Violence in municipal care of older people in Sweden as perceived by registered nurses

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Aims. The main aim was to describe registered nurses’ perceptions of violence and threats, as well as their access to prevention measures and routines for handling violent behaviour in municipal care of older people. Another aim was to compare nurses’ perceptions working solely in dementia care with those working in general elder care where older people have diverse diagnoses.
Background. Violence is often reported in care of older people. The development of dementia units and the implementation of reform have changed care of older people. Dementia disorders have been shown to be a predisposing factor to violence.
Design. A non-experimental, descriptive design with a survey research approach was used. The setting was 60 special types of housing with subunits in a large town. The response rate was 62% (n = 213). Forty-five per cent (n = 95) of the nurses worked in dementia care and 55% (118) in general elder care.
Method. A questionnaire.
Results. Nurses had experienced a high degree indirect threats (dementia care, 45%; general elder care, 51%), direct threats of violent acts (dementia care, 35%; general elder care, 44%) and violent acts (dementia care, 41%; general elder care, 43%). Nurses had witnessed violence and threats towards staff (dementia care, 49%; general elder care, 38%). Even care receivers (dementia care, 20%; general elder care, 19%) were subjected to violence and threats. No statistical differences were found between groups. The nurses in dementia care had more access to education in
Introducing violence and threats, as well as routines for handling violence and a door with a lock to their working unit.

Conclusion. Violence occurred frequently in municipal care of older people without any difference between dementia care and general elder care. Nurses in dementia care were more often offered education on how to manage violence and had routines for when violence occurs.

Relevance to clinical practice. Municipal authorities should increase staff education for handling violence and creating safety routines. Violence needs to be taken seriously with a ‘zero tolerance’ attitude.

Key words: care receiver, municipal elderly care, questionnaire, registered nurse, staff, violence

Introduction

Care providers deal with people who have multiple problems and concerns (Smith-Pittman & McKoy 1999). Increasing attention is drawn to violence in care of older people in Sweden, both towards care receivers (Arnetz et al. 1996, Saveman et al. 1999) and towards nursing staff (Arnetz et al. 1996, Menckel 2000, Menckel & Viitasara 2002, Åström et al. 2002). Violence in care of older people has also been reported on a world-wide scale – from Australia (Jackson et al. 2002, Hegney et al. 2003), Canada (Wierucka & Goodridge 1996), Germany (Goergen 2001), the UK (Manthorpe 2002) and the USA (Lipcomb & Love 1992, Payne & Fletcher 2005)

Saveman (1994) drew attention to the fact that formal caregivers witnessed abuse of older people occurring in their homes. Saveman and Sandvide (2001) reported that 25% of general practitioners were aware that older people were either at risk, or actually suffering from abuse. Saveman et al. (1999) revealed that 11% of 499 nursing staff in special types of housing knew of abuse of older people and 2% admitted to committing abusive acts. Special types of housing include nursing homes, group housing, old people’s homes and service blocks in municipal management (Ministry of Health and Social Affairs 2005). Sandvide et al. (2004) reported that 848 caregivers acknowledged 149 violent events during a one-year period, all directed towards care receivers in special types of housing. Care receivers who were least able to influence the outcome of their care were particularly affected by abuse (Meddaugh 1993), which mostly occurred during personal care activities (Middleton et al. 1999, Saveman et al. 1999). Furthermore, abused persons were often mentally and/ or physically impaired (Saveman et al. 1999, Goergen 2001).

Violence is a major problem for Registered Nurses (RNs), specifically in care of older people and psychiatric wards (Arnetz et al. 1996, Jackson et al. 2002), as well as in accident and emergency departments (Jackson et al. 2002). Arnetz et al. (1996) revealed in a national study in Sweden that 30% of 2690 RNs including midwives had experienced work-related violence. Furthermore, 35% had been threatened, 30% had witnessed violent acts and as many as 27% considered violence to be an occupational problem. The risk of violence was increased in psychiatric and geriatric settings, where 76% and 40%, respectively, had been exposed. In addition, Åström et al. (2002) reported that 42% of RNs were exposed to violence in special types of housing for older people. Likewise, Hegney et al. (2003) indicated that 50% of RNs in the care of older people had been exposed to violence.

