UMIT TIROL
DIE TIROLER PRIVATUNIVERSITÄT

Field research Austria

UMIT

Final version: May 2021

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Intellectual Output - IO1-A3 Field Research AT	
Title:	**Field research Austria** **UMIT** **Final version: May 2021**
Description:	Implementation of national field research reports with two case studies per partner country and the later compilation into a summary report: Defined research questions for the development of all IOs are answered by all responsible partners (discussion and feedback moderated by Hafelekar and MRU).
Partner organisation:	UMIT (in coordination with Hafelekar)
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Due by:	May 2021
Language:	EN

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DIGI-AGEING - overcoming loneliness

1 Introduction

"Loneliness in old age" is a well-known social phenomenon that still receives too little attention. However, the current pandemic clearly shows us that we need to pay more attention to the issue. Older people are increasingly isolated in this situation: Those in care facilities are secluded for their own protection, others have little contact with friends and family or live entirely on their own. People caring for older people are often overwhelmed by the many safety precautions and challenges in their own daily lives. This is also true for family caregivers.

Since October 2020, the international Digi-Ageing consortium has been working on a comprehensive concept that addresses these challenges and develops appropriate measures to counteract the phenomenon of "loneliness in old age". One of the main goals is to increase competences in the use of digital tools in the elderly care sector and to create a strong network that develops joint solutions.

In the Digi-Ageing project, extensive desk research has already been carried out in each partner country to examine the phenomenon of "loneliness in old age" from different angles, to find a uniform perspective regarding the common goals of the project and to use terminology that is as consistent as possible. The results obtained in this way are now to be verified and supplemented by the present field research.

1.1 Research Design for Field Research

In each of the partner countries, at least 10 persons will be interviewed who, either professionally or privately, are entrusted with the care of older people or offer education and training in the care sector. We have agreed on the following target groups for the surveys:

Group 1. Geriatric Caregivers/Nursing Staff/ Social workers (min. of 6 pax)

Group 2. Relatives who care for older people (min. of 2 pax)

Group 3. Persons working in institutions that offer training in geriatric care (min. of 2 pax)

We decided to apply a very flexible research design, so that all partners have the possibility to use best fitting methodology within their own framework and with their own resources. So, partners can carry out interviews (in person, by telephone, online) or via focus groups.

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1.2 Description of the research process in Austria

The interview partners were contacted and recruited through existing contacts in the context of other projects as well as through the study programmes at the private university UMIT TIROL. A total of 12 certified nurses (DGKP) and two teachers (LP), who are active in health care and nursing training, were recruited for an interview. The inclusion criteria for the interview partners of group 1 were a completed health care and nursing training as well as existing practical experience as a professional caregiver in the care and support of older people. The inclusion criteria for the interview partners of group 3 were a teaching licence in health care and nursing training as well as existing practical experience with regard to a teaching activity in nursing training. The interviews were conducted virtually via Zoom or in physical presence. A further seven people completed the interview questions in written form in April and May 2021.

1.3 Sociodemographic data of interviewees

No.	Role (Group 1 - 3)	Gender (d/f/m)	Age Groups: 25 - 45 46 – 65 > 65	Format: Focus Group or 1-1 Interview	Interview: in person or online	Country
1.	DGKP	F	25-45	FG	i.p.	AUT
2.	DGKP	F	25-45	FG	i.p.	AUT
3.	DGKP	F	25-45	FG	i.p.	AUT
4.	DGKP	F	46-65	FG	i.p.	AUT
5.	DGKP	M	25-45	FG	i.p.	AUT
6.	LP	M	25-45	1-1	i.p.	AUT
7.	LP	F	25-45	1-1	online	AUT
8.	DGKP	M	25-45	FG	in writing	AUT
9.	DGKP	W	25-45	FG	in writing	AUT
10.	DGKP	W	25-45	FG	in writing	AUT
11.	DGKP	W	25-45	FG	in writing	AUT
12.	DGKP	M	25-45	FG	in writing	AUT
13.	DGKP	W	25-45	FG	in writing	AUT
14.	DGKP	W	25-45	FG	in writing	AUT

