Threats and violence in Swedish community elderly care

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A B S T R A C T

Violence in elderly care has been reported on a global scale. The aim of this study was to describe nurses’ perceptions of threats and violence, directed at themselves and other staff in community elderly care. Another aim was to describe nurses’ access to prevention measures for handling threats and violence. A questionnaire was answered by registered nurses (RNs) (n = 213) in community elderly care. Data was analyzed by SPSS. The results showed that nurses had experienced high-degree indirect threats (48%), direct threats of violent acts (40%) and violent acts (40%). Forty-five percent of the nurses had witnessed violence and threats toward other staff. Twenty percent of the nurses stated to have access to education in managing threats and violence. The conclusions were that violence occurred frequently in community elderly care, as perceived by nurses, as well as that community authority should increase staff education for handling violence.

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1. Introduction

Violence is a global phenomenon of epidemic proportions in all societies (WHO, 2002). In the European Union estimated three million workers, or two percent of the labor force, have been subjected to physical aggression and violence at work. Earlier studies have reported violence in elderly care in Sweden toward care providers (Arnetz et al., 1996; Menckel and Viitasara, 2002). Violence in elderly care has also been reported on a global scale, for example from Canada (Wierucka and Goodridge, 1996), Germany (Goergen, 2001), United Kingdom (Manthorpe, 2002), Australia (Hegney et al., 2003; Eley et al., 2007), and United States (Nachreiner et al., 2007). Therefore, the first objective of the present study was to describe registered nurses’ (RNs)’ perceptions of threats and violence, directed at themselves and other staff in community elderly care. Another objective was to describe RNs’ access to prevention measures and routines for handling threat and violence.

Work-related violence is a major problem for RNs in elderly care (Arnetz et al., 1996; Eley et al., 2007; Nachreiner et al., 2007), as well as in accident and emergency departments and psychiatric wards (Arnetz et al., 1996). Arnetz et al. (1996) reported that 30% of 2690 RNs including midwives had experienced work-related violence in Sweden. More, 30% had witnessed violent acts. Twenty-seven percent considered violence to be an occupational problem. The risk for violence was increased in psychiatric and geriatric settings, where 76% respectively 40% RNs had been subjected. Hegney et al. (2003) also indicated that 50% of RNs in elderly care had been subjected to violence.

Mullan and Budger (2007) indicated that 51% of care providers had experienced violence in community elderly care. Menckel and Viitasara (2002) also showed that 51% of community staff had been subjected to threats and violence in a one-year period. Of this sample, 75% worked in elderly care and well over half in special types of housing, i.e. nursing homes, group housing, old people’s homes and service blocks in community management. The most vulnerable groups were enrolled nurses and direct caregivers, i.e. staff having close physical contact with care recipients. Many of them were daily exposed verbally (79%) and physically (66%).

Violence is not simply an individual problem that happens from time-to-time. Violence ought to be seen as a process including specific factors, as well as situational and structural factors with much wider socioeconomic, cultural and organizational causes (Viitasara and Menckel, 2002; WHO, 2002). Staff are employed to achieve high-quality care and they are affected by physical, psychosocial and environmental factors. Therefore, they need a functional and supportive environment (Viitasara and Menckel, 2002; Almvik et al., 2007). There are a great variety of definitions of violence. Threats and violence are variously defined and are not always kept separated. In this paper, violence is broadly defined as involving both non-physical and physical violence (WHO, 2002). The definition chosen is: “. . . encompassing threatening behavior and verbal aggression as well as acts of physical assault. Threatening behavior can be verbal only, or it can entail implied physical harm, such as rising clenched fists without actually striking” (Arnetz, 1998).

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2. Materials and methods

2.1. Design

A descriptive design with a survey research approach was used (Polit and Beck, 2004). This study is a part of a larger project in community elderly care reported elsewhere. The larger project sought to describe RNs’ perceptions of their work situation; regarding demand, decision latitude, and social support (Josefsson et al., 2007a); their education and desire to invest in competence development (Josefsson et al., 2007b); as well as their needs and possibilities for competence development (Josefsson et al., 2008).

The study was approved by the Ethics Committee of Karolinska Institutet, Stockholm (D. no: 317/02).

