Care4Care
WE CARE FOR
THOSE WHO CARE

D4.2.Qualitative and Quantitative Dataset

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Partners:

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THE CARE WORKFORCE CHALLENGE IN EUROPE

Rethinking Long-Term Care in Europe: Demographic Pressures, Workforce Challenges, and the Shift to Home-Based Services

EU Member States are navigating an ageing demographic and an increase in chronic health conditions, which pose significant challenges to the sustainability of their economies and social welfare systems (Bloom et al., 2015; Eurostat-Statistics, 2023; Gianino et al., 2017; Parker & Thorslund, 2007), including Long-Term Care (LTC) services. The European Commission expects public spending on LTC to increase from an average of 1.7% of gross domestic product (GDP) in 2019 to 2.9% in 2070 (European Commission, 2021). For these reasons, decision-makers need to re-evaluate current health and social security policies to design new LTC programmes that are cost-effective, sustainable, and supportive of the health and quality of life of EU residents who will use these services. In response, a new strategy emerged: a shift from institutional LTC to providing these services in care receivers' own homes and communities (European Commission, 2022b; Gianino et al., 2017; Spasova et al., 2018). Home-based LTC is considered to be more cost-effective and is the preferred option for older adults as opposed to residential LTC due to its positive effects on the individual's autonomy, social connections and life satisfaction (Barken, 2019; Lee et al., 2020; Risco et al., 2018).

The reality of the workforce sustaining the LTC, however, is complex and often precarious. This sector comprises workers with specific characteristics: they are predominantly female (81%), that are older adults (the 38% is 50 or more years old) and there is a significant migrant labour force, particularly in the home care services (Eurofound, 2020; Spasova et al., 2018).

The care workforce faces a paradox. They perceive their work as more useful and meaningful than the average in other sectors (71% compared to 66% in the healthcare sector and a 50% of the total active workforce). However, satisfaction with their working conditions remains low, with only 22% reporting being very satisfied (Eurofound, 2020). This dissatisfaction is reflected in the challenges they experience at work:

> ***Precarious employment.*** Salaries are often below the national average, schedules are unpredictable, workload pressures are high, and the control over their work is limited (Eurofound, 2020; Genet et al., 2011; Keefe et al., 2011; Spasova et al., 2018). Undeclared work is particularly prevalent in the home care sector and often goes undetected by labour inspectors (Eurofound, 2020).

Physical and psychosocial risks. Care workers are required to make physical efforts in their job (Eurofound, 2020). These physical demands include transferring care receivers or carrying equipment, factors which have been found to contribute to musculoskeletal injury in home care workers (Grønoset Grasmo et al., 2021). Other risk factors identified in the workplace of paid caregivers were exposures to infectious agents or bloodborne pathogens, interpersonal conflicts, and workplace violence (Eurofound, 2020; Markkanen et al., 2007; Sherman et al., 2008). Due to these emotional demands, LTC workers are at a risk of developing mental health problems (Eurofound, 2020).

Lack of support. Having no support from supervisors, working short-staffed and unpaid overtime, and lacking training and recognition were common, especially in home care settings. These factors have been linked to poor occupational health, burnout, and intentions to leave the profession (Grønoset Grasmo et al., 2021; Spasova et al., 2018).

This context not only has an adverse effect on the workers but also impacts the quality of care services. Satisfactory working conditions for home-based LTC workers have been found to be associated with care receives' higher satisfaction with the provided care (Boström et al., 2022). However, there is still insufficient information on the psychosocial risks care workers experience in relation to their well-being. Recently, the EU has formally proposed new strategies for the sector. For example, in 2022 it launched the European Care Strategy for caregivers and care receivers, which focused on improvement of the accessibility of care services and the employment conditions, training and well-being of the care workforce (European Commission, 2022a). Statistics on the LTC sector are often limited, or are reported either compiled alongside other sectors or reported as a whole (Eurofound, 2020), without segregating the results by the different occupational groups that comprise this workforce (for example, whether they work in institutional or home-based settings). This makes carrying out a comparative analysis difficult. This current project aims to tackle precisely this gap in knowledge.

Care4Care: A Comprehensive Approach to Care Workers' Well-Being, Risks and Protective Factors

The 'Care4Care: We Care for Those Who Care' project is financed by the Horizon Europe programme. Its purpose is to contribute to improving the current situation in the care sector and to raise awareness of its importance across EU Member States. The project is organised into numerous work packages to achieve its objectives in a structured way. This report, in particular, forms part of the work package 4 (WP4) 'Care Workers' Well-Being and Rights' Awareness', which focuses on assessing the well-being of care workers.

The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease'. When applied to working life, this principle means looking beyond the prevention of harm. A healthy workplace is one in which employees and managers collaborate to eliminate hazards and foster an environment in which individuals can flourish. Contemporary occupational health guidance therefore asks us to consider well-being as a balance between freedom from distress and actively experiencing positive states (e.g. the Job Demands-Resources (JD-R) framework). With this in mind, a survey was conducted to capture the full range of influences on staff well-being. Four sets of variables were assessed (see Table 1):

- ***Negative well-being indicators*** show where discomfort or strain may already be present.
- ***Positive well-being indicators*** reveal the extent to which employees feel energised and fulfilled.
- ***Risk factors (demands)*** describe aspects of the job that can drain energy and hinder well-being when excessive.
    - **Job**: physical demands, quantitative demands, work pace demands, and tasks beyond job duties (Illegitimate tasks).
    - **Emotional**: emotional demands and demands for hiding emotions.
    - **Relational**: exposure to workplace violence, exposure to discrimination, intragroup conflict (relational and task-related), and workplace incivility.
- ***Protective factors (resources***) highlight the supports that help people cope with and mitigate the effects of highly demanding working environments.
    - **Job**: possibilities for development, variation of work, control over time, and predictability.
    - **Emotional**: meaning of work
    - **Relational**: recognition, emotional support, and instrumental support.

To gain a deeper understanding, focus groups were held in order to discuss these risk and protective factors, and to find out about the coping strategies that employees are already using. These qualitative insights complement the survey figures, helping us to grasp not only what is happening, but also why. By bringing together distress indications, positive experiences, workplace demands and available resources, the study fully aligns with WHO recommendations. The findings enable the organisation to identify areas where risks need to be reduced and strengths reinforced, paving the way for targeted actions to foster a healthy, supportive and sustainable working environment in the care sector.