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2 Executive Summary

In our interviews, it emerged that caregivers define "loneliness in old age" as a subjective feeling that evokes negative emotions, whereby (desired) "being alone" is to be distinguished from this. The caregivers mention **"limited contacts"** as the main factor influencing loneliness in old age. In summary, almost all carers characterised loneliness with a negative feeling, which is related to limited contacts in the family environment and circle of acquaintances. **Loneliness and social isolation** are differentiated in that an individual can choose social isolation - an "extreme form" of being alone - for different reasons. "One can also feel lonely among many people." Nevertheless, loneliness can arise from social isolation, or loneliness in old age is also not infrequently accompanied by social isolation or increased loneliness. **The problem of loneliness among older or elderly people** is generally described as very relevant, especially in the current circumstances of the Corona pandemic. Especially in the area of old people's and nursing homes, this is a major problem for those affected. *"The residents are not afraid of the virus. What is worse for them is being separated from important* caregivers,*"* said the nursing director of a residential home for the elderly. An administrative director of a nursing home in Tyrol said, ... *"during the pandemic period I felt like a prison warden"*. When asked **which digital tools** are used in the respondents' facilities, only the digital care documentation system is mentioned. Digital tools for dealing with the problem of "loneliness in old age" are not known.

The **interviewed group of teachers** understand loneliness in old age as a multidimensional event. Loneliness has both **social** reasons and effects, **physical** reasons or **psychological** causes. Social isolation is not infrequently accompanied by loneliness, but it does not necessarily have to be related, as it can be self-selected. Loneliness is seen as a "phenomenon" with many influencing factors and effects. The **topic is not explicitly addressed in teaching**, but loneliness is "always connoted" as an aspect of activities of daily living (ATLs) in the sense of a "holistic view of care".
Digital tools are used by older people *"less than one would assume".* However, it is observed that mobile phones are increasingly used by teaching relatives. With regard to preventive measures, apps such as Facetime and Skype are mentioned. As a result, **access to digital tools** should be **low-threshold and easy.** In general, voice commands should be used rather than text.

Our **next question was about experiences with networks and external support** offered on the topic of loneliness in old age: Measures to cope with loneliness on the part of caregivers are mainly offering conversations and social activities, such as group activities, parties and celebrations or outings. Support from external persons or partnerships are not mentioned. Only WhatsApp is used for networking and communication within the care team.

The interviewed **caregivers are basically open to participating in a (virtual) regional network for the exchange on the topic of loneliness in old age** and would consider such an initiative useful, especially if criteria such as multi-professionalism or interdisciplinarity (nursing, psychology, medicine, etc.) as well as the inclusion of those affected are in the foreground. The **teachers consider it important to** join **a (virtual) network** in their region.

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Loneliness is usually recognised by the nursing staff through the following criteria: Mood, gestures/mimic, behaviour, verbal expressions, withdrawal, sadness. Possible **triggers for loneliness in old age are** mentioned: Loss of a caregiver, moving into a nursing home, psychiatric illness, general introverted behaviour, pessimistic attitude, egoistic traits, low interest in other people, sudden need for care and illness, poverty, financial aspects or loss of close environment. It is problematic that it depends very much on the personal assessments of the caregivers, since loneliness is not recorded in a standardised way.

The teachers are of the opinion that trainees in care professions should know and recognise the phenomenon of loneliness. Empathy and interest in interacting with elderly people are important basic requirements. Digital tools for identifying loneliness are not covered in the training.

When asked how best to **prevent loneliness in old age,** we received the following answers: Holding personal conversations with those affected, whereby "active listening" is of central importance, as well as planning and implementing regular, different social activities, maintaining and cultivating social contacts. It is also important to **do things in pairs, to** experience things with people, to do things that the person cannot do alone. **Digital tools or methods** to minimise loneliness have not been used so far. However, such tools would be conceivable and desirable, provided that a "realistic offer to prevent and combat loneliness" is provided.

The interviewed **teachers are of the opinion that** older people can prevent and cope with loneliness by making arrangements within the family circle on how to maintain contact. At the same time, structures should be created to remain mobile. Preventive home visits are also seen as an opportunity to curb the problem. **Carers believe that** older people should remain active themselves: Join networks, be more interested in assisted living, day care facilities, shared flats, be open to innovative concepts like "students and older people helping/living together", technologies (get tablets and participate in digital events suitable for seniors), keep contacts and maintain hobbies.