Menckel and Viitasara (2002) showed that 51% of 170 000 municipal staff had been exposed to threats and violence in a one-year period. Of this sample, 75% worked in care of older people and well over half in special types of housing. The most vulnerable groups were enrolled nurses and direct carers, i.e. staff having close physical contact with care receivers. Many of them were exposed daily, often verbally (79%) but also physically (66%). Åström et al. (2002) showed that 40% of 506 staff members were exposed to violence and 18% of them were exposed daily throughout a one-year period.

Violent acts occur in the personal meeting, between care receiver and caregiver through mutual misunderstanding and mutual invasion of personal space (Sandvide et al. 2004). However, violence should be seen as a process including not only specific factors but also situational and structural factors (Viitasara & Menckel 2002). Staff are employed to achieve high-quality care and they are affected by physical, psychosocial and environmental factors. Thus, a functional and supportive environment is important (Viitasara & Menckel 2002). Changes in the work environment can be a starting point for improvement, but it could also be a source of frustration and difficulties for those carrying out the practical nursing work (Arnetz 2001).
A consistent and operational definition of abuse of older people is at the present lacking (Daly & Jogerst 2001). According to Payne and Fletcher (2005), it is essential to recognize that all types of abuse (e.g. financial abuse, neglect, emotional abuse, etc.) may lead to experiences similar to those of physical violence. Furthermore, there is at the present a lack of comparability in the definitions of violence towards staff in health care (Arnetz 1998, Menckel 2000). Overviews of different definitions of violence are presented by Menckel (2000), Arnetz (2001) and Viitasara (2004). There is a distinction between physical and psychological types of violence, which can be unintentional or intentional (Krug et al. 2002). Threats are either included or excluded in the various definitions. The definitions also make a distinction between direct (personal exposure) and indirect (witnessing) violence (Arnetz et al. 1996). There are also different definitions of work-related violence, where violence is expressly related to a person’s work (Smith-Pittman & McKoy 1999, Viitasara 2004).

Taking into account the great variety of definitions of violence, we have included physical and psychological violence either by personal exposure or indirect witnessing. To involve care receivers and staff, as well as non-physical and physical violence we have chosen to use the following definition of violence:

Violence is broadly defined, encompassing threatening behaviour and verbal aggression as well as acts of physical assault. Threatening behaviour can be verbal only, or it can entail implied physical harm, such as raising clenched fists without actually striking. (Arnetz 1998, p. 7)

In the past years, staff reductions in Sweden have often led to stress, lack of staff, personnel burnout and a lowered quality of care and relations with care receivers and their relatives (Sandström 2000, Arnetz 2001). Saveman et al. (1999) indicated that staff abusing older care receivers tended to be hot-tempered, exhausted and burnt-out persons. The level of burnout of the staff and conflicts between the staff and care receivers showed to be stronger predictors of violence than care receivers’ aggression (Pillemer & Moore 1990). Sandström (2000) indicated that burnout and stress is associated with difficulties in feeling empathy. The author also denoted that caring and human contact was often the first things to suffer during staff reductions. Reorganization in the workplace and high workload were predisposing factors of violence (Smith-Pittman & McKoy 1999, Menckel & Viitasara 2002). Thus, Pillemer and Moore (1990) suggested that staff were not villains but are most often the victims of difficult circumstances.

In the past few decades, the Swedish care system of older people has undergone fundamental changes. Since the early 1980s, residences with small, homelike units and a well thought-out care philosophy for people with dementia have become an alternative to traditional institutions, as described by Annerstedt (1995) and Melin Emilsson (2004). Consequently, care of older people has divided into two groups: (1) specialization in dementia care (DC) and (2) general elder care (GC). RNs working in care of older people have the responsibility of nursing persons who often have age-related symptoms, such as multiple somatic and psychogeriatric illnesses, while RNs in DC work with those who have dementia as the main diagnosis (Swedish Society of Nursing 2004). Staff in DC must deal with persons who experience the degenerative nature of dementia (American Psychiatric Association 1994), such as cognitive and communicative impairment.

In Sweden, an organizational reform in care of older people known as the Ädel Reform has meant that care for persons 65 years and older has shifted from the hospital facilities to the municipality (National Board of Health and Welfare 1996). Thus, the municipalities assumed primary responsibility for the care and housing of older people (Ministry of Health and Social Affairs 2005).