Table 1. *Definitions of the variables assessed in the surveys*

Dimension	Variable	Definition
Negative well-being indicators	Burnout (Disengagement and Exhaustion)	Job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed.
	Physical exertion	Perceived level of physical effort required from care workers during their working hours.
	Turnover intentions	Intention or desire of care workers to leave or abandon their role within the care profession.
	Work-Private Life conflict	A form of inter-role conflict, characterised by a clash between the demands of one's professional role and those of their personal or familial responsibilities.
Positive well-being indicators	Work-Private Life enrichment	A process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role.
	Happiness	General levels of happiness with their lives
	Flourishing	The combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships.
Risk factors (demands)	Physical Demands	Frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role.
	Quantitative Demands	Psychological demands that arise from the amount of work that must be completed within a given timeframe.
	Work Pace Demands	Psychological demand associated with the intensity of the work.
	Tasks Beyond Job Duties	Frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan.
	Emotional Demands	Emotional labour that arises from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations.
	Demands for Hiding Emotions	The psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting.
	Exposure to Workplace Violence	The frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace.
	Exposure to Discrimination	Frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year.
	Intragroup Conflict	The frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures (task conflict) or due to personality clashes (relational conflict).

Continuation of Table 1

Dimension	Variable	Definition
Cont. Risk factors (demands)	Workplace Incivility	Low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect.
Protective factors (resources)	Possibilities for Development	The extent to which job performance provides opportunities to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience
	Variation of Work	Whether care work tasks are repetitive (the same) or, on the contrary, diverse or varied.
	Control Over Time	Control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work.
	Predictability	Having adequate, sufficient and timely information needed to perform the job correctly.
	Autonomy	The degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out.
	Meaning of Work	The relationship that work has to values other than those associated with having a job and earning an income.
	Recognition	The appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace
	Emotional Support	Moral support from individuals they interact with at their job.
	Instrumental Support	Help with job tasks from individuals they interact with at their job.

Notes: These variables were selected on the basis of the preliminary findings of a systematic literature review conducted. While the full paper is still under review, main findings was presented at the 22nd European Congress of Work and Organisational Psychology (Kuradchik-Pekarskaya et al., 2025[1]).

A mixed-method approach was adopted to evaluate all the aspects proposed in WP4. Between 2024 and 2025, quantitative information was collected via an on-line survey and qualitative information through focus groups conducted in six EU countries (Spain, Italy, France, Germany, Poland, and Sweden). The target groups were care workers employed in various settings, including urban and rural areas, public and private sectors, institutional/residential facilities and home-based care. Consideration was also given to the variety of occupational groups within this sector, including home health aides or personal care workers; care workers with intermediate qualifications (for example, nursing assistants); and highly specialised care workers, such as nurses or community therapists.

[1] Kuradchik-Pekarskaya, V., Martínez-Corts, I., Gago, C. & Medina, F. J. (2025, May 23). *An Explanatory Model of the Well-Being of Home Care Workers: Findings from a Mixed-Methods Review* [Paper presentation]. 22nd European Congress of Work and Organizational Psychology. Prague, Czech Republic.

The results are presented in the following order:

1. Part 1: Results from the ***quantitative dataset*** (online survey). First, the methodology is described. Second, the data on the demographic characteristics of the participants and the prevalence of the reported risk factors, protective factors, and well-being outcomes are presented, with comparisons made between countries and target groups (cross-sectional data). Finally, the antecedents or predictors of each well-being outcome are identified based on the longitudinal/weekly questionnaire responses.

2. Part 2: Results from the ***qualitative dataset***. As before, the methodology is outlined and the participants are described. The main themes emerging from the discussions with care workers are then presented. The aim of this discussion is to provide additional explanatory depth to the relationships observed earlier, thereby enabling a more precise and nuanced understanding of these connections.

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PART 1. SURVEYING CARE WORK IN EUROPE: From Fieldwork to Findings on Well-Being, Risks and Protective Factors

Chapter 1. Data Collection Process: From Sign-Up to Weekly Check-Ins

This cross-national study examined the perceptions of care workers in six European countries (Spain, France, Italy, Germany, Poland and Sweden) regarding their job-related risk and protective factors, and well-being. The project entailed two data collection components: a general cross-sectional survey and a weekly longitudinal questionnaire completed over a period of four weeks. The general survey collected data on demographics, employment conditions and perceptions of risk and protective factors over the past year. The weekly questionnaire, conducted over four consecutive weeks, assessed how job risks and protective factors influenced the well-being outcomes over time. This repeated-measures approach, often known as a diary study, sheds light on short-term variations in workers' experiences and minimises recall bias.

1.1. Recruiting Care Workers Across Europe

The target population included care workers who were currently employed in home-based or institutional settings. Participants were classified into three groups:

A. Home health aides: care workers who provide care at home, often without formal training.

B. Basic care workers: staff with short-term training working in care institutions, often occupying intermediate level occupations.

C. Professional care workers: individuals with vocational training or a healthcare degree.

Participants were recruited through associations and care institutions, as well as through snowball sampling. Incentives were offered to those who completed all the questionnaires. Participation was voluntary, and the recruitment process aimed to ensure a mix of rural and urban settings, as well as public and private providers.

1.2. From Consent to Completion: Study Steps

Data collection took place between 2024 and 2025 via the Qualtrics platform. After providing informed consent, participants completed the first three sections of the general survey during Week 1:

1. Section 1: Control variables.
2. Section 2: Risk and protective factors
3. Section 3: Well-being outcomes (positive and negative indicators).

From Weeks 2 to 5, participants received a brief weekly questionnaire (5-10 minutes), for which they were sent reminders each weekend. In Weeks 6-7, participants were contacted to receive their incentive payment once completion was confirmed. A unique code was used to match responses over time while maintaining anonymity.

1.3. The Measures Behind the Results

Both the general and weekly surveys included validated scales that had been adapted into the required languages via translation and back-translation. The scales in the weekly version were shortened and reworded reflect weekly experiences (e.g. 'This week...'). The instruments included:

- Job demands/resources: COPSOQ-ISTAS21-III[2]; Autonomy Scale[3]; Intragroup Conflict Scale[4]; Workplace Incivility Scale[5]; Experiences of Discrimination Scale[6]; Requests to perform tasks beyond job duties[7].
- Support: Social Interactions at Work Scale[8] (Peeters et al., 1995).
- Well-being: Oldenburg Burnout Inventory (OLBI)[9]; Borg Rating of Perceived Exertion Scale[10]; Intention to Quit Questionnaire[11]; Work-Family Enrichment Scale[12]; COPSOQ-ISTAS21-III Work-Life Conflict Scale; and Flourishing Scale[13].

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1.4. Ethical Approval and Participant Safeguards

All procedures were approved by the Ethics Committees of both the University of Seville and the Swedish Ethical Review Authority. Participants provided informed consent and confidentiality was ensured. Personal identifiers were collected separately and used solely for follow-up and payment purposes.