The community can also make a valuable contribution by forming volunteer networks. The following existing programmes and initiatives are known to the teachers: Volunteer visits to residents in old people's homes, pastoral care, Catholic Women's Association, kindergarten visits to residents, integrated living, intergenerational evenings in the community centre, etc. The caregivers should create more offers in this regard.

The subject of **loneliness in old age is only a marginal topic in health and nursing education**. In the subject "Care of the elderly", the problem is dealt with to a greater or lesser extent depending on the teacher being taught. The carers would like to see targeted learning opportunities on recognising, preventing and coping with loneliness. **According to the teachers**, *"Loneliness is not a concomitant but a 'diagnosis' with potentially clinical consequences."* There is multi-professional responsibility, but there is a lack of networking and interdisciplinarity in this regard. An app would be an opportunity to connect the various actors.

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The Covid 19 pandemic had - and currently still has - far-reaching effects on the work of health caregivers and family members who take care of elderly. **From the caregivers' point of view, the** measures taken in the context of the pandemic had a largely negative impact on the physical, psychological, and social well-being of the elderly, but also of the caregivers. For the **teachers,** the pandemic brought about the rapid conversion of the entire teaching operation to distance learning, which of course also posed a particular challenge.

In conclusion, it should be noted that the **respondents are very interested in the Digi-Ageing project** and would like to see the development of practical and affordable tools and results. Through the surveys, we have contributed to raising awareness of the topic of "loneliness in old age" and hope to have gained future network partners who will support us in taking the project idea further so that we can work together on solutions.

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3 Main findings via the interviews

3.1 Important findings on the topic of loneliness in old age

The interviewed carers understand loneliness in old age as a subjective feeling. They differentiate between loneliness and "being alone". Loneliness can be desired by the individual and does not necessarily have to go hand in hand with a negative sensation or feeling.

Category 1: Restricted contacts

Carers mention "limited contacts" as the main factor influencing loneliness in old age. Often this main influencing factor correlates with relatives who have already passed away or who do not take care of them. They feel left alone by society and with their problems.

Particularly in the context of the Covid 19 pandemic, caregivers working in a nursing home were able to observe the significant impact of reduced contact on the increasing loneliness of the residents. But also beyond Corona, reduced social contacts, e.g. due to the death of a close relative such as a spouse, are a major cause of loneliness in old age.

In summary, almost all carers characterised loneliness with a negative feeling, which is related to limited contacts in the family environment and circle of acquaintances.

Category 2: Distinction between loneliness and social isolation

Loneliness and social isolation are also differentiated in that an individual can choose social isolation - an "extreme form" of being alone - for different reasons. "One can also feel lonely among many people." Nevertheless, loneliness can arise from social isolation, and loneliness in old age is not infrequently accompanied by social isolation or increased loneliness.

The following characteristics for differentiation or overlap were mentioned by the carers (see Tab. 1 and Tab. 2).

Tab. 1: Differentiation between loneliness and social isolation

LONELINESS	SOCIAL ISOLATION
Subjective individual feeling, rather associated with negative feelings (emptiness, boredom, lack of success, exclusion, resignation)	Objective state of being alone
Feelings of loneliness can be distressing and unpleasant, but are not necessarily associated negatively	Socially and spatially
Loneliness can also lead to positive results (promotion of creativity, personal responsibility, redefinition)	Turning away from friends and acquaintances, insufficient social contacts
Cause: may result from social isolation	
Relation to old people: they have less chance to participate in the social environment	

Tab. 2: Commonalities of loneliness and social isolation

People who are socially isolated (e.g., due to quarantine or immobility) do not necessarily have to feel lonely
Socially integrated people can feel lonely even if they receive love, affection and attention and maintain contacts with fellow human beings
Both "phenomena" can be perceived individually and can appear in every life situation
Causes for both phenomena can be: role changes, housing situation, loss of attachment figures, state of health, retirement, etc.

