people".	5	Ppt with info	Trainer input
Ethical framework	**Ethical framework / rights of the elderly** Presentation Details can be found in the appendix under: "M1 Ethical Framework" and "European Charter_EN.pdf".	10	Ppt with info	Trainer input
National programmes or policies to prevent violence	**Who are the relevant actors / stakeholders involved Stakeholders and their roles** Presentation Details can be found in the appendix under: "M1 National Programmes“	5	Ppt with info	Trainer input
Content and benefits of this training programme	**This training programme as an important contribution to dealing professionally with violence** Presentation: - Structure and contents of the training - Benefit Details can be found in the appendix under: "M1 Content and Benefits“	10	Ppt with info	Trainer input

Topic	Content and brief description	Time	Material	Methodology
Break	**Break**	15		

2. Module 2: Basic understanding of violence in elderly care

2.1. Module description

- Personal experience of violent situations
- Definition of aggression and violence, abuse etc.
- Rights of the elderly / Laws for the protection of the elderly
- Laws for the protection of employees
- Experiencing oneself in the role of perpetrator, victim, witness
- Forms of violence in institutions and at home ... what are they?
- Forms of violence ... how do they show themselves, how can I recognise them?

2.2. Description of the initial situation

Trainers and participants got to know each other in Module 1. It was recognised that and why dealing with the issue of violence in care relationships is an important individual and societal topic and which overarching approaches to violence prevention exist. The participants got an overview of the whole training programme (topics, time structure).

2.3. Description of the needs of the target group

The participants need a basic understanding of the concepts of "aggression" and "violence" as well as the forms of violence in elder care and the associated symptoms in order to avoid violence or to recognise it at an early stage and to be able to de-escalate or clarify the situation. The overview knowledge about relevant legal aspects should also contribute to a safe handling of violent situations.

2.4. Topics of the module

- Personal experience of violent situations (reflection on own practical experiences with aggressive or violent behaviour in the home)
- Definition of aggression and violence, abuse, etc. (what is meant by this, how does constructive or still acceptable aggression differ from destructive violence)?
- Rights of the elderly / Laws for the protection of the elderly

- Laws for the protection of employees
- Experiencing oneself in the role of perpetrator, victim, witness (self-awareness exercise)
- Forms of violence in institutions and at home ... What are they? (Direct and indirect (here also structural and cultural), passive and active violence, high intensity violence and low intensity violence; 6 forms of violence, aggression of residents in general, autoaggression)
- Forms of violence ... how do they manifest themselves, how can I recognise them?
  (For each form of violence: "Which symptoms / observable behaviour of the "victim" or the "perpetrator" would indicate the presence of violence?)

2.5. Learning Outcomes of the Module

- The participants know which forms of aggression, violence and abuse can occur in elder care situations.
- They are able to recognise and attribute violence.
- They have a knowledge of which rights and laws are relevant for the protection of the elderly as well as for the protection of the staff and which criminal law aspects are related to the topic of violence.
- They also know about their reporting obligations and the reporting options.

2.6. Workshop Design

Abbreviations in the workshop design

FC	Flipchart	**CG**	Carer	**Col**	Colleague
Part	Participant	**Exe**	Executive	**Rel**	Relative
Res	Resident				

Duration: 3 hours + 1 hour lunch break

Topic	Content and brief description	Time	Material	Methodology
Engaging personal experiences on the topic	**Personal experience of violent situations**: (linking to the scaling constellation of module 1) 1. What are situations in which the aggression level rises in **ME** (triggered by the behaviour of residents or relatives)? 2. Aggressive behaviour by Res, which in our view is already violence ... 3. Aggressive behaviour by Rel, which in our view is already violence (1) towards CG, (2) towards Res. ... 4. Behaviour of Res towards other Res, which from our point of view is already violence ... 5. CG's behaviour towards Res, which in our view is already violence ...	15	Ppt with the questions	Exchange of experience / discussion in plenary
Definition of aggression and violence, abuse etc.	**Definition of aggression and violence, maltreatment etc.:** Input from trainers: Details can be found in the appendix under: "M2 Definition Aggression and Violence"	15	Info-ppt	Trainer input + clarification of any questions
Legal aspects	**Rights of the elderly / Laws for the protection of the elderly** First, a short discussion in groups of three (approx. 8 minutes): Which legal aspects or which concrete legal paragraphs in connection with residents' rights and residents' protection come to mind? What legal terms come to mind in connection with "violence"? Then input by trainer: Details can be found in the appendix under: "M2 Legal aspects In doing so, also consider the **"legal responsibility", e.g.:** Duties of the employees incl. the obligation to report, duties of the managers and authorities.	35	Ppt with question Info-ppt	Buzz group Trainer input + clarification of any questions

Topic	Content and brief description	Time	Material	Methodology
Legal aspects	**Laws for the protection of employees** Details can be found in the appendix under: "M2 Legal aspects In doing so, also consider the **"legal responsibility", e.g.:** Duties of the employees incl. the obligation to report, duties of the managers and authorities.	15	Info-ppt	Trainer input + clarification of any questions
Lunch break	**Lunch break**	60		
Self-awareness in different roles	**Experiencing oneself in the role of:** ➢ **Perpetrator** ➢ **Victims** ➢ **Witness** Details in the appendix under: "M2 Klupperl Exercise Instructions". For time reasons, rather choose the short version (35 minutes) (the long version takes about 50 minutes).	35	Klupperl (clothes pegs) Klupperl Exercise Instructions Cymbal, horn or similar (for stop signal)	Klupperl exercise Then go deeper into it
Forms of violence in institutions and at home	**Forms of violence in institutions and at home ... what are they**? Details can be found in the appendix under: "M2 Forms of violence in institutions and at home". Presentation of the forms of violence • Directly and indirectly, here also structurally and culturally • Violence by ... to ... • 6 Forms of violence • Aggression by residents in general, autoaggression • Distinguish between passive and active violence	20	Info-ppt	Trainer input

Topic	Content and brief description	Time	Material	Methodology
	• Distinguishing between high intensity violence and low intensity violence			
Recognising forms of violence	**Forms of violence ... how do they show themselves, how can I recognise them?** Small groups. They receive the "handout on the forms of violence" and are supposed to work on it together and document it on Flip: For each form of violence: "Which symptoms / observable behaviour of the "victim" or the "perpetrator" would indicate the presence of violence? Group A: Physical violence, intimate assault Group B: Psychological violence Group C: Measures restricting freedom, financial exploitation Group D: Active and passive neglect Presentation and discussion in plenary If necessary, additional information by trainers, as well as information on "Identifying characteristics of potential violence". Details can be found in the appendix under: "M2 Recognising violence“	30	Handout on the forms of violence Ppt with question and group assignment Flipchart Info-ppt	Small groups (10 - 12 min) Presentation and discussion in plenary If necessary, additional information by trainer (max. 20 min)
Break	**Break**	15		

3. Module 3: Recognising and assessing risk factors for violence

3.1. Module description

- The profile of a particularly vulnerable elderly person
- Risk situations in the everyday life of the elderly
- Risk factors that promote violence
- Signs of increased tension (early warning signals)
- Trigger factors for aggression
- Risk assessment and assessment tools
- Summary and conclusion of the day

3.2. Description of the initial situation

In Module 2, the participants reflected on their own practical experiences with aggressive or violent behaviour in the home.

In a self-awareness exercise, they could experience themselves in the roles of perpetrator, victim and witness.

They have developed a basic understanding of the definitions of "aggression" and "violence".

They know the forms of violence in elder care and the associated symptoms in order to avoid violence or to recognise it at an early stage and to be able to de-escalate or clarify the situation.

They have an overview knowledge of relevant legal aspects.

3.3. Description of the needs of the target group

Participants need a basic understanding of the risk factors in the organisation, the individual staff member and the resident that can contribute to the likelihood of violent incidents. They need an awareness of the special vulnerability of the elderly.
They need to know about early warning signs that may indicate an imminent aggressive outburst, knowledge of the main triggers for violence and how to assess the risk.

3.4. Topics of the module

- The profile of a particularly vulnerable elderly person

- Risk situations in the everyday life of the elderly
- Risk factors that promote violence (at the levels of organisation/system, individual staff and residents)
- Signs of increased tension, trigger factors for aggression
- Risk assessment and assessment tools
- Summary and conclusion of the day

3.5. Learning Outcomes of the Module

- Participants will be able to make a realistic assessment of their practice system with regard to risk factors (including a possible self-assessment).
- They are able to recognise an impending aggressive escalation in time.
- They have knowledge about which triggers can lead to violence.
- They know about the possibility of risk assessment and the corresponding assessment tool.