In sum, care of older people is a high-risk area for violence. A changed healthcare structure was introduced by the Ädel Reform. After the development of dementia units, care of older people has split into two groups, DC and GC. Thus, it is of interest to compare the perceptions of RNs working in DC with those working in GC, regarding the prevalence of violence and threats, prevention measures and routines for dealing with violence.

Aims
The main aim of the study was to describe RNs’ own perceptions of violence and threats, directed at themselves, other staff and care receivers in municipal care of older people. The second aim was to describe RNs’ access to prevention measures and routines for handling violence and threats. Considering the specific structure in care of older people, the third aim was to compare RNs’ perceptions working solely in DC with those working in GC, where older persons have diverse diagnoses.

Instrument and method
Design
This study is part of a larger questionnaire survey in municipal care of older people reported elsewhere. The larger
The 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. 2007c). A non-experimental, descriptive design with a survey research approach was used (Polit & Beck 2004).

Participants

The target population was a convenience sample including 342 RNs working in municipal care of older people – 143 in DC and 199 in GC. In total 213 RNs participated, 45% \((n = 95)\) in DC and 55% \((n = 118)\) in GC. This comprised 62% of the target population. The RNs worked at 60 special types of housing with subunits, including those offering daytime activities. Of these units 33 were in DC, 20 were in GC and seven had both DC and GC. Subject characteristics are described in Table 1.

The questionnaire

The questions were developed from a questionnaire by Aronsson’s et al. (1992). The domains examined were background characteristics such as age, gender and number of active years as an RN. Year of nursing examination and form of employment were registered as well. Specific examined domains were RNs’ perceptions of violence and threats towards themselves, other staff and care receivers. An additional domain examines access to prevention measures and routines for handling violence and threats.

Data collection

The questionnaire was tested by five RNs working in DC and five in GC, regarding the logistics and relevance of the questions, usage and expected time to fill in the questionnaire (Altman 1997).

Data were collected during a one-year period (2003–2004). Local municipal managers with overarching responsibility for care of older people and the managers for each of the special residences approved the study. The residence managers provided the information on the total number of employed RNs and their names and whether they worked in DC or GC. The questionnaires were distributed in sealed envelopes to the RNs, either by their managers or by the principal investigator. Participation was voluntary.

The envelope to the RNs included an introductory letter explaining the purpose of the study, that data would be kept confidential and that the RNs’ identification would be protected. A postage-paid return envelope was also included. Three reminders were sent directly to the RNs when necessary.

The reasons of non-respondents \((n = 129)\) were recorded. A form with the following statement was distributed:

Table 1 Subject characteristics across groups, dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>DC ((n = 95))</th>
<th>GC ((n = 118))</th>
<th>Total ((n = 213))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, (n) (%)</td>
<td>90 (95)</td>
<td>109 (92)</td>
<td>199 (93)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Md (min–max)</td>
<td>52* (25–76)</td>
<td>49 (23–68)</td>
<td>51 (23–76)</td>
</tr>
<tr>
<td>Quartiles(^7)</td>
<td>46–60</td>
<td>40–56</td>
<td>43–57</td>
</tr>
<tr>
<td>Employment, (n) (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>81 (85)</td>
<td>103 (87)</td>
<td>184 (86)</td>
</tr>
<tr>
<td>Per hour</td>
<td>10 (11)</td>
<td>15 (13)</td>
<td>25 (12)</td>
</tr>
<tr>
<td>Deputyship or contract</td>
<td>4** (4)</td>
<td>0</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Years worked, Md (min–max)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At current work place</td>
<td>3*** (0–8–40)</td>
<td>1-58 (0–8–25)</td>
<td>2 (0–8–40)</td>
</tr>
<tr>
<td>RN</td>
<td>17 (1–51)</td>
<td>19 (0–75–43)</td>
<td>18 (0–75–51)</td>
</tr>
<tr>
<td>RN in elderly care</td>
<td>9**** (0–25–30)</td>
<td>6 (17–29)</td>
<td>8 (0–17–30)</td>
</tr>
</tbody>
</table>

\(^*p = 0.014; \)**\(^p = 0.038; \)**\(^*p = 0.003; \)**\(^*p = 0.020,\)
\(^7\)The 25th and 75th percentile; \(^5\)One internal loss; \(^5\)Two internal losses.
I have not answered the questionnaire because...'. Non-respondents’ motives were analysed by their manifest content and were discussed with an outsider researcher. The motives of RNs are reported elsewhere (Josefsson et al. 2007a).