Category 3: Relevance of loneliness in older people

The problem of loneliness among older or elderly people is generally described as very relevant, especially under the current circumstances of the Corona pandemic. Especially in the setting of old people's and nursing homes, this is a major problem for those affected. "The residents are not afraid of the virus. What is worse for them is being separated from important caregivers," says the nursing service manager of a residential home for the elderly. Any social activities have also been greatly reduced since the pandemic began. "I've never had so much help from our psychologist as I'm getting now," reports another qualified caregiver. But even independent of the limited contact possibilities due to Corona, an increasing loneliness is often observed, especially when entering a home. It is striking that an increase in loneliness is also accompanied by an accelerated physical decline. One nurse, like many of her colleagues, mentioned that loneliness is a present topic in everyday nursing care with older people, since one is directly confronted with those affected at the "bedside" and should also offer help in the hospital, in the sense of an initial assessment. However, the significance of loneliness in old age in terms of its appearance, causes, risk factors, frequency and/or preventive measures only became clear to them in the discussion with colleagues from different care settings, who reported about their helplessness and their limited

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possibilities to reduce loneliness, especially in the pandemic period. An administrative director of a nursing home in Tyrol said, ... "during the pandemic period I felt like a prison warden".

Category 4: Use of digital tools (carers & older people in institutions, teachers in training institutions)

When asked which digital tools are used in the **facility**, only the digital care documentation system is mentioned, in which the entire care process is planned and documented per caregiver. Digital tools for coping with the problem of "loneliness in old age" are not used by the persons concerned.

The **teachers** understand loneliness in old age as a multidimensional event. Loneliness thus has **social** reasons and effects (e.g., death of the spouse, relocation to a retirement home or similar, lack of accessibility), **physical** reasons (e.g., lack of physical care and love due to physical limitations, restricted mobility or similar) or **psychological** causes (e.g. due to depression or medication side effects). Social isolation is not infrequently accompanied by loneliness, but it does not necessarily have to be related, as it can be self-selected. Loneliness is seen as a "phenomenon" with many influencing factors and effects.
The topic is not explicitly addressed in the teaching, but loneliness is "always connoted" as an aspect of the activities of daily living (ATLs) in the sense of a "holistic view of care". Loneliness can thus directly influence the ATLs. Since the pandemic, digital tools have been increasingly used by teachers in their courses (Moodle, Zoom, Teams, etc.).

Digital tools are used by **older people** "less than one would assume". In some cases, elderly residents in institutions do not even use the telephone connection. However, it is observed that the mobile phone is increasingly used through the training of relatives.

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Category 5: Preventive measures

Apps such as Facetime, Skype, etc. would be important here. However, a distinction must be made between, for example, 65-year-olds and over 85-year-olds. Today, digital competences may be present in 60–70-year-olds and decrease with increasing age. Access to digital tools should be low-threshold and easy. The teachers could imagine a recommendation by the family doctor as well as technical support for the installation on site. In general, voice commands should be used rather than text.

3.2 What we have learned about existing networks and external help

Measures to cope with loneliness on the part of the caregivers are mainly offering conversations and social activities, such as group activities, parties and celebrations or outings. Support from external persons or partnerships are not mentioned. Only WhatsApp is used for networking and communication within the care team.

Category 1: Participation in a (virtual) network

The **caregivers** are basically open to participating in a (virtual) regional network for the exchange on the topic of loneliness in old age and would consider such an initiative to be useful. The networking of institutions such as nursing homes is considered particularly useful. Important criteria would be multi-professionalism or interdisciplinarity (nursing, psychology, medicine, etc.) as well as the inclusion of those affected. In addition, the need was expressed not to establish a purely virtual network, but also to enable meetings of a physical nature. "Sharing ideas could broaden one's horizon. In this way, new ways of thinking can probably be created to be able to counteract the problem of loneliness in the institution," said a certified caregiver.

The **teachers** consider it important to join a (virtual) network in their region that deals with the topic of loneliness in old age. It would be recommendable to deal with the problem of loneliness in an interdisciplinary way due to its multidimensionality, so that different healthcare professionals integrate the topic more into their work in an advisory capacity, but also as multipliers of work results. In order to adapt such a network regionally, relevant region- and culture-specific framework conditions should be identified (e.g. migration, changes in family groups based on social changes, divorce rates, number of singles, childlessness, structural conditions, type of residence, infrastructure, public transport, etc.).