3.6. Workshop Design

Abbreviations in the workshop design

FC	Flipchart	**CG**	Caregiver	**Col**	Colleague
Part	Participant	**Exe**	Executive	**Rel**	Relative
Res	Resident				

Duration: 2 hours

Topic	Content and brief description	Time	Material	Methodology
The profile of a particularly vulnerable elderly person Risk situations	**The profile of a vulnerable elderly person / risk situations** 2 small groups (A and B). They are to work out (1 person takes notes): - "What makes elderly people in need of care particularly vulnerable to becoming victims or perpetrators of violent acts?" 2 small groups (C and D). They are to work out (1 person takes notes): - "What are typical situations in the everyday life of the elderly person (in the home or at home) in which violence is triggered particularly easily or frequently?" Plenary: Part report, trainer writes on 2 pin boards	20	2 pin boards with questions and space for writing	4 small groups work in parallel (10 min) Collection in plenary (10 min)
Risk factors that promote violence Aspects in the organisation or institutional factors that have a reinforcing effect	**Risk factors that promote violence** Small groups. They should work together and document on Flip: "What factors in each area can contribute to the likelihood of incidents of violence becoming greater?" Group A: Lack of competence of the care system or organisation in dealing with violence Group B: Working conditions conducive to violence Group C: Personal risk aspects among employees Group D: Risk factors or causes for violence among residents Presentation and discussion in plenary If necessary, additional information from the trainer - Details can be found in the appendix under: "M3 Risk Factors that Promote Violence“	40	Ppt with question and group assignment Flipchart Info-ppt	Small groups (15 min) Presentation and discussion in plenary If necessary, additional information by trainer (max. 25 min)
Break	Break	15		

Topic	Content and brief description	Time	Material	Methodology
Signs of increased tension Trigger factors for aggression Verbal, non-verbal	**Signs of increased tension, trigger factors for aggression** Input from trainers - Details in the appendix under: "M3 Early warning signals / triggers for aggression and violence". Discussion, field reports, clarification of questions	20	Info-ppt	Input by trainer, discussion, clarification of questions
Risk Assessment and Assessment Tool	**Risk assessment and assessment tools** Input by trainer: aims and benefits of such methods, show some examples in overview, refer to handout - Details can be found in the appendix under: "M3 Assessment and Risk Assessment - The tools are located in the sub-folder "M3 Toolbox".	15	Info-ppt	Input by trainer, clarification of questions
End of the day	**Summary and conclusion of the day** Talk in groups of three: • What was particularly helpful, interesting, ... for me today? ("The TOP 3 of my findings today")	10		Discussion in groups of three

4. Appendix

4.1. M1: Content and benefits

In this learning module, you will be introduced to general topic-specific backgrounds, the definition as well as the areas of violence by caregivers towards residents, but also violence by residents towards caregivers. Violence between residents and relatives is also focused on. In addition, possible causes and forms of violence, violence in the context of gerontopsychiatric illnesses using the example of Alzheimer's dementia, as well as effects of medication, are included. The escalation spiral, legal framework conditions, suitable coping strategies as well as preventive measures and de-escalation measures are also addressed.

Violence in care must be prevented at all costs. 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, we have already taken a first step against violence. Only then are we in a position to become sensitive to signs of violence and to recognise violence - already 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 possibilities there are to take action against violence in care. This topic must not be taboo, but must be recognised and addressed in all its forms.

Objective

Training and courses can have different contents and in this context also serve different purposes:
a. the correct recognition of maltreatment and abuse
b. dealing with and good management of violent situations
c. raising awareness and overcoming one's own tendencies towards violence

- Violent assaults are to be minimised and measures are to be derived.
- Raising staff awareness on the topic of violence prevention in care and support.
- Early recognition of possible danger to residents by staff.
- Early detection of danger to residents from other residents.

4.2. M1: Ethical framework

Elderly people often face negative attitudes and age discrimination, especially in access to health care, employment, goods and services, information and education. They also face increasing barriers to their participation, become more dependent on others and lose some or all of their personal autonomy.

These threats to their dignity can make them more vulnerable to neglect, abuse and violation of their rights.

Basic ethical orientations can be found in almost all relevant care models - in the sense of value attitudes in dealing with elderly people and their rights for a needs-oriented and dignified life (e.g.: Activities of Daily Living (ATL), Krohwinkel, etc.).

Often, however, caregivers are faced with an ethical dilemma in the area of tension between self-determination and care, namely when the person being cared for rejects sensible acts of care and the non-action would cause harm to the person being cared for.

Essential fundamental rights of the older person / Ethical principles

An overarching ethical framework is provided by the "European Charter on the Rights and Responsibilities of Elderly people in Need of Assistance and Care" with its ethical principles (Source: https:// www.pflege-charta.de)

1. **Self-determination and help for self-help (autonomy)**
2. **Physical and mental integrity, freedom and security**
3. **Privacy**
4. **Care, support and treatment (welfare)**
5. **Information, counselling and education**
6. **Appreciation, communication and participation in society (respect for dignity and integrity)**
7. **Religion, culture and world view**
8. **Palliative care, dying and death**

Information on this can be found, for example, at:

- https://www.age-platform.eu
- https:// www.pflege-charta.de
- https://www.wege-zur-pflege.de/pflege-charta/
- https://www.zqp.de/pflege-charta/

Other ethical / legal concepts or organisations:

- ICN - Code of Ethics for Nurses
- Centre for Quality in Care (ZQP)
- Legal provisions of measures involving deprivation of liberty in care

4.3. M1: National programmes

The worldwide intervention and prevention measures and model projects relating to violence against elderly people can be divided into four groups: (Source: Paper Josef Hörl "Prävention und Intervention bei Gewalt gegen ältere Menschen" (2012), **"**Prävention und Intervention bei Gewalt gegen ältere Menschen. Concepts and measures in an international context and legal aspects in Austria**"** (PDF, 1 MB)

- Client-centred services
- Training and awareness raising
- Innovative organisational development
- Legal superstructure

Stakeholders or relevant actors:

- Residents (rights and duties)
- Relatives (report incidents, ask for clarification)
- Employees (professional care and support, legal obligation to report)
- Managers (organisation of structures and processes, control and reporting obligations, interventions)
- Supporting organisations (e.g. establishment of internal reporting centres as at SeneCura)
- Residents' representative
- Senior Citizens' Advisory Council
- Home Supervision
- Associations and organisations (awareness raising; collection of data, etc.)
- Training organisations ("Dealing with violence" as subject matter in nursing training)
- Violence counselling centres, emergency call centres, counselling and crisis telephones, helplines, hotlines
- Whistleblowing hotlines
- Police, regulatory authorities
- Federal government, provinces, municipalities (e.g.: Federal Ministry BMASK / "Violence in old age" programme; public relations campaigns (federal government, provinces, municipalities)

See also Care Charter:
https://www.wege-zur-pflege.de/pflege-charta/arbeitsmaterial

4.4. M1: Sources of potential violence in the care of elderly people

On the one hand, elderly people are in a weaker position precisely because they need care. They experience dependencies, often have no alternatives and also no "escape options".

On the other hand, elderly people often show challenging behaviour. This can be a reaction to inappropriate behaviour on the part of the caregiver. On the other hand, it can be caused by life experiences, personality structure or other factors - and trigger aggression in the caregiver.

Aggression can build up in a destructive escalation cycle and ultimately result in acts of violence.

What increases the potential for violence?

Factors in the elderly

- Due to their state of health (frailty, progressive dementia, depression, anxiety disorders, psychoses) or personal problems, elderly people sometimes behave impatiently, desperately or intransigently towards relatives or carers, which can provoke counter-reactions.
- Limited ability to communicate
- Elderly people are often physically frail or poorly oriented and are generally unable to defend themselves adequately against intimidation, torment or physical attacks.
- Out of false respect for the authorities, fear of disadvantages and shame, elderly people often keep their experiences of violence to themselves.

Factors in the caregiver

- Carer is overloaded (too much, too long, double burden)
- Carer does the care only reluctantly
- Mental or psychosocial problems
- Life crises
- Alcohol and substance abuse
- Insufficient self-control skills
- Low education and superficial professional motivation
- Need to exercise power
- Too little information about support services and lack of opportunities to share experiences put caregivers under pressure

Dynamics between the cared-for and the caregiver

- Communication difficulties, misunderstandings
- Unresolved conflicts between caregivers and persons in need of care (inherited burdens, conflicts in everyday care, dependencies, different goals)
- Boycott: Care measures are partly boycotted by the people cared for, instead of recognition there is often only mistrust and accusations.
- Asymmetrical relationship: Care dependency overall indicates an asymmetrical relationship, an essential component of such a relationship can be the exercise of power and the use of violence.
- Non-consensual care relationship
- Frustrations on both sides

Factors from the care system

- External influences that aggravate the care situation / care stress e.g.:
  - Rigid guidelines without the possibility to have a say
  - Time pressure
  - Chronic understaffing / high staff turnover
  - The need to save
  - Conflicts with colleagues or superiors, tensions in the team
  - Lack of prevention measures (incl. culture promoting violence)

4.5. M1: Key numbers

Abstract

For various reasons, there is still no precise data on violence in long-term care facilities. A WHO report from 2011 shows how highly relevant the topic of "violence against elderly people" is (source: "European report on preventing elder maltreatment").
It is estimated that in Europe annually

- around 4 million elderly people suffer abuse
- about 2,500 people even die from it
- something like 30 million elderly people are exposed to psychological violence

Only a fraction of the cases of abuse actually come to light. But the daily violence takes place behind closed doors and is often covered up by the environment.