1.5. How the Data Was Analysed

The data were analysed using SPSS, Mplus and Jamovi. Descriptive statistics (frequencies, means and standard deviations) were reported, and inferential analyses (ANOVA, regression and repeated measures tests) were conducted at a significance level of $p < .05$. Only participants who completed the general survey in full and at least three weekly surveys were included in the longitudinal analysis. Of these, 696 participants completed the general survey, and 437 participants completed both the general survey and the weekly surveys idem

Table 2. *General survey and weekly questionnaire response rate per country*

Country	Surveys sent	Completed GS	Completion rate GS	Completed GS+WQ	Completion rate GS+WQ
Spain	316	157	49,7%	111	35,1%
Germany	214	139	65,0%	113	52,8%
France	200	102	51,0%	73	36,5%
Italy	253	106	41,9%	73	28,9%
Poland	142	78	54,9%	67	47,2%
Sweden	127	114	89,8%	97	76,4%
Total	**1252**	**696**	**55,5%**	**534**	**42,7%**

***Note*: GS - General Survey (sent in three parts), WQ - Weekly questionnaires (3 consecutive at the least). "Survey sent" indicates the number of individuals that agreed to participate and were sent the questionnaires.**

Table 3. *General survey number of observations*

Country	Target A	Target B	Target C	Total
Spain	303	105	63	471
Germany	45	114	258	417
France	186	63	57	306
Poland	42	66	126	234
Italy	72	144	102	318
Sweden	30	114	198	342
Total	**678**	**606**	**804**	**2088**

***Note*: The General Survey was divided into three parts to avoid respondent fatigue. The numbers result from multiplying the total number of participants by three, which gives the total number of completed questionnaires in the General Survey dataset.**

Table 4. *Weekly questionnaire number of observations*

Country	Target A	Target B	Target C	Total
Spain	322	83	32	437
Germany	36	136	269	441
France	195	55	40	290
Poland	43	71	152	266
Italy	56	119	114	289
Sweden	36	116	236	388
Total	**688**	**580**	**843**	**2111**

***Note*: Participants who completed at least three consecutive weekly questionnaires were included in the longitudinal/weekly dataset (most completed all four consecutive weeks). The table shows the number of weekly questionnaires completed by each group in each country.**

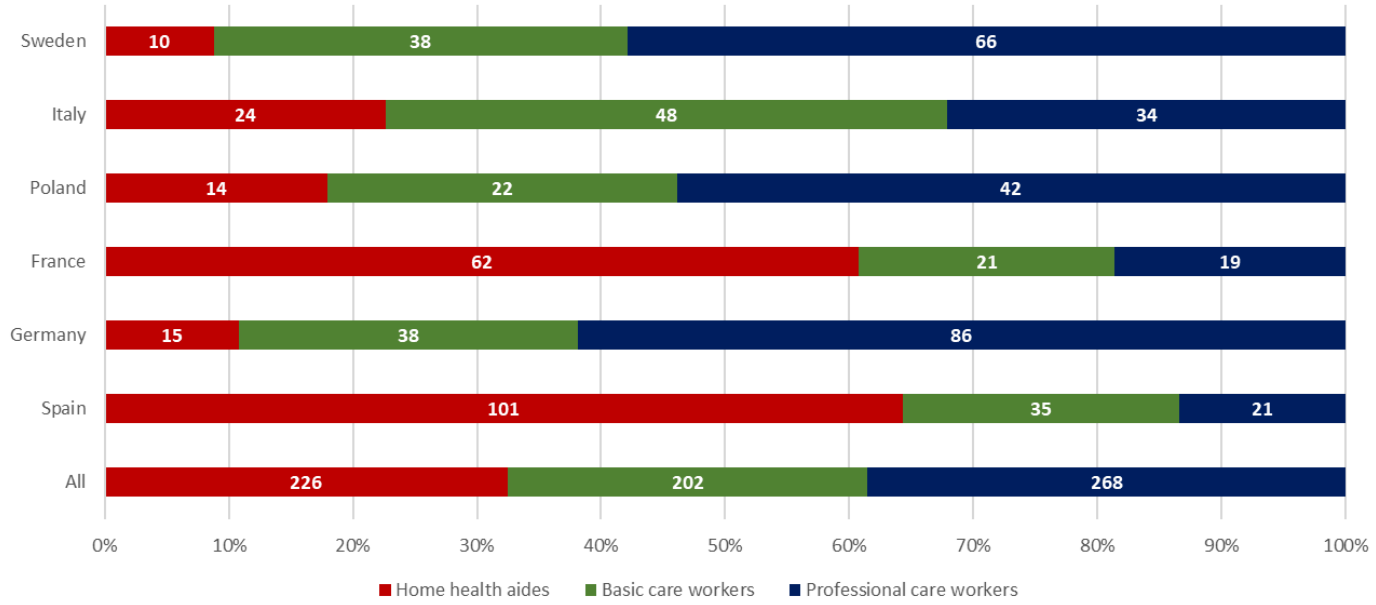
1.6. How Consistent the Measures Were

The internal consistency of the scales was assessed and found to be acceptable to good overall, with Cronbach's alpha coefficients exceeding 0.70.

Chapter 2. Who Cares? Profiling the People Behind Europe's Care Workforce

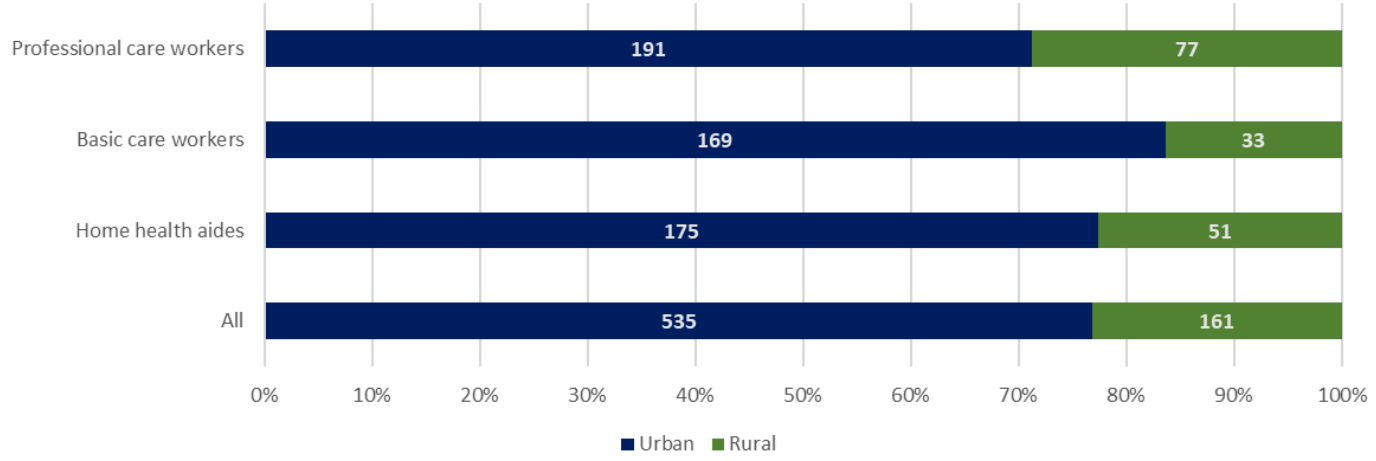
This study draws on data from 696 care workers across five European countries: Spain, Germany, France, Poland, Italy, and Sweden. Participants were engaged in various types of care work, including home-based care and institutional settings. The sample comprised 226 home health aides (Target A), 202 basic care workers (Target B), and 268 professional care workers (Target C). The participants mostly worked in urban settings.