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3.3 Ways to identify loneliness

Category1: Recognising loneliness

Loneliness is usually recognised by the nursing staff through the following criteria:

- Mood: depression, hopelessness, denial, indifference
- Gestures: hand holding, eye contact, posture bent and turned inwards
- Facial expression: expression of sadness, unemotional
- Behaviour: introverted, little self-confidence
- Statements: e.g. "no one helps me", "unfortunately I am always alone", "I have no one", "I don't get anything from the outside world", "I have nowhere to go", "if only my husband/wife were still here, then everything would be better".
- High need for communication on the part of the client: If they are reluctant to let carers go, fixate on carers, maintain conversations and demand closeness; Or the opposite: resignation, refusing help despite visible need for support, attitude "otherwise I'll do everything on my own".
- Non-verbal behaviour, such as increasing withdrawal (type A)
- Increasing social contact (Type B)
- External assessment (subjective) of sadness

Category 2: Possible triggers for loneliness in old age

Possible triggers for loneliness in old age can be the loss of a caregiver, moving into a nursing home, psychiatric illnesses such as depression or side effects of certain medications. Also, an experienced carer mentioned that general introverted behaviour, pessimistic attitude (Is the glass half full or half empty?), selfish traits, low interest in other people, sudden need for care and illness, poverty, financial aspects (offers and digital devices cost money), loss of social networks due to illness, loss of close environment, are triggers or risk factors that can be the probability for loneliness.

Category 3: Standardised recording of loneliness

Loneliness is not recorded in a standardised way by the **carers.** However, it is mentioned that loneliness can be assessed through professional observation and assessment.

The **teachers are of the** opinion that trainees in care professions should know and recognise the phenomenon of loneliness. Empathy and interest in interacting with elderly people are important basic requirements. Digital tools for identifying loneliness are not covered in the training. Apart from the good psychometric properties of such a tool, a tool for the target group of those affected or their relatives should use simple language as well as speech recognition.

3.4 How best to prevent loneliness in old age

Category 1: Personal strategies or interventions

The main strategies to prevent or cope with loneliness include holding personal conversations with those affected, where "active listening" is of central importance, as well as planning and implementing regular, different social activities, such as group exercise (with music), excursions, play afternoons, singing rounds or "music café", creative design (painting, etc.), mobile shopping, and others. Older people are also advised to maintain and cultivate social contacts with relatives, caregivers, family, and friends as much as possible.

It is also important to **do things together,** to experience something with people, to do things that the person cannot do alone. This intervention was explained by an interviewee using an example she experienced while performing daily care: "Client has been living in the living room since a fracture, can no longer go upstairs. Her bedroom has moved to the ground floor, and she was very unhappy with all the clothes hanging over the chairs at the dining table. Although she lives in a house with her daughter and grandson, she felt alone with this problem. She often mentioned that if her husband were still alive, there would have been a solution long ago. I presented her with options during a home visit and showed her various items via a smartphone that could make her living space more beautiful for her. We then went to the DIY store together, bought a clothes rail and a partition wall and made the living and dining area beautiful. The client was almost impossible to get home, she wanted to talk to other people outside and felt lively. She noticed and talked about many things in the outside world on the short drive to the DIY store. This indicated to me that she is very lonely, although she is not socially isolated. She has a large environment and is also mobile outside the house).

Category 2: Best/Good Practice Models

The carers are not aware of any projects or programmes that primarily aim to prevent or manage loneliness in old age. However, they would consider community actions, such as self-help groups or similar, to be useful for those affected. Digital tools or methods to minimise loneliness are not used yet. However, such tools would be conceivable and desirable, provided that a "realistic offer to prevent and combat loneliness" is provided.

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Category 3: Contribution of older people against loneliness

The **teachers** believe that older people can prevent and manage loneliness by making arrangements within the family circle on how to maintain contact. At the same time, structures should be created to remain mobile (e.g., construction measures). Preventive home visits are also seen as an opportunity to curb the problem.

Carers believe that older people should be able to join networks, take up offers, show more interest in assisted living, day care facilities, shared flats, use Meals on Wheels (once a day contact), be open to innovative concepts such as 'students and older people helping/living together', technology (get tablets and participate in digital events suitable for older people), keep in touch and maintain hobbies (reading, listening to music, going for walks etc.).