Data analysis

Statistical tests used were the chi-square test to examine the distribution of one variable in two independent groups. The Mann–Whitney U-test (z) examined differences between two independent samples (Altman 1997). A level of \( p < 0.05 \) was considered statistically significant. The decimals under and above 0.5 were rounded off to the nearest whole number. The internal loss of data was minimal and data were neither replaced nor imputed. The statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) for Windows version 13.0 (SPSS Inc., Chicago, IL, USA).

Ethical permission

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

Findings

Self-reported exposure to violence and threat

Table 2 indicates RNs’ self-reported violence and threats, to which RNs were exposed to in their work. The most common source of violence and of direct and indirect threats towards RNs were from care receivers. Indirect forms of threat, such as harassment and insinuations,

### Table 2 Prevalence of self-reported violence and threats towards Registered Nurses (RNs) in dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC (n = 95)</th>
<th>GC (n = 118)</th>
<th>Mann–Whitney U (z)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt; 3 times n (%)</td>
<td>1–3 times n (%)</td>
<td>&gt; 3 times n (%)</td>
</tr>
<tr>
<td>RNs exposed to indirect threats of violent acts, such as harassments and insinuations by</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care receivers</td>
<td>23 (24)</td>
<td>20 (21)</td>
<td>30 (26)</td>
</tr>
<tr>
<td>Relatives of care receivers</td>
<td>7 (7)†</td>
<td>23 (24)</td>
<td>8 (7)</td>
</tr>
<tr>
<td>Visitors</td>
<td>1 (1)†</td>
<td>14 (15)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>3 (3)</td>
<td>10 (11)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>2 (2)</td>
<td>14 (15)</td>
<td>4 (3)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>3 (3)</td>
<td>11 (12)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>RNs exposed to direct threat of violent act by</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care receivers</td>
<td>19 (20)</td>
<td>14 (15)</td>
<td>19 (16)</td>
</tr>
<tr>
<td>Relatives of care receivers</td>
<td>0</td>
<td>14 (15)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Visitors</td>
<td>0</td>
<td>4 (4)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>0</td>
<td>3 (3)</td>
<td>0</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>0</td>
<td>5 (5)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>1 (1)</td>
<td>2 (2)</td>
<td>0</td>
</tr>
<tr>
<td>RNs exposed to act of violence by</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care receivers</td>
<td>19 (20)</td>
<td>20 (21)</td>
<td>20 (17)</td>
</tr>
<tr>
<td>Relatives of care receivers</td>
<td>0</td>
<td>2 (2)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Visitors</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>0</td>
<td>1 (1)</td>
<td>0</td>
</tr>
<tr>
<td>Other nursing staff</td>
<td>0</td>
<td>3 (3)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Managers/superiors</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*The differences between groups in each variable were not significant.
†One internal loss; †The answer ‘No time’ was included in the analyses.
towards RNs were reported in firsthand from care receivers and thereafter from relatives of the care receivers. The Mann–Whitney U-test revealed no significant differences between DC and GC groups.

Forty-four per cent of the RNs in DC and 41% in GC had been exposed to direct act of violence by the care receivers (Fig. 1). Forty-five per cent of the RNs in DC and 51% in GC had experienced indirect threats. Direct threats were also higher in GC (44%) than in DC (35%), although not statistically significant.

Two per cent of RNs in DC and 3% in GC reported feeling fear of being seriously hurt by violence or threats to such a degree that they were absent from work. During the past year, 16% of RNs in DC and 15% in GC had felt fear of being exposed to violence or threats, to such a degree that they had felt physically and psychologically worn down.

**Witnessed violence and threat**

RNs in both groups had witnessed violence and threats towards staff (Table 3) and care receivers (Table 4) in the last two years. Violence and threats towards staff was reported, to occur more often than towards care receivers. RNs reported that 18% of the exposed staff in DC and 9% in GC required a visit to health care as a consequence of violence, see Table 3. The chi-square test revealed no significant differences between groups (Tables 3 and 4).