2.2. Participants and settings

The target population was a convenience sample including \( n = 342 \) RNs working in community elderly care. In total \( n = 213 \) RNs participated. This comprised 62% of the target population. The RNs worked at 60 special types of housing with subunits. Subject characteristics are described in Table 1.

2.3. The questionnaire

The data collection was compiled from a questionnaire by Aronsson et al. (1992). The questions had given response categories, of which were rated in nominal scales, sometimes with an alternative ‘do not know’. Opportunity was given to add their comments at the end of the questionnaire. The areas examined were background characteristics such as age, gender and number of active years as a RN. Year of nursing examination and form of employment were registered as well. Specific examined areas were RNs’ perceptions of threats and violence toward themselves and other staff. An additional area included questions about RNs’ access to prevention measures and routines for handling threats and violence.

2.4. Data collection

The questionnaire was tested by 10 RNs working in community elderly care. This was done in order to control the logistics and relevance of the questions, usage, and expected time to fill in the questionnaire (Altman, 1997). Data collection was compiled from a questionnaire by Polit and Beck (2004). This study is a part of a larger project in community elderly care. The software used was Statistical Package for the Social Sciences (SPSS) for Windows version 16.0 (SPSS Inc., Chicago, IL, USA). The internal loss of data was minimal and data was neither replaced nor imputed.

2.5. Data analysis

The motives of non-respondents (\( n = 129 \)) were recorded and are reported elsewhere (Josefsson et al., 2007a). A form was distributed to them and they were asked to respond to the following statement: “I have not answered the questionnaire because...”. Non-respondents’ motives were analyzed by their manifest content and were discussed with an outsider researcher.

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3. Results

Table 2 presents RNs’ self-reported threats and violence, to which RNs were exposed to in their work. The most common source of violence and of direct and indirect threats toward RNs was from care recipients. Indirect forms of threats, such as harassment and insinuations, toward RNs were in first hand from care recipients and thereafter from relatives of the care recipients. Furthermore, the results revealed that RNs (\( n = 212 \)) had experienced violence act by the care recipients (42%), as well as indirect threats (48%) and direct threats (40%) of violence act. RNs had witnessed threats and violence toward staff (Table 3) during the last two years.

Table 4 provides a summary of statistics for RNs perceptions of preventative measures against violence and routines in the event when violence occurs. The results revealed that \( n = 41 \) (20%) RNs had access to education in managing threats and violence.

**Table 1**

Characteristics of the RNs (\( n = 213 \)).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Units</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>n (%)</td>
<td>199 (93)</td>
</tr>
<tr>
<td>Age</td>
<td>Median (min-max)</td>
<td>51 (23–76)</td>
</tr>
<tr>
<td>Year of nursing examination</td>
<td>Median (min-max)</td>
<td>1983 (1956–2002)</td>
</tr>
<tr>
<td>Employment</td>
<td>n (%)</td>
<td>184 (86)</td>
</tr>
<tr>
<td>Per hour</td>
<td>n (%)</td>
<td>25 (12)</td>
</tr>
<tr>
<td>Deputyship or contract</td>
<td>n (%)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Years worked</td>
<td>At current work place</td>
<td>Median (min-max)</td>
</tr>
<tr>
<td>RN in elderly care</td>
<td>Median (min-max)</td>
<td>18 (0.75–51)</td>
</tr>
<tr>
<td></td>
<td>Median (min-max)</td>
<td>8 (0.17–30)</td>
</tr>
</tbody>
</table>

* The 25th and 75th percentile.
* Three internal losses.
* Four internal losses.

**Table 2**

Prevalence of self-reported threats and violence toward RNs during the years working as RN in elderly care (\( n = 212 \)).