But the reverse dynamic is also becoming more and more evident and relevant: Violence against caregivers.

- 40 - 60% of caregivers report experiences of violence
- 70-80% face verbal attacks again and again.

Long version

To date, there is no precise data on violence in long-term care facilities.
This may be due to the fact that there is no uniform definition of the term violence and the occurrence is difficult to investigate. It is also difficult because the duty to report sometimes conflicts with the duty of confidentiality and data protection, and relevant incidents are often trivialised or hushed up.
Figures on violence in long-term care facilities are not recorded representatively in Austria, partly because criminal statistics are not disaggregated by age. (Source: http://ageing.at/document/mission-austria (2015); excerpt p. 6: 24.: "There are no representative data concerning domestic violence against older persons for Austria, in part because criminal statistics are not disaggregated by age. Reasons for underreporting include the privacy barrier in family relationships, the lack of awareness and the fear that older persons have of reprisals by the caregivers. Moreover, collective prejudice against elderly people and public awareness influence the way in which abuse and violence is perceived, recognised and reported").

In contrast, more **studies** examine the topic of "violence against elderly people".
The following estimates for Europe from a WHO report from 2011 (source: "European report on preventing elder maltreatment") show how highly relevant the issue of "violence against elderly people" is.
It is estimated that around four million elderly people in Europe suffer abuse every year and around 2,500 people even die as a result. Only a fraction of the abuse cases actually come to light. But the daily violence takes place behind closed doors and is also often covered up by the environment.

See file:
"VIOLENCE PREVENTION in CARE | Numbers, Data, Facts - Incidence of Violence in Care.pdf".

Violence against elderly people: The elderly person as victim
(= Experiences of violence by people over 60 / Europe total)
Source: WHO report from 2011 ("European report on preventing elder maltreatment").

2,7 %	Physical violence (4 million people)
19,4 %	Psychological violence (29 million people)
0,7 %	Sexual violence (1 million people)
3,8 %	Financial overreach/exploitation (6 million people)

Violence by professional carers

(= In a German study on the incidence of abuse and neglect in inpatient care, 81 caregivers from eight old people's homes were interviewed (Görgen, 2006).

Source: Görgen, T. (2006). "As if I just didn't exist"-Elder abuse and neglect in nursing homes. In Cain, M. & Wahidin, A. (eds.): Ageing, Crime and Society. Devon (UK): Willan.

>70 %	Caregiver has behaved in a problematic way towards residents of the home
37 %	Forms of physical and verbal abuse
20 %	Physical violence
27 %	Nursing neglect

Violence by family carers

Source: Görgen, T., Herbst, S., Kotlenga, S., N gele, B. & Rabold, S. (2012).

48 %	Psychological abuse
19 %	Physical violence
rare	Nursing neglect

Violence against carers:

Source: Zeh A , Schablon A , Wohlert C et al. (2009). Violence and aggression in nursing and care professions- A literature review . Gesundheitswesen 71 : 449 - 459.

Inpatient care:

63 %	"have experienced violence in the last year"
78 %	"have been verbally assaulted in the last year"

Mobile care:

40 %	"have experienced violence in the last year"
71 %	"have been verbally assaulted in the last year"

Addition:

Study results on violence against elderly people in long-term care facilities

An American retrospective cross-sectional study showed different forms of physical violence (Schiamberg, Oehmke, Zhang, Bar-boza, Griffore, Von Heydrich, Post, Weatherill, & Mastin, 2012, n.d.).

- The frequency of physical injuries such as hitting, kicking, beating, pinching and shaking a resident vigorously showed up 44 times (27%).
- Furthermore, inappropriate restrictions of mobility were addressed. Entering meals under duress, the use of physical measures restricting freedom as well as the overdose of medication were observed in 103 cases (62%).
- In the end, 8 times (11%) residents were found to have been forced into sexual acts and raped.

A quantitative, descriptive study from Israel identified incidents of various forms of violence in nursing homes (Natan, & Lowenstein, 2010, p. O.S.).

- Most incidents (64%) were in the form of physical and mental neglect, followed by psychological violence (23%) and physical violence (12%).
- The staff of 24 selected nursing homes in Israel indicated in the questionnaire that these incidents occurred more than 16 times per year.

A study from Canada, a comparison of Canada and Scandinavia also shows the presence of structural violence in long-term inpatient care. (Banerjee, Daly, Armstrong, Szebehely, Armstrong, & Lafrance, 2011, p. 396)

4.6. M2: Definition of aggression and violence

The concept of violence - different perspectives, different views

The term violence is associated by most individuals with something negative, whereby each person has a different perception of violence. As a result, a uniform definition of the term is difficult.
Here is a relatively general definition, as it seems helpful for the field of care for the elderly:

> ***"Violence** is everything that restricts people in their individuality, forces them or is intended to force them to do something against their will or to refrain from doing something against their will."*

Alternative definition:

> ***"Violence** is the use of coercive means of any kind with the aim of persuading a person to change his or her behaviour against his or her will."*

The World Health Organisation, or WHO, generally defines the term as follows.

> *"**Violence** is the intentional use of threatened or actual physical coercion or physical power against one's own or another person, group or community that results either concretely or with a high probability in injury, death, psychological harm, maldevelopment or deprivation."*

In addition to this general definition, the WHO also developed a definition of violence against elderly people.

> *"**Elder abuse is defined as** a single or repeated act or failure to respond appropriately in the context of a relationship of trust, causing harm or suffering to an older person."*

Violence often starts with small gestures or verbal expressions, which are often dismissed as meaningless or not worth mentioning. In such cases, one does not yet speak of violence and only becomes aware of it after taking a closer look.
Violence can gradually creep into everyday life. If no attention is paid to this initial phase, the perpetrator's readiness to commit further acts of violence increases.
The worst form of violence in care is the killing of residents.

*"If the **basic needs of a person** and/or their environment are impaired, restricted or their satisfaction prevented - **even by mere threat** - this is already violence".*
The Ombudsman Board and its OPCAT commissions also assume a very broad concept of violence

*"No one shall be subjected to torture or to **inhuman** or **degrading** treatment or punishment".*
Article 3 ECHR - Prohibition of torture
*"**Inhuman"**, according to the ECJ case law, means in particular treatment that is intentional, lasts for several hours and causes either physical injury or intense or physical suffering.*
***"Degrading"** treatment is when it is likely to cause feelings of fear, anguish or inferiority in the victim, which are likely to humiliate or degrade the victim.*
Here, too, the mere **threat** is **punishable**!
However, "humiliating" can also refer to staff members who are victimised by such behaviour on the part of residents or relatives.
Here is the International Labour Organization's definition of violence in the **workplace:**

"Violence at work is any act, occurrence or deviation from proper behaviour whereby a person is seriously insulted, threatened, injured, wounded in the course of or as a direct result of their work."

Violence, coercion and abuse are always a question of intensity

- of the exercise (perpetrator) and
- of feeling (sacrifice)

A borderline area in this context is "caring violence" (e.g.: measures restricting freedom for the self-protection of the person in need of care or for the protection of others) or "organisational violence" (e.g.: enforcing sensible organisational necessities).

Aggression - the energy behind violence

Most definitions of "aggression" also have a negative undertone, e.g. a definition by the International Council of Nurses, 2001:

"*Aggression is humiliating, belittling or other behaviour that shows a lack of respect for a person's dignity and worth."*

In a neutral view, aggression can also be seen in this way:

Aggression is a life-sustaining, active energy that we use to realise our elementary needs:

1. *"I want something" ... and get it for myself*
2. *"I don't want something" ... and ward it off*
   In each case: if it doesn't work in the nice, friendly way

4.7. M2: Recognising violence

Perception of violence

Violence against elderly people can occur anywhere: in one's own home, in a nursing home, in a hospital. In this respect, caregivers can sometimes perceive symptoms or warning signs that point to an effect of violence in another system.

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 help to perceive violence. In order to become aware of violence, it is also important to be able to listen well to the person in need of care (Andratsch and Osterbrink 2015, 54-57).

Indicators are only "signs" and no hasty causal judgements should be made. Most of the mentioned conspicuousnesses and symptoms can of course have the most diverse causes and do not necessarily have to be connected with phenomena of violence. However, if several of the indicators occur at the same time, it will in any case be useful to subject the more detailed circumstances to close scrutiny.