**Prevention and routines**

RNs perceptions of preventative measures against violence and routines for when violence occurs are shown in Table 5. There were significant differences between groups regarding the RNs’ education in managing violence and threats at work.

### Table 3 Numbers of Registered Nurses (RNs) who witnessed violence and threats towards staff during the last 2 years in dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC (n = 90)</th>
<th>GC (n = 105)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious and terrifying direct threat of violent act without physical injuries</td>
<td>30 (34)§</td>
<td>25 (24)*</td>
<td>2.391*</td>
</tr>
<tr>
<td>Other threat of violence or threatening situation (e.g. threatening allusions or behaviour, harassment)</td>
<td>34 (39)§</td>
<td>40 (39)*</td>
<td>0.001*</td>
</tr>
<tr>
<td>Violence without physical injuries</td>
<td>41 (47)§</td>
<td>45 (44)*</td>
<td>0.225*</td>
</tr>
<tr>
<td>Violence with lighter physical injuries without requiring visit to health care</td>
<td>43 (49)§</td>
<td>39 (38)*</td>
<td>0.570*</td>
</tr>
<tr>
<td>Violence with physical injuries requiring visit to health care</td>
<td>16 (18)*</td>
<td>11 (11)*</td>
<td>2.201*</td>
</tr>
</tbody>
</table>

*The differences (df = 1) between groups in each variable were not significant.

Five and 13 RNs were excluded as they had worked < 2 years as an RN in elderly care; §three and *two internal losses.

### Table 4 Numbers of Registered Nurses (RNs) who witnessed violence and threats towards care receivers during the last 2 years in dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC (n = 90)</th>
<th>GC (n = 105)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious and terrifying direct threat of violent act without physical injuries</td>
<td>10 (11)§</td>
<td>8 (8)*</td>
<td>0.726*</td>
</tr>
<tr>
<td>Other threat of violence or threatening situation (e.g. threatening allusions or behaviour, harassment)</td>
<td>17 (20)§</td>
<td>18 (18)*</td>
<td>0.112*</td>
</tr>
<tr>
<td>Violence without physical injuries</td>
<td>17 (19)*</td>
<td>20 (19)*</td>
<td>0.000*</td>
</tr>
<tr>
<td>Violence with lighter physical injuries without requiring visit to health care</td>
<td>18 (20)*</td>
<td>14 (14)*</td>
<td>1.602*</td>
</tr>
<tr>
<td>Violence with physical injuries requiring visit to health care</td>
<td>7 (8)*</td>
<td>7 (7)*</td>
<td>0.094*</td>
</tr>
</tbody>
</table>

*The differences (df = 1) between groups in each variable were not significant.

Five and 13 RNs were excluded as they had worked < 2 years as an RN in elderly care; §three and *two internal losses.
and regarding the existence of a door with a lock to the working unit. Significant differences were also revealed in RNs’ opinions on whether or not there were routines in the event of witnessing violence towards care receivers or staff.

**Discussion**

**Discussion of the findings**

The main focus of this study was to describe RNs’ perceptions of violence and threats towards themselves and other staff in municipal care of older people. We also reported violence and threats towards care receivers. Another interest was to examine preventative measures and routines for handling violence and threats, as perceived by RNs. This was accomplished by comparing RNs’ opinions working in DC with those working in GC.

The main findings indicated that half of the RNs reported to have experienced an indirect threat of a violent act and just over 40% had experienced violent acts. Similarly, Arnetz et al. (1996) reported a prevalence of violence towards RNs 40% in geriatric settings and Åström (2002) indicated 42% in special types of housing for older persons. Jackson et al. (2002) also revealed that the literature clearly suggests that violence is a major problem for RNs. Furthermore, Hegney et al. (2003) indicated that 50% of RNs in the care sector of older people had been exposed to violence. However, it is important not to overlook the fact that violence might be equally high and even higher in other work units for RNs, for example accident and emergency departments and psychiatric wards (Arnetz et al. 1996, Jackson et al. 2002).