<table>
<thead>
<tr>
<th>Variables, n (%)</th>
<th>1–3 times</th>
<th>&gt;3 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care recipients</td>
<td>53 (25)</td>
<td>44 (21)</td>
</tr>
<tr>
<td>Relatives of care recipients</td>
<td>15 (7)</td>
<td>55 (26)</td>
</tr>
<tr>
<td>Visitors</td>
<td>4 (2)</td>
<td>25 (12)</td>
</tr>
<tr>
<td>RNs</td>
<td>4 (2)</td>
<td>25 (12)</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>6 (3)</td>
<td>37 (14)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>6 (3)</td>
<td>26 (12)</td>
</tr>
<tr>
<td>Care recipients</td>
<td>35 (16)</td>
<td>42 (20)</td>
</tr>
<tr>
<td>Relatives of care recipients</td>
<td>1 (0.5)</td>
<td>26 (12)</td>
</tr>
<tr>
<td>Visitors</td>
<td>1 (0.5)</td>
<td>11 (5)</td>
</tr>
<tr>
<td>RNs</td>
<td>0</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>1 (0.5)</td>
<td>10 (5)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>1 (0.5)</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Care recipients</td>
<td>36 (17)</td>
<td>46 (22)</td>
</tr>
<tr>
<td>Relatives of care recipients</td>
<td>1 (0.5)</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Visitors</td>
<td>0</td>
<td>2 (1)</td>
</tr>
<tr>
<td>RNs</td>
<td>0</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>2 (1)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* One internal loss.
had been subjected to threats and violence and in Viitasara, 2002). In the past years, austerity policy and staff factors of violence (Smith-Pittman and McKoy, 1999; Menckel and
nursing homes was subjected to violence by care recipients. The results agreed with earlier studies showing that the most common source of violence toward RNs was care recipients. The results indicated that half of the RNs' reported to had experienced an indirect threat of a violent act and 40% had experienced violent acts. The results also showed that RNs had witnessed that all main actors such as other staff (45%) had been subjected to threats and violence in community elderly care. One-fifth of the RNs reported to have access to education in managing threats and violence.

The results indicated that half of the RNs' reported to had experienced an indirect threat of a violent act and 40% had experienced violent acts. Arnetz et al. (1996) also reported a prevalence of violence toward RNs 40% in geriatric settings. Hegney et al. (2003) indicated even higher incidence (50%) of RNs been subjected to violence in the elderly care. Our study showed that the most common source of violence toward RNs was care recipients. The results agreed with earlier studies (Menckel and Viitasara, 2002; Hegney et al., 2003; Nachreiner et al., 2007).

The results also showed that RNs had witnessed that other staff (45%) had been subjected to threats and violence in community elderly care. The results concurred with Menckel and Viitasara (2002), Mullan and Budger (2007). Furthermore, Menckel and Viitasara (2002) reported even a higher prevalence of violence (51%) toward community staff, including staff working in elderly care and special types of housing. As well as Mullan and Budger (2007) also indicated, that 51% of care providers had experienced violence in community elderly care. Goergen (2001) reported similarly high figures where 50% of staff working in nursing homes was subjected to violence by care recipients.

Reorganization at work and high workload is predisposing factors of violence (Smith-Pittman and Mckoy, 1999; Menckel and Viitasara, 2002). In the past years, austerity policy and staff reductions and in Sweden have often led to stress, lack of staff, personnel burnout and a lowered quality of care and relations with care recipients and their relatives (Sandstrom, 2000). Consequently, it is important to emphasize that staff are not villains but are most often the victims of difficult circumstances (Pillemer and Moore, 1999).

Of interest was that only 20% of RNs had access to education in managing violence and threats. This is astonishing since the employer is obliged to ensure that the staff is educated and informed to safely manage their work (Swedish Work Environment Authority, 1993). More, 22–26% of the RNs in our study did not have routines in the event of witnessing violence at work, in spite of the importance with preventive managing of threats and violence (WHO, 2002; Mullan and Budger, 2007). This is not acceptable since threats and violence at work should be reported, documented and resolved (Swedish Work Environment Authority, 1993; National Board of Health and Welfare, 2005). Our study also showed that 37% of RNs did not know if their employers offered education on how to manage violence and threats. This indicated unclear work conditions.

Earlier studies have reported effects of violence. Arnetz and Arnetz (2001) showed that violence experienced by staff was associated with lower patient ratings of the quality of care. Furthermore, Chambers (1998) showed that staff who experienced violence feels that they are powerless to avoid it. This was supported by Mullan and Budger (2007) who reported short-term consequences, such as lack of confidence and powerlessness. Needham et al. (2005) reported about non-somatic effects of patients’ aggression to nursing staff, such as anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame and shame. These effects existed despite differing countries, cultures and nursing settings. Hoel et al. (2002) revealed that the effects of violence also appeared to extend to bystanders, where a ‘climate of fear’ produces similar reactions. Other effects might be lesser work satisfaction (Arnetz and Arnetz, 2001; Hoel et al., 2002), job turnover (Pillemer and Moore, 1999; Hoel et al., 2002) and loss of public goodwill toward elderly care (Hoel et al., 2002).