Particular attention should be paid to:

- Signs of fluid deficiency (dry skin, skin folds, etc.)
- Possible signs of injuries (bruises in places not typical for a fall).
- Injuries of a bony nature
- Bleeding in the rectal and genital area (sexual assault)
- Skin hemorrhages of a special form that could indicate an impacting object
- Abrasions and reddening on wrists and/or ankles, i.e. injuries that can be caused by rough restraint or by fixations
- Recumbent ulcers etc.
- Signs of depression, isolation
- particularly aggressive behaviour on the part of the person in need of care

Symptoms in the resident's behaviour

- shows fear towards a certain person
- jerks back when touched
- appears anxious for no apparent reason
- Anxiety before bathing or going to the toilet
- Appears easily agitated and quickly irritated
- appears depressed and withdrawn
- generally appears uninterested, apathetic
- has insomnia
- suddenly changes his eating habits
- Expresses suicidal thoughts

- often begins to tremble, has crying fits
- falls into a rigid posture
- appears helpless, hopeless, sad
- Makes contradictory statements without any mental impairment being present.
- hesitates to speak, waits until someone else (e.g. the caregiver) answers
- avoids physical, eye, speaking contact with certain persons (e.g. the caregiver).

Symptoms in the behaviour of the carer or relative

- raises reproaches for certain behaviour (e.g. incontinence).
- wants to prevent talking to the older person alone
- wants to prevent certain examinations or treatments from being carried out
- the doctors used for treatment are frequently changed for no apparent reason
- Reacts defensively to questions, looks for excuses, behaves rudely and hot-temperedly
- avoids eye, body and speaking contact
- Treats the older person like a child
- threatens, insults, bullies the older person
- Exercises control over the finances and assets of the older person
- seems to have difficulties in coming to terms with his own life
- avoids eye, body and speaking contact

Warning signs of abuse

Here is an overview of symptoms with the assignment to the respective form of violence, which, however, is not clear in many cases, especially since several forms of violence often interact.

Physical and sexual abuse

- Inadequately explained fractures, contusions, dislocations, sprains
- Bruises, bruises, bumps
- Redness, swelling or scratches in atypical areas
- Restraint injuries to wrists and/or

- Ankles
- Cuts, bleeding or poorly healed wounds
- Burns / burns
- Weals
- internal injuries
- Punctures
- Poisoning
- Scalds
- Dehydration
- Hypothermia
- Malnutrition
- Unexplained venereal disease, pain or itching in the genitals
- Difficulty sitting or walking
- Flinching when touched
- Anxiety before bathing or going to the toilet

Mental/emotional abuse

- The person shows unexplained behavioural changes such as withdrawal from usual activities, inexplicable changes in attention, or a lack of concentration.
- Resignation
- Anxiousness
- Shame
- Depression
- Confusion
- excessive passivity
- Angry outbursts
- Insomnia
- The caregiver prevents contact with the outside or prevents visits
- The caregiver criticises, scolds or behaves insultingly, controls, threatens or blackmails or prevents or refuses social contacts and behaves indifferently

Measures involving deprivation of liberty

- Marks on the skin from ropes, buckles or belts
- Fetlock marks on wrists and ankles
- Drowsiness due to medication

Neglect

- Lack of basic personal hygiene, proper nutrition, clean and suitable clothing
- Malnutrition
- Weight loss without medical cause
- Dehydration
- Hypothermia
- sunken cheeks and eyes, severe pallor
- Untreated wounds, injuries
- negligent hygiene care
- Tattered and/or inappropriate clothing for the season
- Lack of aids such as glasses, hearing aids, dentures, walking aids or incontinence care
- Insufficient supply of medication, non-adherence to prescribed medication
- Risk of infection is not taken into account
- People with dementia are left to their own devices
- Bedridden people do not receive care and attention
- Untreated pressure ulcers
- Unkempt flat, damaged household items
- Poorly equipped flat (no cooker, no refrigerator, no heating, no functioning water and electricity installation, with fire or safety risk).
- No access to adequate health or social services
- No companionship when going out, no walking aid
- Lack of social, cultural, mental or physical stimulation

Symptoms of self-neglect (neglect)

- social withdrawal
- excessive austerity
- Anxiousness, mistrust
- Inadequate, unhealthy diet
- Malnutrition
- Dehydration
- neglected flat, lack of safety (trip hazards, etc.)
- Collecting and hoarding waste
- Poor personal hygiene
- inappropriate, unusual clothing
- Keeping a variety of animals
- Refusal to pay bills
- Extremely rigorous insistence on respect for independence and privacy

Financial exploitation

- Theft or misuse of money, property or personal belongings:
- People in need of help "voluntarily" give disproportionate amounts of money or costly gifts so that they can receive support or companionship
- Control of finances (despite mental clarity) by another person
- Abuse of a power of attorney or adult representation
- inexplicable differences in signatures in documents
- The old person has signed documents such as a donation or a new will under threats or without understanding the meaning
- Carers dispose of the money of the person in need of care without financing the basic necessities of daily life

Follow

- Rent or bills remain unpaid
- Disposal of property without apparent reason

- Shortage of money for essential purchases, acquisitions
- Lack of money for activities outside the home, leisure time
- Dwindling savings
- Disappearance of possessions, objects
- Those affected cannot afford amenities
- Resistance to the drafting of a will or to advice on financial matters

Identifying characteristics of potential violence

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

- if individual lifestyle habits are not taken into account or are denied.
- when individual needs are ignored.
- when personal property is reserved.
- when structural processes are put before self-determination.
- when personal needs are put before patient and resident needs.
- if communication skills are not taken into account.
- when regulations and standards are put before human dignity.
- if predominantly physical symptoms are observed.
- when employees are overwhelmed.
- if problems are not addressed.
- if the service handover involves more than 70% somatic and basic care issues.
- if psychosocial measures are not included in the care planning.
- if staff members do not know which measures are planned in the care documentation.
- if there are conflicts and disagreements in the care team.
- when the mood of the staff depends on who is on duty with whom.
- if more than 40% of residents in long-term care have been prescribed psychotropic drugs.
- if measures involving deprivation of liberty or restriction of liberty are set due to structural or personnel circumstances.
- when the daily routine is dominated by basic care activities.
- when there is no laughter.

- when residents in the nursing home are in bed after dinner.
- when the individual good is put before the general good.
- when the wishes of relatives are put before the needs of patients and residents.
- if there is no or disturbed interdisciplinary communication.
- if the duty rosters are staff-oriented instead of resident-oriented.
- when meal plans and meal times are based on the kitchen staff.
- if there are more controls instead of talks.
- when staff turnover and sick leave pile up.
- when employees complain more than they propose solutions.
- when mistakes are not allowed to be.

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

4.8. M2: Forms of violence in institutions and at home

Violence in care can be perpetrated on the one hand by carers and on the other hand by residents, but also by relatives:

- Violence by **resident/resident** against staff *physically*
- Violence by **resident/resident** against staff *psychological*
- Violence by **resident/resident** *mutually*
- Violence by **resident** against *him/herself*
- Violence by **relatives** against resident/occupant
- Violence by **relatives** against staff
- Violence by **staff** against staff
- Violence by **staff** against resident/occupant

Direct and indirect violence

Direct (personal) violence: Here, the perpetrator and the victim face each other. This always has negative consequences for the weaker person. The will of the person is actively counteracted and damage is left behind. The violence is immediately recognisable as such.

Indirect violence: This refers to the effects of the different forms of violence, which always take place in a multidimensional way. Physical violence is usually accompanied by psychological violence and psychological violence by neglect through isolation.

Structural and cultural aspects can also promote the emergence of aggression on the one hand and on the other hand make it difficult or even impossible to recognise or deal constructively with violence. This also includes the lack of appropriate prevention measures.

Structural violence is based on external conditions and circumstances and is not linked to a concretely acting person. It is based on institutional and social structures that influence people in the way they are set up and predetermined. These include all house and home rules, the staffing, narrow daily structures, the spatial equipment and thus the lack of privacy and intimacy, ever shorter days of stay in hospitals in order to save costs, as well as more and more activities remote from the patient, the documentation, hygiene regulations, standards and legal requirements of care and health insurance companies. This form of violence is seen and stated by most staff as the main risk factor for violence in health care professions. Examples are:

- Forced communitarisation in institutions
- Organisational specifications (externally determined daily routines, inadequate concepts, too few and inadequately trained staff)
- Invasion of privacy and intimacy
- Restrictions on contacts with the outside world
- Obstruction of autonomy
- No focus on biography, negation of preferences (including mealtimes and bedtimes, same-sex care)

Cultural violence is the violence of prejudices and attitudes that prevail within a culture and determine action. This refers to the values of a society. Old age, illness and dependency are often associated with being unable to perform and being very expensive. In society, being old or suffering from chronic diseases means not being worth anything and not being able to contribute to society.

Violence by carers towards residents

Caring for the elderly requires empathy, strength and enduring patience from caregivers. In contrast to temporary treatment care, nursing home care seems to be an endless permanent treatment. In this setting, no fundamental improvement but death is to be expected.