Our findings also indicated, according to the RNs perceptions, that all main actors, such as care receivers, RNs and other staff had experienced violence and threats in municipal care of older people. Our findings are in line with previous studies, for both care receivers (Saveman & Sandvide 2001, Sandvide et al. 2004) and staff (Menckel & Viitasara 2002, Åström et al. 2002. The violence towards staff in DC (49%) was greater than the prevalence of 40% found by Åström et al. (2002). On the other hand, this can be compared with findings of Menckel and Viitasara (2002) who reported a higher prevalence of violence (51%) towards municipal staff, including staff working in care of older people and special types of housing. Goergen (2001) reported similarly high figures where 59% of persons working in nursing homes stated that they had been exposed to violence by care receivers.

No statistically significant differences were found between RNs’ perceptions in DC and GC regarding the prevalence of violence among care receivers, RNs or other staff. This was despite the fact that the degenerative natures of dementia (American Psychiatric Association 1994), such as cognitive and communicative impairment, confusion and agitation predispose violence (Meddaugh 1993). This might be related to the fact that RNs in DC had significant higher access to education in managing violence and threats. In contrast to our findings, Middleton et al. (1999) and Åström et al. (2004) reported a greater degree of violence in DC compared with other special types of housing and traditional long-term care. On the other hand, staff in DC might expect and accept violence to be a natural consequence of working daily with people suffering from dementia due to the dementia symptoms (Middleton et al. 1999, Sandvide et al. 2004). Thus,
violence might be under-reported. However, our findings might emphasize that violence should be seen as a process (Viitasara & Menckel 2002) influenced not only by specific factors, but also by situational and structural factors in the context (Lipscomb & Love 1992, Smith-Pittman & McKoy 1999, Sandström 2000, Arnetz 2001, Goergen 2001, Viitasara & Menckel 2002).

RNs in both groups stated that a greater degree of violence occurred towards staff than towards care receivers. Violence within a caring organization is not synonymous with good quality care and good and proper behaviour of the staff (Saveman et al. 1999). The topic can be taboo and staff may have problems identifying violence (Saveman et al. 1999). Therefore, there is a risk that violence is under-reported, especially violence towards care receivers. Accordingly, Goergen (2001) indicated that 79% of persons working in nursing homes had abused or neglected care receivers and 66% had witnessed victimizations of care receivers by staff.

RNs reported that the most common source of violence towards themselves were care receivers, which is in line with Menckel and Viitasara (2002) and Hegney et al. (2003). Furthermore, our study showed that the care receivers’ relatives were the second source of threat, with harassments and insinuations towards RNs. This might be due to the fact that relatives can be stressed and worried (Smith-Pittman & McKoy 1999). In addition, relatives are also had an impact by reorganization in care of older people, staff reductions and high workload, which all are predisposing factors to violence (Smith-Pittman & McKoy 1999, Sandström 2000, Arnetz 2001, Goergen 2001, Menckel & Viitasara 2002).

This study investigated, during a one-year period, the effects of RNs’ fear of being exposed to violence or threats. Findings revealed that 16% of RNs in DC and 15% in GC reported to had felt at some point physically or psychologically worn down because of the fear of being exposed to violence. However, it had almost never led to absence from work. Needham et al. (2005) reviewed articles from 1983–2003 about non-somatic effects of patients’ aggression to nursing staff. Findings showed that predominant effects were anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame and shame. These effects existed despite differing countries, cultures and nursing settings.

A surprising finding was that only 19.5% of RNs had access to education in managing violence and threats. RNs in GC had a significantly lower access to education in managing violence and threats. Findings also showed that 33% of RNs in DC and 47% RNs in GC did not know if their employers offered education on how to manage violence and threats. These are distressing findings as staff must be properly prepared to identify and manage violent situations (Pillemer & Moore 1990, Lipscomb & Love 1992, Saveman et al. 1999, Arnetz & Arnetz 2000, Jackson et al. 2002, Manthorpe 2002). Moreover, the employer is obliged to ensure that the staff is educated and informed to safely manage their work (Swedish Work Environment Authority 1993). Staff should also have support and supervision if there is a recurrent risk of violence and threats. Our findings corroborated with Jackson et al. (2002) literature review, which suggested that many organizations did not provide adequate measures to support RNs who experienced violent acts. Furthermore, Karasek and Theorell (1990) highlighted that competence improves staff’s possibilities to control situations occurring at work. Our findings are also in line with Menckel and Viitasara (2002), indicating that employers offered information or education about violence to only 25% of staff in the year after being exposed to violence.