Category 3: Society's contribution against loneliness

The **community** can also make a valuable contribution by forming volunteer networks. The following existing programmes and initiatives are known to the teachers: Volunteer resident visits to old people's homes, pastoral care, Catholic Women's Association, kindergarten visits to residents, integrated living (residential house with old people and families - "House of Generations"), generation evenings in the community centre, television, radio and media.

More offers should be created on the part of the carers:

- Low-threshold services especially in rural areas
- Building networks in the neighbourhood for mutual support,
- Organisation of visiting services and volunteering (organised by the municipality)
- Placement of pastoral care, pastor in the home
- Participation of the older generation in their thinking
- Acceptance of their speed
- Taking senior citizens to events and involving them in them

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3.5 Addressing the issue in education and training

The subject of loneliness in old age is only a marginal topic in the training for the higher service for health care and nursing. In the subject "Care of the elderly", the problem is dealt with to a greater or lesser extent depending on the teacher being taught.

Carers would like to see targeted learning opportunities on recognising, preventing and managing loneliness.

According to the teachers, the topic of "loneliness in old age" is anchored in the curriculum and is mainly addressed in the subject "care of the elderly" as well as in the ATLs. However, the teachers see a clear need to deepen the topic in basic training and in further training. "Loneliness is not a side effect, but a 'diagnosis' with potentially clinical consequences." There is multi-professional responsibility, but there is a lack of networking and interdisciplinarity in this regard. An app would be an opportunity to connect the various actors.

3.6 Changes due to the pandemic: main need identified

The Covid 19 pandemic has had and continues to have far-reaching effects on the work of health care workers and nurses. Strict hygienic requirements, such as the permanent wearing of nasal masks, the adherence to safety concepts to contain the occurrence of infections, the regular testing of staff members are described as psychologically and physically stressful. Socially, the effects are also serious. The nursing staff had to compensate for the loss of important caregivers for nursing home residents. From the point of view of the caregivers, the measures taken during the pandemic had a largely negative effect on the physical, psychological and social well-being of the elderly, but also of the caregivers. Quite a few nursing home residents died in autumn 2020, and their relatives were not able to say goodbye to them. The entire situation since the beginning of the pandemic is generally assessed as "catastrophic" by the nursing staff.

For the teachers, the pandemic had less catastrophic effects, but here too there were some changes which were initially described as challenging. The rapid conversion of the entire teaching operation to distance learning and the technical requirements associated with distance learning and working from home presented the teachers with new challenges, which were, however, generally well managed.

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4 Case studies Austria

4.1 Case Study 1 "Anna" - Austria

Name (pseudonym): Anna
Gender: Female
Age group: <45
Role: Certified health and nursing care worker in a nursing home
Slogan: A professional relationship must be established for high-quality care that is oriented towards the individual.

About my current situation:

I am Anna and have been working in long-term care for over 10 years. During my training as a health and nursing assistant, I already realised that I enjoy working with older people. You get a lot of thanks and appreciation back from this generation, who have interesting things to tell from the past. I am grateful for the work with "our elderly". I couldn't work in the acute sector because I am convinced that high-quality nursing and care that is individually adapted is only possible if you build up a kind of "professional relationship" with the residents over a longer period of time. Biography work, which usually extends over many weeks, plays an important role here.

My main concerns are:

Since the Covid 19 pandemic, we have been having hard times. The measures to protect our residents and ourselves are basically understandable and sensible, but they also have serious side effects. Of course, we had quite a few deaths, but these are an integral part of our profession and especially in the setting of long-term care in the nursing home. The tragic thing about the deaths in autumn 2020 was that many relatives did not have the opportunity to say goodbye. This was initially a tragedy for the dying person and for the bereaved it continues to be an inconsolable situation.

But also apart from the deaths, Corona made our everyday work more difficult. We had to compensate for all the restrictions in terms of social contacts and activities. In addition, we had very strict hygiene requirements, which made the work difficult not only psychologically but also physically. The permanent wearing of protective clothing, masks and visors was stressful in every respect. Quite a few staff members thought of quitting their jobs. However, the moral obligation we have towards our old people does not allow this in the end - so we continue to work under difficult conditions and partly at the breaking point.