Figure 1. *Targets*



Note: **Home health aides** (target A): domestic and outpatient nursing and care staff without specific training who care for or look after elderly, sick or other persons in need of care at home. **Basic care workers** (target B): nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course. **Professional care workers** (target C): specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree.

Figure 2. *Geographical setting*



2.1. Demographic Profile

2.1.1. Gender, Age, and Marital Status

Participants were predominantly female (82.4%), with only 17.1% identifying as men, and a small number identifying as non-binary or preferring not to disclose their gender. The average age across the participants was 44.2 years. When categorised into age groups, 38.6% of participants were aged 35-49, 36.4% were 50-64, and 23.4% were younger adults aged 18-34. Only 1.6% were 65 or older. The marital status of participants showed that over half (57.8%) were married or in domestic partnerships, while 27.3% had never married, and 14.9% were separated, divorced, or widowed.

Figure 3. *Gender*

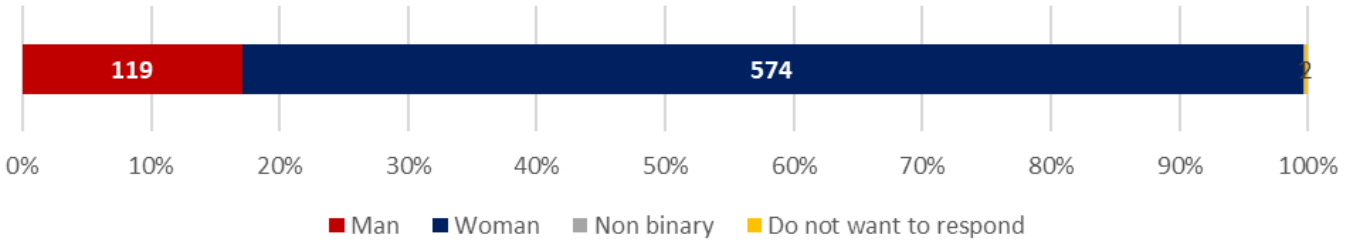


Figure 4. *Age and age groups*

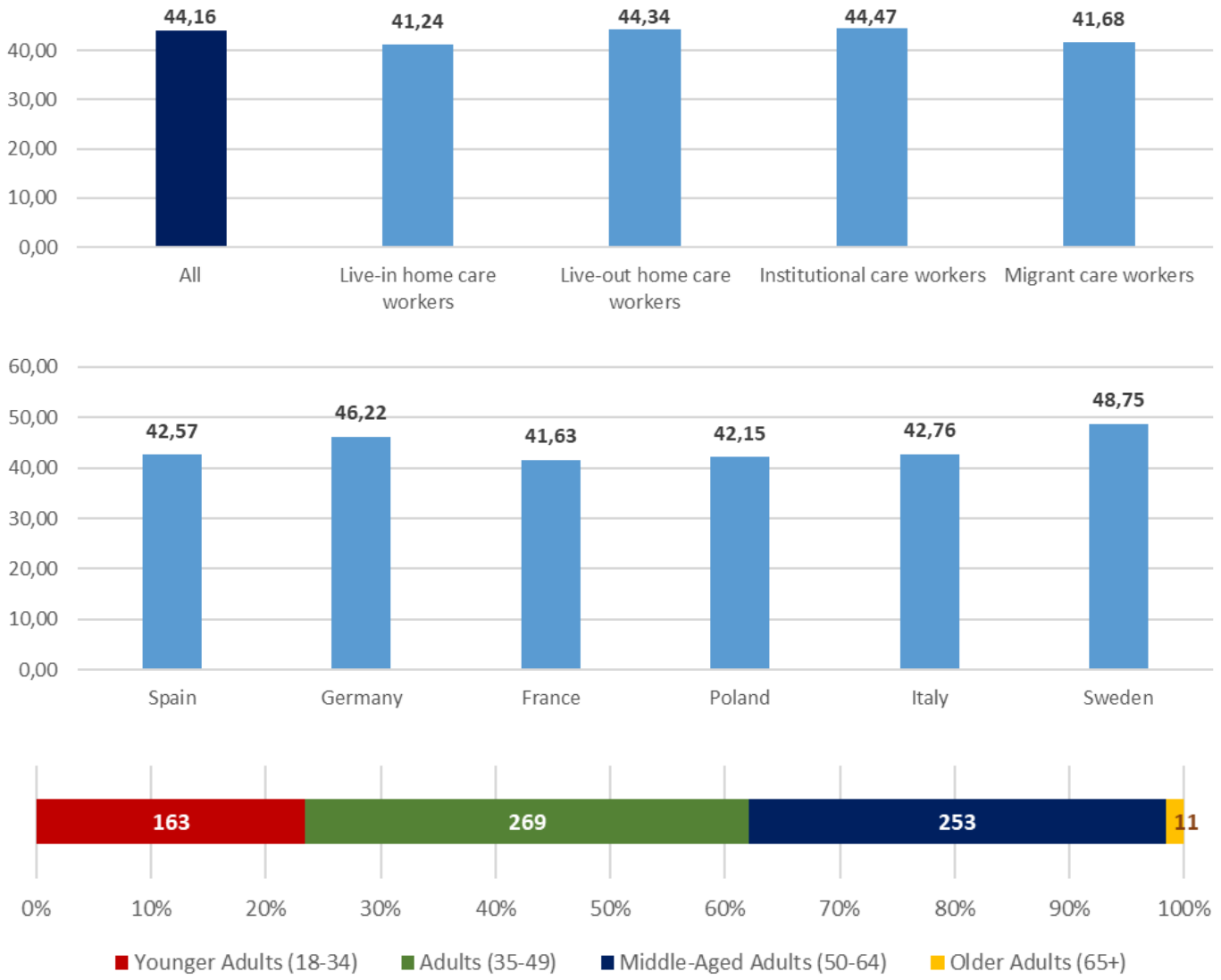
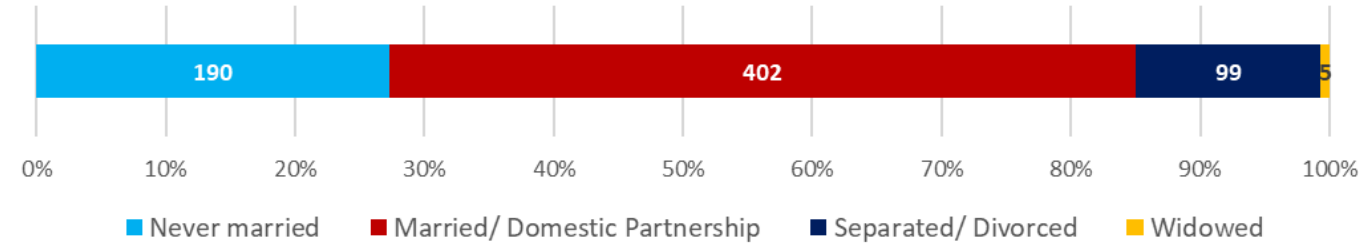