It will be critical for RNs, other staff and employers to work diligently to improve the safety in elderly care. Therefore, it is an urgent matter to introduce prevention measures such as staff education and routines how to do in the event of staff witnessing violence. There are several recommendations for practice to eliminate violence in the elderly care. One recommendation is to be aware of that violence is a major problem in elderly care and assess risk for imminent violence (Almvik et al., 2007). Secondly, violence ought to be seen as a process including specific factors, as well as situational and structural factors with much wider socioeconomic, cultural and organizational causes (Viitasara and Menckel, 2002; WHO, 2002). Thirdly, nursing students should have a basic understanding of this problem—a crucial policy change for incorporation into their curricula. More recommendations, in line with WHO (2002) are: staff and employers ought to formulate clear antiviolence workplace policies and programmers; supporting legislation and guidelines from national and local government; the dissemination of case studies of good practice in preventing violence at work; improvements of the working environment;

Table 3
Numbers of RNs who witnessed threats and violence toward staff during the last two years (n = 195).a

<table>
<thead>
<tr>
<th>Variables</th>
<th>Yes n (%)</th>
<th>Min–max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious and terrifying direct threat of violent act without physical injuries</td>
<td>55 (29)b</td>
<td>1-many times</td>
</tr>
<tr>
<td>Other threat of violence or threatening situation (e.g. threatening allusions or behaviour, harassment)</td>
<td>74 (39)b</td>
<td>1-daily</td>
</tr>
<tr>
<td>Violence without physical injuries</td>
<td>86 (45)b</td>
<td>1–&gt;300</td>
</tr>
<tr>
<td>Violence with lighter physical injuries without requiring visit to health care</td>
<td>82 (43)b</td>
<td>1–&gt;300</td>
</tr>
<tr>
<td>Violence with physical injuries requiring visit to health care</td>
<td>27 (14)c</td>
<td>1–3</td>
</tr>
</tbody>
</table>

a Eighteen RNs were excluded since they had worked lessor than years as an RN in elderly care.
b Five internal losses.
c Four internal losses.

Table 4
Prevention measures and routines at current working place (n = 213).

<table>
<thead>
<tr>
<th>Variables, n (%)</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education in management of threats and violence</td>
<td>137 (64)</td>
</tr>
</tbody>
</table>

a Three internal losses.

4. Discussion

4.1. Discussion of the result

The first objective was to describe RNs’ perceptions of threats and violence toward themselves and other staff in community elderly care. Threats and violence toward care recipients as perceived by RNs are also reported. Another objective was to describe preventative measures and routines for handling threats and violence. The main results showed that just under half of the RNs’ reported to had experienced an indirect threat of a violent act and 40% had experienced violent acts. The results also showed that RNs had witnessed that all main actors such as other staff (45%) had been subjected to threats and violence in community elderly care. One-fifth of the RNs reported to had access to education in managing threats and violence.

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greater opportunities for training; counseling and support for those affected.

4.2. Methodological considerations

The lack of a consistent and operational definition of violence complicated the comparability and reliability of results (Arnetz, 1998). Violence is not synonymous with good quality care. The topic can be taboo and staff may have problems identifying violence. Staff might accept violence to be a natural consequence of working daily with people suffering from dementia due to the dementia symptoms (Sandvïde et al., 2004). Thus, violence might be underreported (Wierucka and Goodridge, 1996).

5. Conclusions

Nearly half of the RNs reported that they had been both subjected to violence themselves and 45% had witnessed violence and threats toward other staff. One-fifth of the RNs reported that they were offered education in managing threats and violence. Violence is unacceptable. Thus, given the growing care providers shortage, it will be critical to work diligently to improve the safety of care providers at work. There is need of further investigations of employers’ and policy makers’ perceptions of violence in elderly care.

Conflict of interest statement

None.

Acknowledgements

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References


Chambers, N., 1998. We have to put up with it—don’t we? The experience of being the registered nurse on duty, managing a violent incident involving an elderly patient: a phenomenological study. J. Adv. Nurs. 27, 1308–1318.