Findings showed that 18% of RNs in DC and 35% in GC stated that they could not lock the doors to their working unit. One can speculate whether locked doors are good or not for care receivers and staff because many ethical issues are raised especially in association with home-units. In addition, security benefits for care receivers in DC should not be overlooked.

This study showed that RNs in GC had far fewer routines than RNs in DC on how to handle violence. This is not acceptable as violence and threats in municipal care of older people should be reported, documented and resolved (Swedish Work Environment Authority 1993, Swedish Social Service Act 2001:453, National Board of Health and Welfare 2005). Moreover, the municipalities have a duty to inform staff about their obligations to report violence and threats in care of older people. This study revealed that 15% of the RNs in DC and 24–27% in GC did not have routines if they should ever witness violence. This demonstrates the importance of offering routines on how to report and register violent events to staff (Smith-Pittman & McKoy 1999, Mantorhpe 2002). The Violent Incident Form (VIF), together with a support forum for discussing incidents has led to an increase of reporting violent incidents (Arnetz & Arnetz 2000). Moreover, the introduction of the VIF have led to a greater awareness of the risk situations for violence, how potentially dangerous situations could be avoided and how to deal with aggressive patients.

The importance of offering education and routines to reduce violence towards staff cannot be underestimated. Arnetz and Arnetz (2001) showed that violence experienced by healthcare staff was associated with lower patient ratings of the quality of care. Furthermore, effects of violence could be impairment of physical and mental health.
(Hoel et al. 2002, Menckel & Viitasara 2002) and long-term trauma (Hoel et al. 2002). The effects also appeared to extend to bystanders, where a ‘climate of fear’ produces similar reactions (Hoel et al. 2002). Other effects might be staff’s antipathy against care receivers (Äström et al. 2004) and less enjoyment in working with care receivers (Arnetz & Arnetz 2001, Hoel et al. 2002). Thus, violence was an important factor in recruitment and retention of staff (Jackson et al. 2002). Violence might also affect job turnover with reduced productivity (Pillemer & Moore 1990, Hoel et al. 2002). Sick leave leads to economical losses both for individuals and the organization. The loss of public goodwill towards the organization might be another more intangible cost (Hoel et al. 2002). A recommendation for practice is to be aware that violence is a major problem in care of older people. Thus, it is an urgent matter for managers to introduce violence preventive programs in care of older people. Management intervention should focus on prevention measures such as staff education and routines how to do in the event of staff witnessing violence in the care of older people.

Methodological considerations

The questionnaire offered no operational definition of violence. The definition of violence might vary from individual to individual, but it was improbable to do so systematically between DC and GC groups. Hence, the findings of this study were not interpreted as a result of systematic error. It should be noted that an under-reporting of violence is a major obstacle when measuring prevalence of violence towards care receivers and healthcare staff (Lipscomb & Love 1992, Wierucka & Goodridge 1996, Menckel 2000, Arnetz 2001). The absence of a consistent and operational definition of abuse of older people and violence impeded the comparability and reliability of results (Wierucka & Goodridge 1996, Arnetz 1998, Daly & Jogerst 2001, Viitasara 2004, p. 5–7). This study is also limited by the one-sided perspective resulting from the lack of perceptions from non-RN staff. Nevertheless, these findings have an important value and are relevant for clinical practice.

Conclusion

RNs in both DC and GC reported that they had been both subjected to violence themselves and had witnessed violence and threats towards other staff and care receivers. There were no statistical differences between the groups. The most common source of violence and threats towards RNs were care receivers. Some RNs had felt physically or psychologically worn down because of the fear of being exposed to violence, but only 2–3% had been absent from work as a result. RNs in DC were offered education in managing violence and threats to a greater extent than RNs in GC. Moreover, DC more often had a door with a lock to the working units. RNs in DC reported more frequently than RNs in GC that there were routines in the event of witnessing violence. Regardless of whom the victim or offender is, violence is unacceptable. Violence needs to be taken seriously with a ‘zero tolerance’ attitude. Further investigations concerning the perceptions of violence held by municipal staff and especially by employers in care of older people, are necessary.

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Contributions

Study design: KJ, T-BRW, LS; data collection and analysis: KJ; manuscript preparation: KJ, T-BRW, LS.

References

Older people

RN’s perceptions of violence and threats