Caring for dying and terminally ill people sometimes places a heavy psychological and physical burden on carers. Parallels to the high demands of individuals in need of support and care in general can be seen here.

Experiences of stress can sometimes manifest themselves in perceived or acted out aggression towards residents. Negative feelings of pressure and overload have a negative impact on everyday care and represent exceptional situations for all persons involved.

In the following, reference is made to aggressive behaviour of individuals, which is closely linked to acts of violence. According to Richter (2013), aggressive behaviour consists of...

> *"[...] when an action can lead to physical or mental harm to a person and/or is perceived by the target person as threateningly harmful. The aggressive action can be physical (also non-verbal through facial expressions and gestures), but also non-physical through verbal statements. [...]."*

Violence by residents towards carers

With a high need for care and the resulting move to a nursing home, part of the independence is lost. Due to various factors, the resident is no longer able to take care of himself or herself sufficiently. Since the resident is thus dependent on help, a dependency arises. This certain power of care staff towards the resident favours the development of aggression. In a nursing home, the personal sphere is almost completely controlled. The resident has to orientate and adapt to the rules of the respective institution.

As a result, individuals in need of care lose part of their autonomy. The latter can lead to an increased experience of stress and in turn express itself in the form of aggressive behaviour.

Violence by relatives against residents and carers

However, aggressive behaviour and violence in the context of long-term care can also be directed by relatives against residents and staff. In this context, parallels to hospital or home care by family carers can be identified.

Aggressive behaviour and violence are largely a sign of excessive demands, which can be perceived on a physical, psychological, social or financial level. As international studies show, relatives of residents in need of care often experience the existing situation as extremely stressful. Examples

include years of lay care, financial constraints, the transition to a long-term care facility or severe illnesses that have a negative impact on communication or the physical condition of the person concerned.

The aspects mentioned are in turn trigger points for aggressive behaviour and violence. These can erupt in the form of verbal or physical violence against caregivers, as they work closely with the residents and their social environment. Irrespective of this, violence against residents can also be seen as something supposedly "good" on the part of relatives.

In the belief that they know what satisfies the resident's needs, activities are carried out against the resident's will. Examples include taking food, mobilisation or administering medication.

Forms of violence

The following forms of violence, which can occur individually or in combination, can be found in the care of elderly people:

1. Physical violence
2. Psychological violence
3. Measures restricting freedom
4. Neglect
5. Financial exploitation
6. Intimate assaults

Physical violence or abuse

All forms of abuse that deliberately inflict pain on the other person, e.g.:

- Inflicting pain (e.g. pinching, slapping fingers, giving a slap, hitting).
- Grasping too tightly, pushing, pulling
- Position uncomfortably
- Unauthorised use of measures restricting liberty / detaining against the will
- Water temperature too cold or too hot during personal hygiene
- Administering food too quickly

- Force to eat
- Put drinks at an unreachable distance
- To avoid going to the toilet Use incontinence articles or indwelling catheters
- Inappropriate use of aids
- Take away aids such as bell, glasses, prosthesis or walking stick
- Forced entry of psychotropic drugs

Examples:

- *In the course of basic care, a resident with dementia begins to resist with all his might; among other things, he tries to pinch. When he then begins to hit the carer, the carer loses patience and hits the resident in the face.*
- *A resident with an open leg is having her dressings changed. The resident cries out in pain, the nurse says: "Don't be like that, it will be over soon".*
- *A resident has her nose held and the strained food is poured into her mouth.*

Psychological violence

Unlike physical violence, psychological violence is often not visible, although it is no less hurtful and damaging. It is problematic that the injuries to the soul often cannot be named by the person affected.

All behaviour that causes fear in the other person or violates the dignity and soul, e.g.:

- Yelling at
- Insult, abuse, offend, devalue, expose
- Ridicule, ridicule
- Threaten, intimidate
- Disregard or ignore, do not listen, remain consistently silent, do not let them finish.
- Avoid eye contact
- Make decisions about daily routines, employment or contacts without the involvement of the person concerned.
- Trivialise needs
- Using inappropriate or derogatory language
- Entering a room without knocking in front of it

- Disregard religious circumstances
- Make bad conscience
- Disregard for privacy, violation of the sense of shame

Example:

- *In the course of a team meeting, some caregivers make disrespectful comments about the residents. There are statements like: "They all stink out of their mouths. They eat like pigs. The constant shitting is unbearable".*
- *A caregiver punishes residents if they do not behave as she deems appropriate. For example, they do not get breakfast.*
- *One resident is refused to watch TV because he has not finished his supper.*
- *A care assistant humiliates and threatens especially dementia patients and immobile patients. If they complain, he even threatens to beat them or kill them.*

Measures restricting freedom

Measures restricting the freedom of residents in nursing homes can also be classified as acts of violence if not indicated. According to the Housing and Residential Care Amendment (2010), these are only permissible if...

- An existing illness endangers one's own life or that of others.
- Thereby dangers can be counteracted indispensably and appropriately.
- No safe alternative measures are available.

As a consequence, all measures taken by caregivers that cannot be justified with one of the three arguments listed above are to be understood as acts of violence against residents (even the threat of such a measure is violence!):

- Preventing people from getting out of bed, wheelchair or armchair by using belts, side rails, tables or sensor mats.
- Preventing people from leaving rooms or buildings by locking doors.
- Making doors and exits unrecognisable.
- The inappropriate administration of sedating medication.
- Stealing aids that are necessary for mobility or communication with the environment.

Example:

- *A resident was diagnosed with frontotemporal dementia a few years ago and now also shows an increasing tendency to run away, which disturbs the daily work of caregivers. In order to counteract this fact, the resident is deliberately mobilised by carers into a deep armchair in order to prevent her from getting up or mobilising on her own.*

Neglect

In this case, actions are omitted. Passive omissions are those that result in a misjudgement of needs and subsequent harm. Active omissions are those that are deliberately refused by the caregiver.

Neglect is defined as any refusal of help and aids as well as the misuse or incorrect use of aids. The refusal of conversations, contacts and attention should also be mentioned here.

Active neglect (conscious)

- Omit necessary care services (e.g. prophylaxis, positioning, wound care, provision of food, fluids, medication): Prophylaxis, positioning, wound care, provision of food, fluids, medication).
- Do not observe safety and hygiene measures
- Withholding human warmth
- Reacting inappropriately to requests for help (placing call bells out of reach/switching them off, not cleaning promptly after wetting or vomiting).
- No support with mobilisation, walks, spending time outdoors etc.
- Lack of cleaning of the bed, not changing dirty clothes
- Refusal of medical assistance
- React slowly on purpose, Let wait for help for a long time
- Ignoring sources of danger

Passive neglect (unconscious, in case of wrong assessment)

- Failure to recognise problematic circumstances that lead to health damage (e.g. malnutrition, pressure sores, incontinence, immobility)
- Lack of pain prevention and pain treatment, lack of palliative care
- Lack of person-centred attention and communication

- Refusal of professional diagnosis, medical assistance, therapy and rehabilitation

Example:

➢ *In one resident, changes in the skin and nails are ignored and simply not treated. As a result, the skin becomes sore and starts to change, the wounds ooze and smell. The nurse in charge nevertheless puts stockings over them and fails to provide proper care for the resident.*

Financial exploitation

Financial exploitation is also to be understood as a form of violence. This form of violence occurs more often through 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 massive psychological and physical violence.

This can be reflected in the activities listed below:

- Disposing of the resident's personal assets without authorisation, e.g. selling shares in the assets of the person concerned against his or her will.
- Withholding of pension or care allowance for own benefit
- Compulsion to relinquish control over one's own finances
- Persuading or coercing to give money gifts
- induce to change wills
- the withholding of information

Example:

➢ *A caregiver repeatedly addresses a resident about the care services provided for him/her and the efforts involved. The tone is unfriendly. In the course of a conversation, the carer again draws attention to the resident's need for support and asks whether it would not be appropriate to compensate him financially for his continued efforts. Otherwise, according to the carer, this could have a negative effect.*

Intimate assaults

Intimate assaults are also a form of violence, for example:

- Unsolicited opening of letters or documents from the resident

- Violating the resident's sense of shame or privacy by, for example, leaving the room door open or not using privacy screens in the shared room.
- Sexual violence: This form of violence includes all those acts against a person in need of care in which sexuality is used as a means of humiliation and injury. Forms of this are sexual harassment, sexual assault of any kind (e.g. inappropriate physical contact, forcing sexual acts, non-consensual intimate contact), rape and sexual abuse. However, sexual violence can also be expressed in verbal, suggestive remarks and looks.
- Note: Acts of care that involve nudity or touching in the intimate area can also be perceived by the resident as sexual assault.