Figure 5. *Marital status*



2.2.2. Nationality and Country of Origin

Most participants held the nationality of one of the countries in which the survey was conducted, with the largest groups being German (19%), Sweden (15.9%), Spanish (15.1%), French (13.4%), Italian (12.5%), and Polish (11.6%). Nevertheless, some participants were foreign-born: 13.9% were born outside of their employment country, originating from diverse regions including Europe, Asia, Africa, and Latin America (see Figure 6).

Among migrant care workers (n = 97), 68% reported having a legal work permit, while 32% did not. Regarding language dominance in the workplace, most participants (62.9%) reported no difficulty speaking or understanding the language. However, 36.1% of migrant workers indicated they could understand and communicate well but occasionally faced language-related challenges, and 1% of them struggled significantly with understanding or expressing themselves. The average duration of residence in the host country among migrant workers was approximately 11.4 years. However, this differed considerably between countries. Migrant workers in Spain had the shortest average residence time (five years), followed by those in Germany (112.3 months, or nine and a half years) and Italy (ten years). By contrast, those in France reported a long average residence of 27 years, while migrants in Sweden had the highest average duration of residence at 394.2 months (approximately 32.8 years).

Table 5. *Nationality of all participants*

Country	Participants	Percentage
German	132	19
Sweden	111	15.9
Spanish	105	15.1
French	93	13.4
Italian	87	12.5
Polish	81	11.6
Peruvian	14	2
Colombian	12	1.7
Nicaraguan	9	1.3
Venezuelan	8	1.1
Honduran	7	1
Romanian	7	1
Portuguese	3	0.4

Continuation of Table 5

Country	Participants	Percentage
Ukrainian	2	0.3
Algerian	2	0.3
Cameroonian	2	0.3
Moldovan	2	0.3
Belarusian	1	0.1
Belgian	1	0.1
Bolivian	1	0.1
Salvadorian	1	0.1
Guatemalan	1	0.1
Iranian	1	0.1
Croatian	1	0.1
Philippine	1	0.1
Dominican	1	0.1
Argentine	1	0.1
Ecuadorian	1	0.1
Senegalese	1	0.1
Somali	1	0.1
Brazilian	1	0.1
Moroccan	1	0.1
Sri Lankan	1	0.1
Danish	1	0.1
Finnish	1	0.1
Norwegian	1	0.1
Total	696	100