Apart from that, our work also thrives on non-verbal communication with our residents. Especially for people with dementia, this constant "mummery" was a big problem. The residents also deteriorated physically as a result of the psychological and social stress.

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These are my coping strategies:

Basically, there are no strategies that normalise this situation, at most you can make it a little more bearable. The use of our psychologist was an important resource during this time - both for the residents and for us caregivers. Since the work was very stressful and draining, I tried - even more than usual - to organise my free time in such a way that I could switch off well and also recover physically. To be honest, Netflix helped me the most. Lying on the couch, eating a good ice cream and watching a comedy (NOT news!) were the most relaxing things for me during this time. Also during work, we tried to sit together as a team at least once a day and do "mental hygiene". That helped in the short term. But for me, getting plenty of sleep and rest were the most important building blocks for good regeneration and energy on the job.

If I could make one wish - related to the outcomes of the project (including ICT/apps, etc.):

A tool to combat loneliness among our residents would have been important in 2020. But loneliness in old age is of course a constant companion, also independent of Corona. Ideally, a tool would be able to quickly and easily identify loneliness (either for self-assessment or for assessment by others) and offer ways to manage loneliness. On the one hand, the tool could offer a kind of distraction - but this would only (temporarily) suppress the feeling of loneliness - on the other hand, a tool could also get to the root of the problem and thus enable social contacts. Even if a video call with the grandchild is not the same as a physical meeting, many who currently do not have this possibility would be happy about it. But of course we also have residents for whom contact with caregivers is not possible because there are no caregivers. Here, of course, it would be great if you could also make new social contacts with this tool. There are all kinds of possibilities and apps for young people (Facebook, Instagram, WhatsApp, Tinder, etc.). So it would be about time to create something for the (in this respect neglected) population of old people as well.

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4.2 Case study 2 "Peter" - Austria

Name (pseudonym): Peter
Gender: Male
Age group: <45
Role: Certified health and nursing care worker in a nursing home
Slogan: Many old people are more afraid of being alone than of a virus.

About my current situation:

I have been working in an old people's home for several years, where I take on nursing tasks and care activities and am responsible for the nursing process in my department.

My main concerns are:

With regard to loneliness in old age, I must state that this is a fundamental problem, but one that has become much worse in the context of the Covid 19 pandemic. It is not uncommon for our residents to suffer from loneliness. This can be detected through various factors. Either it is directly verbalised or behavioural changes occur, such as an increased withdrawal into one's own four walls and a reduced mood.

These are my coping strategies:

In principle, we offer many different social activities for the residents, but many undertakings could not be implemented due to the pandemic and the accompanying restrictions or hygienic protection measures. The worst thing for the elderly was the contact restrictions. Maintaining social contacts with caregivers is an essential resource when entering the home and beyond. This was lost in the last few months, leading to an increase in loneliness, which also made them physically worse. For example, we have one resident, "Rudi". Rudi has been living with an ulcus cruris, or open leg, for several years. Due to his poor vascular status, the wound is no longer curable, but we have been optimising the wound care for months so that there has been no further deterioration. In autumn 2020, however, the wound deteriorated so much (despite the most careful care) that the leg had to be amputated. We assume that the psychological effects of the pandemic were partly responsible for this.

When the visiting restrictions were in place, we sometimes tried to facilitate video calls with relatives, which I think were helpful for the lonely persons. However, we had to resort to our private smartphones and tablets for this, which was of course suboptimal.

The most important solution to the problem was basically the vaccination. Now that all the old people have been vaccinated (at least those who have been vaccinated - but that was the majority of the residents), more visits can take place again and the first social activities, such as play

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afternoons or the like, are also taking place again. I think that the most difficult time for those affected is now over.

If I could make one wish - related to the outcomes of the project (including ICT/apps, etc.):

Since, of course, many elderly people are also afflicted by the feeling of loneliness outside of Corona, a tool for the social networking of elderly people would already make sense. I think that the standardised survey of loneliness would also be an important first step to create more awareness and visibility of this problem among the staff. Basically, we do a comprehensive assessment of the care and support needs of all persons in the home, i.e., a care history, but the dimension of loneliness is hardly mentioned here. A valid instrument for a simple and quick assessment of loneliness could probably be easily integrated into the standard assessment.

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