Example:

- *In the course of caring for a resident with dementia who is standing naked in the middle of the room, two caregivers make primitive and condescending remarks about his private parts and laugh at the resident.*
- *A resident grabs the private parts of a female resident who is lying in a nursing chair. The care team ignores the situation.*
- *The night service increasingly observes sexual assaults at night by the husband on his wife who suffers from dementia. These assaults lead to haematoma and skin damage in the chest area. The wife cannot defend herself due to her immobility.*

Active and passive violence

Active violence: Here, the violence consists of an *action*, usually abuse (e.g. physical or psychological violence, restriction of freedom, intimate violence, ...).

Passive violence: Here the violence consists of an *omission* (e.g. neglect), which then leads to harm to the person affected.

Violence among residents and tasks of staff members

Violence among residents has received little attention in the past decades, as the focus has been on the use of violence by caregivers. Due to demographic change and the resulting high value of professional long-term care, the first studies now also refer to conflicts between residents. Aggressive behaviour and violence can also occur in this environment.

The latter focus primarily on verbal and physical violence, sexual harassment and disrespect for privacy.

It is striking that women, compared to men, are more often exposed to aggressive and violent behaviour by other resident persons of a nursing home.

According to a study from Germany, residents who are prone to violence also tend to have functional as well as cognitive impairments.

In most cases, however, the use of violence is due to communication problems, environmental factors, illnesses or symptom intensities, and subjectively perceived dissatisfaction. These causes are often interrelated.

Examples:

- *A resident enters the room of a female resident of the same nursing home whom he does not know without being asked to do so. A verbal argument ensues and it turns out that the resident has unintentionally entered the wrong room due to a lack of orientation.*
- *A resident with dementia enters the wrong room and steals objects believing them to be her personal property. When asked about this by the rightful owner, she reacts with incomprehension.*
- *Several residents with low care needs react to the repetitive words and movement patterns of a fellow resident with dementia. The fact that both parties meet every day causes an increasingly negative basic attitude towards the resident with dementia. They feel restricted in their quality of life.*
- *A resident with cognitive impairments demonstrates aggressive behaviour towards other residents. They feel provoked by the threats and react with aggression as well.*
- *A resident with metastatic breast cancer presents with increasing pain despite persistently reflective therapy measures. The resulting despair manifests itself in aggressive behaviour towards other residents. She is disappointed and feels betrayed*.

Aggression and violence on the part of the residents:

- Hitting, scratching, biting, kicking, pushing, pulling hair
- Slamming windows and doors
- Throwing clothes and objects
- Destroy objects
- make a mess
- Provoking extra work (e.g. through deliberate spilling, deliberate wetting)
- Constantly ringing

- Smear walls
- Set fire
- Unnecessary independence
- Boycotting the care programme
- Permanent nagging and complaining
- Excessive expectations or demands
- Sexual harassment
- Autoaggression

Autoaggression ... *is often a last signal for the need for attention!*

- Scratching, cutting yourself
- Banging your head against the wall
- Pulling out hair
- Burning or scalding of limbs
- Suicide

4.9. M2: „Klupperl“ exercise Instructions

Groups of three

There are 3 situations; the participants experience themselves in 3 roles: Victim, perpetrator and observer/witness.

Basic theme from practice: A caregiver is supposed to do something for a resident (e.g.: wash, change an insert, change clothes, give food, mobilise, ...), but the resident does not want to do it and resists.

In this exercise, the element of "pressure versus resistance" is to be tried out through a "neutral projection possibility" without having real care situations in mind.

Starting situation: each group of three receives 1 clothes peg (= Klupperl), the participants agree on an order (A, B, C). In the first round, person A is in the role of caregiver, B is resident (not demented), C is observer.

Note: Keep a few clothe pegs in reserve because they sometimes get broken

Short version: Time: approx. 35 minutes

In situation 1 and 2 there is one pass, in situation 3 there are three passes

Situation 1: All 3 persons are standing (C stands a little further away as an observer).
A has the rattle and the task to put the rattle on B's clothes.
B, however, does not want this and protests against it (verbally and possibly also with defensive movements, turning away or walking away).
A is supposed to get B to accept the rattle. B should continue to resist, unless A really succeeds in convincing or motivating B.
Time: approx. 3 minutes (the trainer ends with an acoustic signal)
Important: Stick to the term "Klupperl" and do not construct a practical reference (e.g. "Klupperl").
(e.g. "Klupperl" stands for "wash").
Short debriefing (2-3 min.): How did I feel as A ("perpetrator")? How did B feel (as the "victim")? What did C perceive as an observer, how did he feel as a "witness"?

Situation 2: same task as in situation 1 (= to put a ball in place).
C is the carer, A the resident, B the observerSpatial
setting: carer and observer stand, resident sits on chair.
This is to simulate the limited mobility of the "victim" (wheelchair, bed) ... i.e.: Escape is not possible.

Situation 3: same task as in situation 1 (= to put on the bludger).
Spatial setting: caregiver and observer stand, resident sits on chair with eyes closed.
This is to simulate the limited mobility of the "victim" (wheelchair, bed) and a clear restriction of perception.
This is the most intense of the three situations, so each participant should experience it in all three roles.

In round 1, B is the carer, C is the resident, A is the observer.

Then the roles are changed:
In the 2nd round A is the carer, B the resident, C the observer;
In the 3rd round C is the carer, A the resident, B the observer.

Final discussion in the group of three: Our findings from the 3 situations ...

Then debriefing in the plenary + practice transfer

Long version: Time: approx. 50 minutes

In each of the three situations there are three passes

Situation 1: All 3 persons are standing (C stands a little further away as an observer).
A has the rattle and the task to put the rattle on B's clothes.
B, however, does not want this and protests against it (verbally and possibly also with defensive movements, turning away or walking away).
A is supposed to get B to accept the rattle. B should continue to resist, unless A really succeeds in convincing or motivating B.
Time: approx. 3 minutes (the trainer ends with an acoustic signal).
Important: Stick to the
term "Klupperl" and do not construct a practical reference (e.g. "Klupperl" stands for "wash").
Short debriefing (2-3 min.): How did I feel as A ("perpetrator")? How did B feel (as the "victim")? What did C perceive as an observer, how did he feel as a "witness"?

Then the roles are changed:
In the 2nd round C is the carer, A the resident, B the observer;
In the 3rd round B is the carer, C the resident, A the observer.

Situation 2: same task as in situation 1 (= to put on the bludger), same roles.
Spatial setting: caregiver and observer stand, resident sits on chair.
This is to simulate the limited mobility of the "victim" (wheelchair, bed) ... i.e.: Escape is not possible.

In the 1st round, A is the caregiver, B is the resident, C is the observerIn the
2nd round, C is the caregiver, A is the resident, B is the observerIn the
3rd round, B is the caregiver, C is the resident, A is the observer

Situation 3: same task as in situation 1 (= to put on the bludger), same roles.
Spatial setting: caregiver and observer stand, resident sits on chair with eyes closed.
This is to simulate the limited mobility of the "victim" (wheelchair, bed) and a clear restriction of perception.

In the 1st round, A is the caregiver, B is the resident, C is the observerIn the 2nd round, C is the caregiver, A is the resident, B is the observerIn the 3rd round, B is the caregiver, C is the resident, A is the observer

Final discussion in the group of three: Our findings from the 3 situations ...

Then debriefing in plenary + practical transfer

4.10. M2: Legal aspects

Rights of the elderly / Laws for the protection of the elderly

Adult Protection Act (ErwSchG)

The central element here is autonomy and self-determination or the support of persons with a lack of decision-making capacity by persons authorised to represent them.

In this sense, there are clear restrictions on interventions by relatives that conflict with an assumed will or recognisable needs of the elderly person.

Right of residence

The "Federal Act on the Protection of Personal Freedom while Staying 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 need nursing or care due to old age, a disability or an illness.

The Nursing Home Residence Act (Heimaufenthaltsgesetz, HeimAufG) regulates the prerequisites and review of restrictions on liberty in old people's and nursing homes, homes for the disabled and other facilities where at least three mentally ill or mentally disabled people can be permanently cared for or looked after (Halmich 2020, 102).

This also entails supervisory and due diligence duties.

Legal framework in the context of violence against residents:

Principle of trust as a basis

Health care workers may generally assume that all health care professionals, such as doctors, nurses or paramedics, are up to the assigned tasks and act with due care.

However, the principle of trust does not apply if it is clearly recognisable that colleagues have acted in breach of duty of care or if it is obvious due to concrete circumstances.

In this case, warning and intervention obligations apply.

Duty of notification (§ 7 Abs 1 GuKG = Health Care and Nursing Act)

Health professionals are obliged to report to the criminal investigation department or the public prosecutor's office if, in the course of their professional activities, there are reasonable grounds to suspect that a judicially punishable act has

- death, grievous bodily harm or rape has been caused, or
- Children or young people are or have been abused, tormented, neglected or sexually abused, or
- **adults who are incapable of acting or making decisions or who are defenceless due to frailty**, **illness or a mental disability** are or have been abused, tortured, neglected or sexually abused.