Figure 6. *Country of origin of all participants*

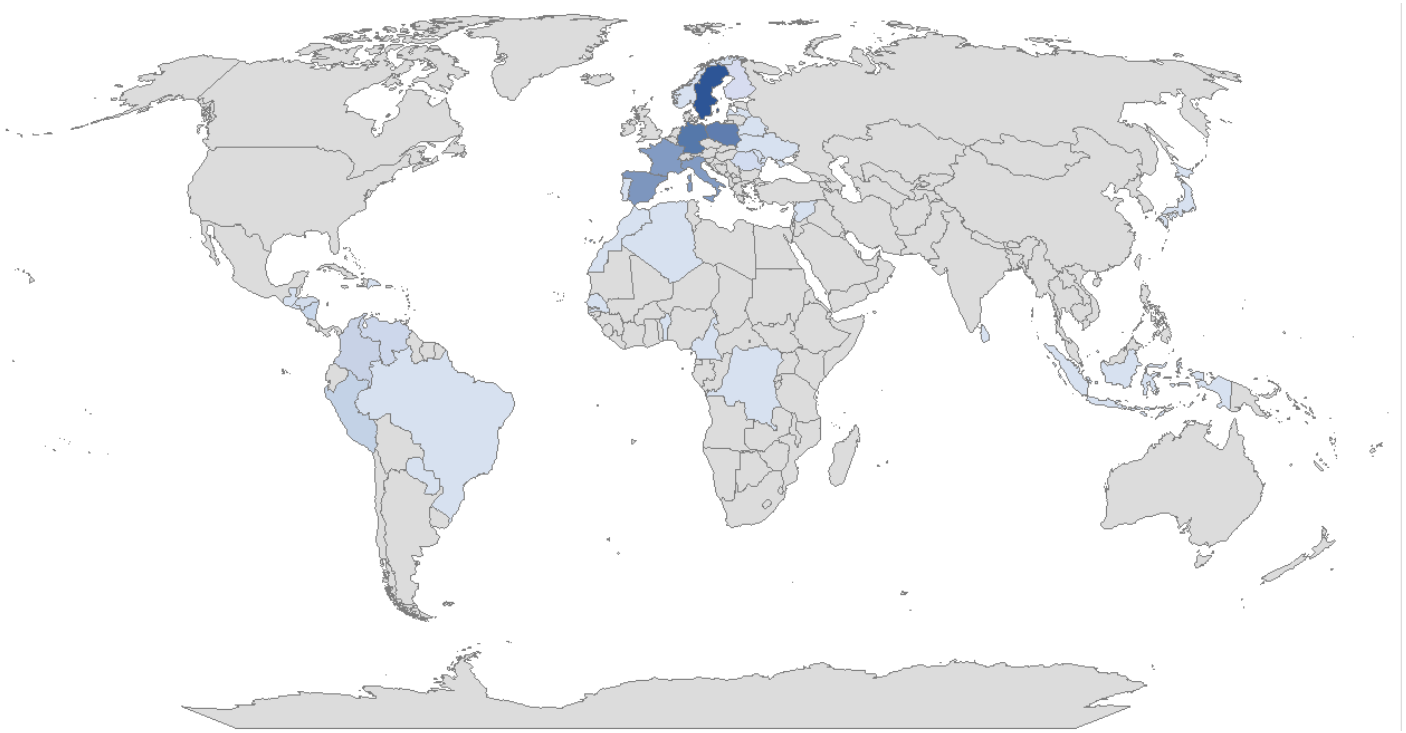


Figure 7. *Immigration status*

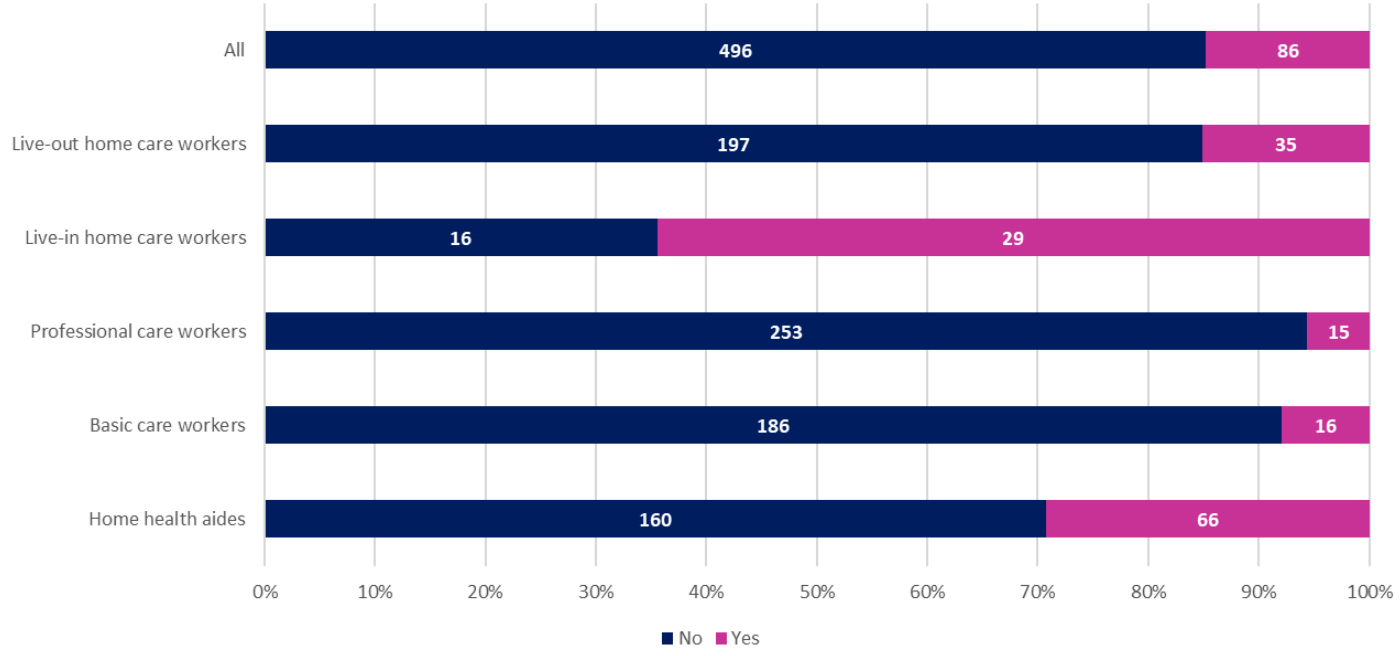


Figure 8. *Legal status*

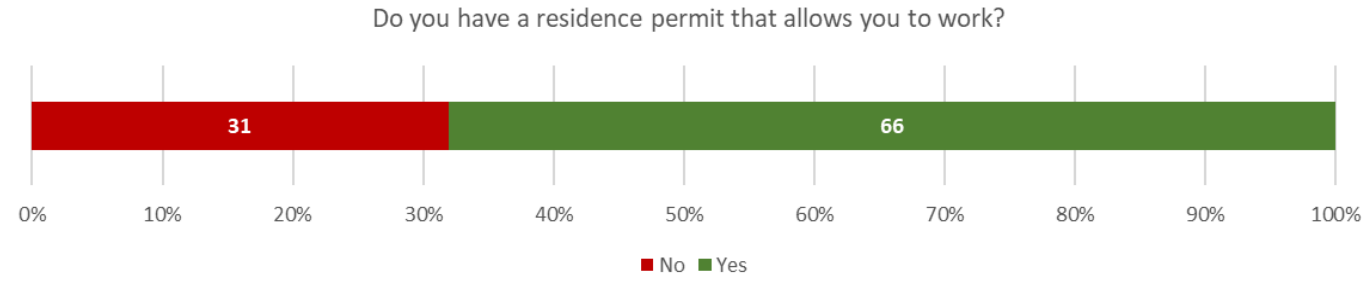


Figure 9. *Language dominance*

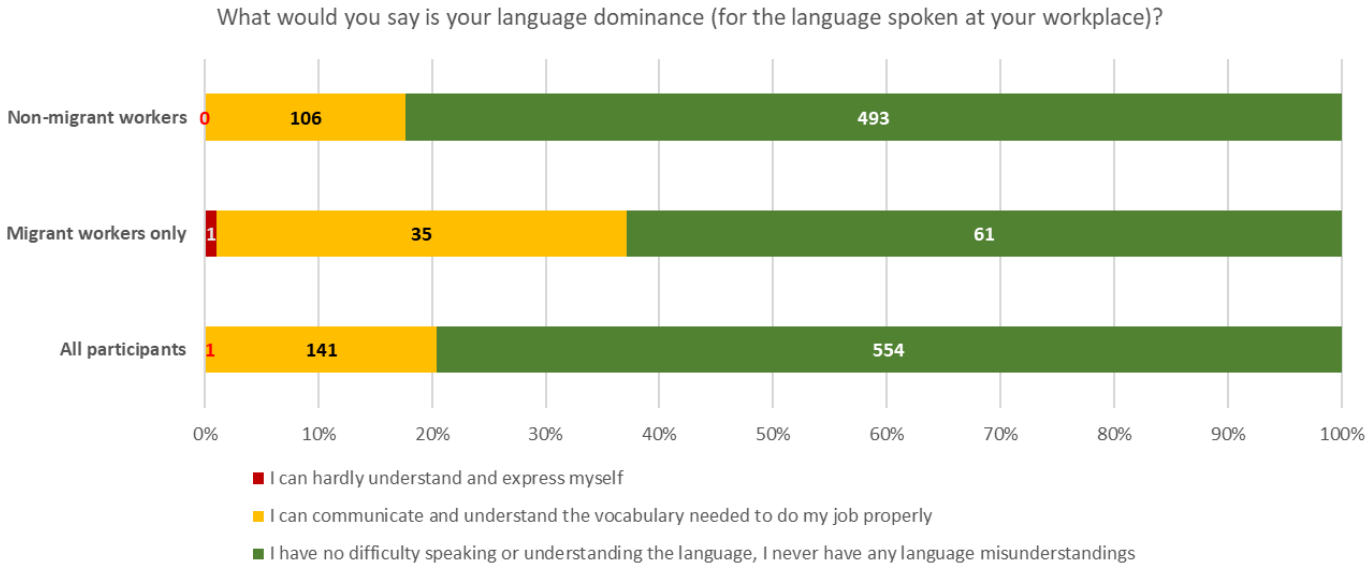
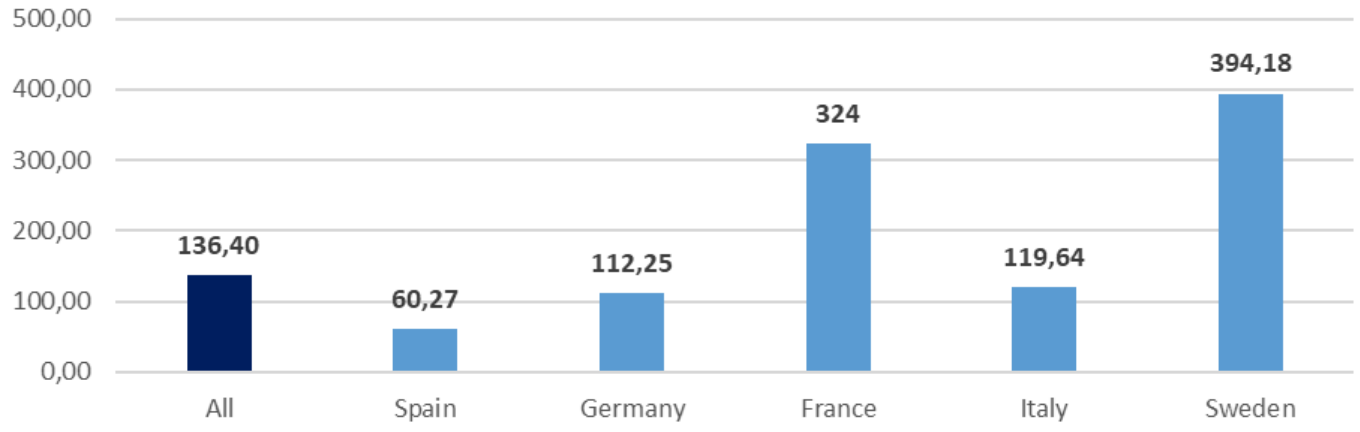


Figure 10. *Months of residence in the country (migrant workers)*



2.2. Education and Career Pathways

2.2.1. Education, Tenure in the Care Sector and Training

In terms of general education, over half (54.3%) had completed post-compulsory education of three or more years, 15.1% had up to two years of post-compulsory education, and 24.6% had completed secondary school. Only a small proportion had completed primary school (4.6%) or had no formal schooling (1.3%).

On average, participants had worked in the care sector for 167.5 months (approximately 14 years). Tenure varied notably by group. Those working in institutional care settings had the longest average tenure at 190.4 months (15.9 years), followed by live-out home care workers at 144.6 months (12.1 years). By contrast, live-in home care workers reported a substantially shorter average tenure of 98.5 months (8.2 years). Among migrant care workers, average tenure was also relatively low at 93.6 months (7.8 years).

Formal education in care services was reported by 80% of participants. When proportions were compared by target group, basic care workers were the most likely to report formal education in care services (89.1%), followed by professional care workers (82.8%). Home health aides were the least likely to report this training (68.6%).

In terms of specific training, 53.9% had received training in activities of daily living (ADLs), 36.2% in instrumental ADLs, 53.2% in healthcare, and 39.8% in the diagnosis or needs of their care receivers. Safety training was provided to the majority: 64.9% reported having received it from their current employer, while an additional 18.2% had received such training previously or independently. A minority of participants (16.8%) had never received safety training, with home health aides being the most likely to report this (25.2%).