Exceptions according to § 7 para 2 GuKG (Health Care and Nursing Act)

- **There is no obligation to report,**
- if the notification would contradict the express will of the patient who is capable of making a decision and there is no immediate danger to him/her or to another person
- if in the specific case the report would impair the professional activity - the effectiveness of which requires a personal relationship of trust - unless there is an immediate danger to that person or to another person
- if the professional exercising his or her professional activity in the employment relationship has made a corresponding report to the employer **and a report has been made by the** employer to the **criminal investigation department or the public prosecutor's office.**

Note

- But note that the legal consequences continue: **if the supervisor fails to report in breach of duty, the duty to report reverts to the health professional.** Then the employee is again obliged to report.
- In general, the report must be made as soon as possible, immediately or without culpable delay!

In addition to the "duty to report" defined in the Health Care and Nursing Act, there is a "**general right to** report" in the Code of Criminal Procedure (section 80 of the Code of Criminal Procedure): "Anyone who becomes aware of the commission of a criminal offence is entitled to report it to the criminal police or the public prosecutor's office".

In some cases, the duty to report is offset by the **duty of confidentiality** (§ 6 GuKG).

SeneCura internal reporting system ("Big five")

1. **Home management / Nursing service management**
2. **Ombudswoman for Personnel Regina Sitnik** (r.sitnik@senecura.at), T.: 0664 88174817)
3. **Ombudsman's office for residents** (ombudsmann@senecura.at)
4. **Josef Renner Compliance Dept**.(j.renner@senecura.at), T.: 0664 88174643
5. **Whistleblower Platform** (https://orpea.signalement.net/)

Further procedure individually depending on the occasion

Violence by a resident against a defenceless other resident

The Security Police Act may apply here:
Prohibition of entry and approach for protection against violence (§ 38a SPG)

Legal framework in the context of violence against employees

- Employer's duty of care (section 1157 ABGB)

  (1) The employer shall arrange the services and, with regard to the rooms and equipment to be provided or made available by him, shall ensure at his own expense that the life and health of the employee are protected as far as possible according to the nature of the service.

  (2) If the employee is accepted into the employer's household, the employer shall make the necessary arrangements with regard to the employee's living and sleeping quarters, meals and working and recreation time, taking into account the employee's health, morals and religion.

  Accordingly, the employer's **duty of care is** understood to mean that the employer must organise the working conditions in such a way that the life and health of the employee are protected as far as possible and that other material and immaterial interests of the employee are also safeguarded.

- Employee Protection Act, e.g. duties of the employer (§ 3 ASchG)
- Employee Liability Act
- Equal Treatment Act (§ 6: Sexual Harassment, § 7 Harassment)
- Accommodation Act (if there is a mental illness and this poses a serious threat to the life or health of the carers).
- Self-defence / assistance in an emergency (§ 3 StGB)

Legal classification of violence and abuse

(Source: "Prävention und Intervention bei Gewalt gegen ältere Menschen", bmask.gv.at)

- From a legal point of view, the term "***violence***" is defined by criminal law. Only if there are corresponding acts defined by the penal code are legal consequences drawn from them. The aspects of culpability and intent or negligence are also relevant.
- The suspicion that such an act has been committed is sufficient to trigger reporting or notification obligations. Suspicion exists if there are circumstances which, according to human experience, indicate with some probability that a criminal offence has been committed. For a suspicion to exist, there must be concrete indications which, according to forensic experience, make it appear obvious or possible that physical or psychological abnormalities have been caused by maltreatment, sexual abuse etc.
- ***Maltreatment*** is understood to be any inappropriate treatment of another person that affects physical well-being in a not entirely insignificant way, i.e. causes pain or discomfort.
- ***Torture occurs*** when physical or mental pain is inflicted on a person. Physical torture can be caused by injuries as well as by ill-treatment or restriction of liberty, whereas mental torture can also be caused by threats, insults or other humiliations.
- ***Neglect*** is understood to be cases of violation of the duty of care and custody if they are gross and can lead or have already led to considerable damage to health or physical or mental development.
- ***Sexual abuse occurs when sexual*** acts are carried out with a minor or a person of full age who cannot look after his or her own interests. Touching and exposure can already fulfil the offence.
- A ***slight bodily injury occurs*** if the health impairment or occupational disability is up to 24 days and there is no intrinsically serious health impairment (section 84 (1) StGB). Every intrinsically serious health impairment as well as every health impairment and occupational disability of more than 24 days constitutes a ***serious bodily injury.***

Possible offences related to violence:

- Maltreatment/physical injury (§ 83 StGB, § 84 StGB, § 88 StGB)
- Torturing/neglecting defenceless persons (§92 StGB)
- Overexertion of persons in need of protection (§93 StGB)
- Deprivation of liberty (§ 99 StGB, §3 HeimAufG)
- Homicide (§ 75 StGB, § 77 StGB, § 78 StGB)

- Failure to render assistance (§ 95 StGB)
- Stabbing an injured person (section 94 of the Criminal Code)
- Coercion (§ 105 StGB)
- Dangerous threat (§ 107 StGB)
- Continued use of violence (section 107b StGB)
- Trespassing (§ 109 StGB)
- Insult (§ 115 StGB)
- Defamation (§ 111 StGB)
- Defamation (§ 297 StGB)
- Neglect of care, upbringing or supervision (section 199 StGB)
- Rape (§ 201 StGB), Sexual Assault (§ 202 StGB)
- Sexual abuse of a defenceless or mentally impaired person (section 205 StGB)
- Sexual harassment and public sexual acts (Section 2018 StGB)
- Unauthorised medical treatment (§ 110 StGB)

4.11. M3: Assessment and risk assessment

Checklists are suitable for assessing risks or evaluating existing prevention concepts and can be used to determine the current situation. They can also be used for evaluation after planning and implementing further development measures.

Here are some examples:

- **Checklist Risk Assessment.docx:**

  This is suitable for a fundamental analysis of a facility for the care of elderly people with regard to violence-related risk potentials and corresponding preventive measures.
- **M3 Risk factors that promote violence.docx:**

  This text lists a number of risk factors that experience has shown can promote the occurrence of violent acts. These risk factors concern (1) the care system as a whole including the working conditions, (2) the individual staff member and (3) the individual resident.

- **Prevention opportunities.docx:**

  In this text, a number of prevention options are listed, namely at the levels of

- Verbal behaviour
- Nonverbal behaviour
- Inner attitude / personal attitude
- Organisation, procedures, rules
- Prevention among professional carers

- **Questionnaire Violence Prevention for Managers and Employees.docx:**

  This checklist shows essential prevention factors. They can be assessed to what extent they are realised in the facility.

  A number of open questions can be used to explicitly name conducive and disruptive factors, as well as any suggestions for improvement.

- **Guide_Care_Charta.pdf:**

  This catalogue of guiding questions is an aid to action for the application and implementation of the Care Charter in inpatient care facilities. It takes up the structure of the Care Charter with the articles and their comments and translates them into questions for the facilities.

  Through the self-evaluative questions, the guideline encourages the implementation of Charter requirements that are within the scope of action of the institutions and providers.

  Ultimately, this can support the further development of the organisation in terms of its orientation towards basic values and rights, as well as a user-oriented presentation of services and the dissemination of good practice.

  Variant for outpatient care: **Leitfaden_Pflegecharta_ambulant.pdf**

Supplement

In a 2019 review by Anderson and Jenson ((Source: "Anderson, Jenson_2019_Violence risk-assessment screening tools for acute care mental health settings. Literature review. Archives of Psych nursing 2019 33.pdf") 8 assessment methods are described in overview. However, they are mostly used in psychiatric settings.

This also applies to the frequently used "Brøset violence checklist (BVC)". (see also the file "Aggression assessment in inpatient settings.pdf")

4.12. M3: Early warning signals / triggers for aggression and violence

Aggressive behaviour always has a cause (trigger) and a motive (motive, intention).

The knowledge and deeper understanding of these causes and motivations is a prerequisite for being able to respond to our counterpart in a de-escalating way.

By noticing his current needs, problems and feelings behind the aggressive behaviours, I can

- come into contact with the human being
- Understand and reassure him
- Help him and myself to cope with the situation
- Prevent further escalation

Signs of increased tension or imminent aggressive behaviour

- **Body:**
  - Increased body tension, unconscious trembling
  - One "puffs up", body tends to go forward
  - Face: tense jaw muscles, eyes become narrow or suddenly open, "piercing" gaze
  - heavy breathing, muscle twitching or reddening of the skin
- **Language:**
  - Voice becomes louder (sometimes also menacingly quiet), "sharper" and higher-pitched
  - Language becomes faster
  - Expressions of displeasure, threats, accusations, devaluations, provocations, etc.
- **Emotions / Unpleasantness:**
  - Indignation, anger, rage
  - Being annoyed
  - Disgust, revulsion
  - Disappointment
  - Fear
  - Powerlessness / helplessness
  - Shame / humiliation / degradation
  - Insult / Offence

Triggers for aggression and violence

- **Physical pain:** If pain is inflicted on us arbitrarily and provocatively, we respond with aggression. If the person causing the pain is not accessible to us, we react non-specifically, i.e. against the one who is there at the moment. This phenomenon is called displacement.
- **Social pain:** Social rejection, contempt, exclusion, humiliation, etc. are processed in the same brain centres as physical pain and are the strongest triggers of aggression. One reason for this is that in the course of evolution we have learned that we can survive better in groups.
- **Threat**: If escape is impossible, one goes on the attack
- **Fear** (= imagined threat)
- **Low self-esteem**: Through aggression, one tries to appear stronger on the outside than one feels on the inside.
- **Goal blockages**: when something or someone prevents me from achieving something that is important to me.
- **Frustration**: Any frustration over a disappointed expectation (i.e.: gap between desire and reality) leads to aggression. Possibility of coping: Adhere less to expectations
- Accumulation of stressful moments / Previous repression ("**full discount card**"): What has been swallowed down for a long time can come up explosively
- If the **internal stress** becomes **too great**, exceeding the load limit
- **Relationship disorder**: I see a person in front of me with whom I have had bad experiences and react with aggression. It can also be that the real person reminds me of someone else from my past with whom I have experienced something unpleasant ("transference").
- **Helplessness**
- **Limited ability of** the resident **to communicate**
- **Invasion of privacy**
- Misjudging the situation (**misunderstandings**)
- **Disregard for feelings and needs**
- Inappropriate contact, coercion, abuse, **violence by caregiver**
- **Employees with high stress levels** (mirror neurons)
- **Temporary loss of inhibition** (e.g. due to illness or tiredness, stress, medication)

4.13. M3: Risk factors that promote violence

Violence becomes visible when it takes place between persons. In addition to this personal level, violence in care situations can also take place on a structural and cultural level.

The structural level refers to the emergence of indirect violence through framework conditions. Examples include country-specific laws or guidelines and directives that contribute to a framework conducive to violence. Restrictive visiting rules or rigid daily routines can also be mentioned as examples of structural violence.

The cultural level refers to existing values of a society that have a negative impact on residents. For example, prejudices against elderly people and people in need of care or how they are "talked about" could be mentioned here.

The causes of violence in care relationships are as complex as their forms. Violent incidents rarely occur without signs and all of a sudden - rather, violence and aggression have a longer history in most cases.

Violence usually arises from the interaction of various causes that influence each other, whereby the effect can in turn be the cause of further escalation. Causes and effects must therefore always be considered together.

Risk factors or causes of violence from the care system

Lack of competence in dealing with violence

- There is no generally binding definition of violence and carers do not even know where and when violence begins.
- There is too little training on violence prevention (for both staff and management).
- Lack of prevention: Either the facilities do not have standards for dealing with problematic situations or the caregivers do not know the content of such standards.
- Not taking conspicuous and suspicious facts seriously (culture of looking the other way or covering up)
- Managers do not perform their control duties sufficiently (presence in the living area, nursing rounds, night duty checks, ...)
- Carers are unsure how to address colleagues about violence they have observed.
- Lack of de-escalation competence
- Too few opportunities for mental hygiene or aftercare following incidents of violence

Working conditions conducive to violence

- Standards and specifications on the part of the management or the provider that cannot be fulfilled with the available resources.
- High and unmanageable workload, time pressure, care stress
- Too little time for residents
- Understaffing
- Long working periods, unfavourable working hours
- Often have to step in
- Enormous documentation effort
- Authoritarian leadership, no say - "we are not asked".
- Rigid guidelines, rigid hierarchies
- Lack of transparency
- Insufficient support from the leadership
- No support in difficult situations
- Too little recognition and appreciation from inside and outside
- Poor working atmosphere, team conflicts
- Errors in communication
- Irritations due to different cultures and languages
- Supervision is not offered or taken up by staff members
- Team and case discussions are not used enough
- Too little payment
- No professional lobby
- Increased noise level as well as reduced freedom of movement in dining and common rooms
- Gathering of people with different needs in one space
- Heat and poor ventilation in summer

Personal risk aspects among employees

- Burden of death, old age, illness & suffering
- Psychological factors
- Personality-related low aggression threshold or low self-control
- Insufficient social competence (e.g.: lack of communication skills and ability to deal with conflict)
- Lack of or low self-esteem
- Health problems

- Private problems, personal conflicts / financial, social, health problems
- Continuous emotional stress
- Overstrain, overload (burnout)
- Carers overestimate their competences and abilities, overtax themselves, cannot cope with stress adequately, lack the ability to self-care (e.g. lack of sleep)
- Life crises (e.g.: marital conflicts, divorce)
- Multiple workloads ("second job"), nursing case in own family
- Frustration
- low frustration tolerance
- own experiences of violence
- Lack of identification with the profession of geriatric care, lack of aptitude for the profession
- Thoughtlessness, carelessness, ignorance
- Conflicting relationship with the person in need of care
- The person being cared for bears a resemblance to an unsympathetic person
- Alcohol or substance abuse
- Side effects of medication
- Psychopathic personality structure

Risk factors or causes of violence among residents

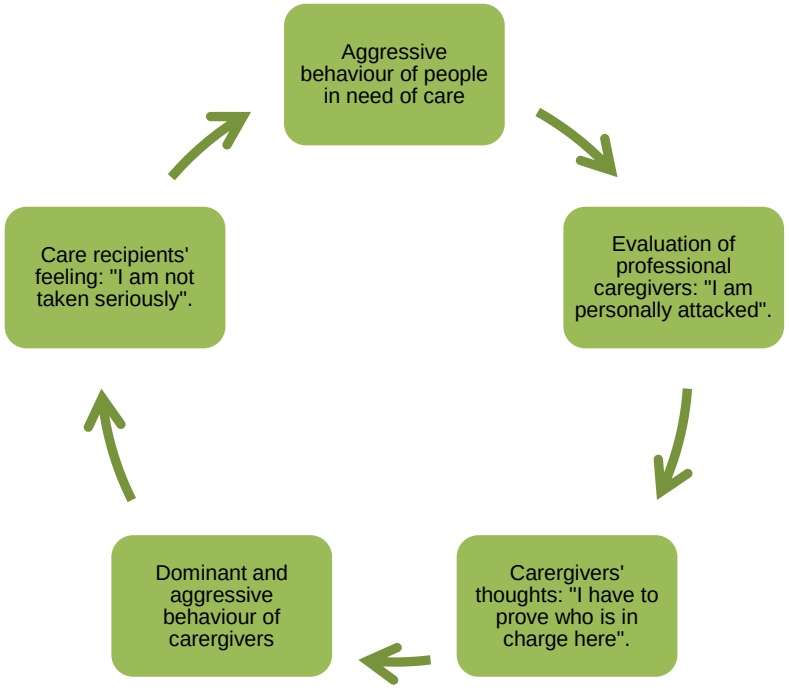
- Gerontopsychiatric diseases
- Traumatisation
- Loss of control over emotions due to illness
- Sensory impairments
- Psychological factors, family background
- Low social competence / conflicts have always been "solved" violently....
- Previously practised constructive ways of conflict resolution are no longer available due to illness
- Burden of death, old age, illness & suffering
- Dissatisfaction with one's own life situation / struggling with fate / unfulfilled wishes (lack of quality of life)
- Helplessness and powerlessness
- Fear
- Despair
- Grief, homesickness

- Feeling threatened, e.g.:
  - Feeling not understood / disregarded
  - Feeling harassed / attacked
  - do not understand (in terms of content or because they have difficulty hearing)
  - Feeling overwhelmed / not being able to cope with the situation
  - not be protected
- Alcohol or substance abuse
- Carer bears resemblance to an unsympathetic person
- Lack of self-determination, dependence, role change
- Environment (temperature, overstimulation, restlessness, ...)
- Deprivation of liberty
- Caregiver violence
- Extreme physical closeness
- Penetration of intimacy
- Communication problems (also hearing loss)
- Side effects of medication
- Aggressive or disruptive behaviour by residents (especially physical attacks) provokes violence by carers
- Pressure from relatives / disagreements with relatives

Escalation spiral

Almost every violent situation has a history. Sudden attacks are rare. Aggression on the part of carers and people in need of care can cause such aggressive behaviour, whereby a so-called vicious circle emerges due to mutual build-up.

The described escalation spiral shows the vicious circle of aggression and violence. If the resident often does not feel understood or taken seriously, this can lead to aggressive behaviour. The carer in turn interprets this behaviour as a personal attack and exercises power, which can lead to dominant and aggressive behaviour. As a result, the resident feels restricted in his or her freedom and not properly perceived. The latter is reflected in increased aggressive behaviour. The cycle begins again.



Once such a spiral of violence has developed, in most cases it is no longer possible to determine which behaviour was the trigger and who is to be described as the perpetrator or victim. People in need of care often blame the living situation, whereas caregivers blame the residents entrusted to them.