Figure 11. *Educational status*

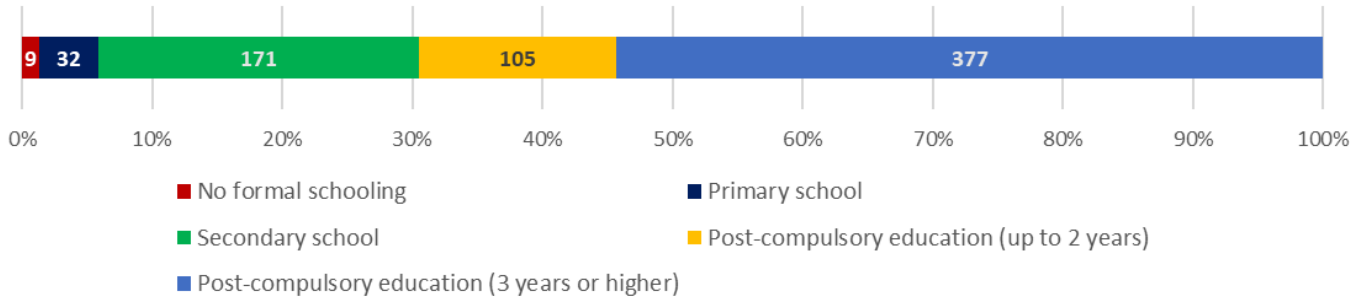


Figure 12. *Tenure in the care sector*

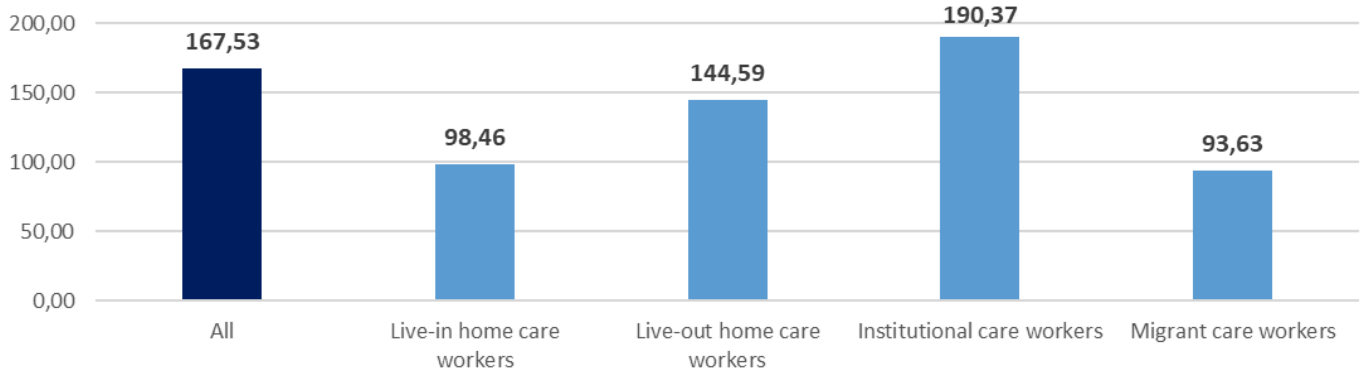


Figure 13. *Formal education in care services*

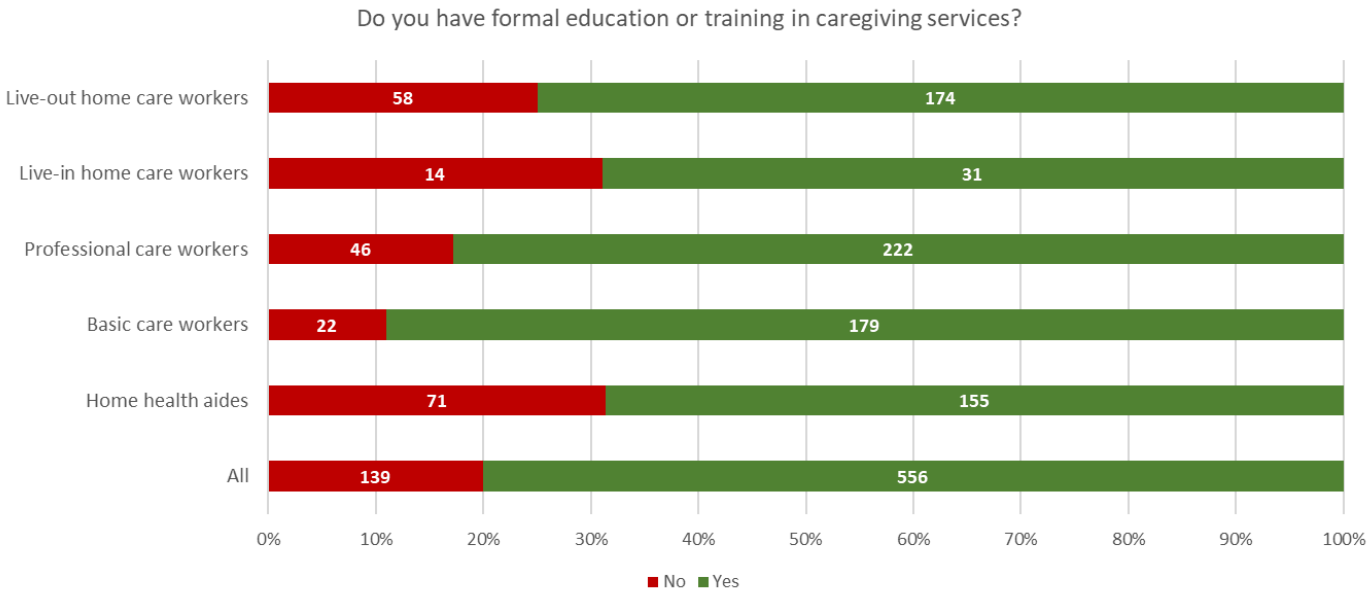
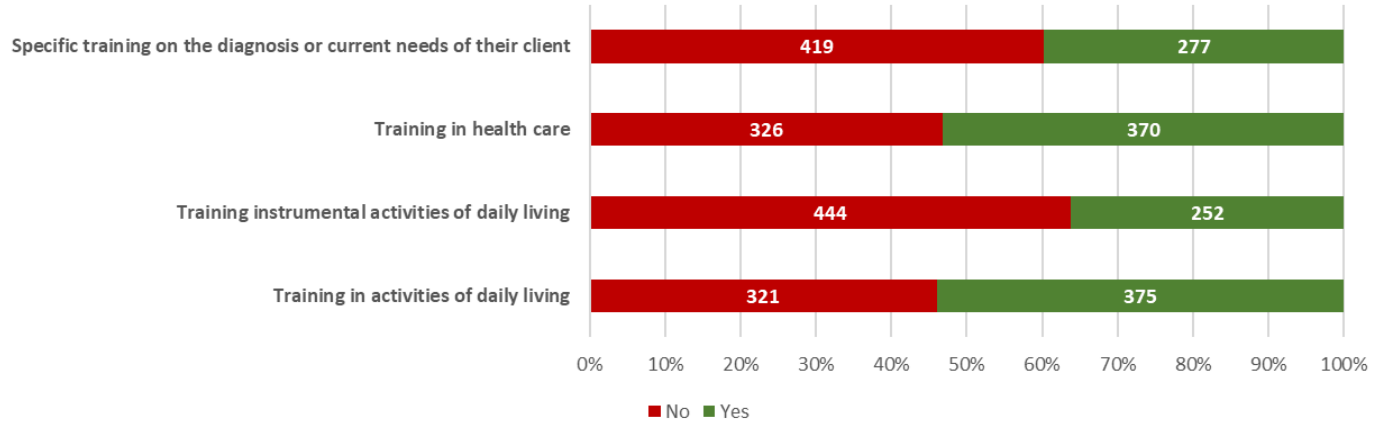


Figure 14. *Type of training received*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 15. *Safety training*

2.3. Employment Characteristics

2.3.1. Professional Roles and Care Settings

Home health aides worked exclusively in home care settings, while professional care workers were primarily based in institutional settings (79.5%). Basic care workers were predominantly institutional-based as well (89.6%), though a small number (10.4%) worked in home care. Among home care workers (n = 277), 16.2% lived with their care receivers (live-ins), while 83.8% were live-outs. Live-in care was more frequent in Spain (27.4%) and Italy (39.3%), and rare or absent in other countries.

Among live-in care workers, the average duration of weekly stay was 5.85 days. Most lived in adequate housing conditions, with 80% having a separate room and 80% a separate closet. However, 28.9% reported that it was too hot inside the house, and 11.1% said it was too cold.

Figure 16. *Place of work*

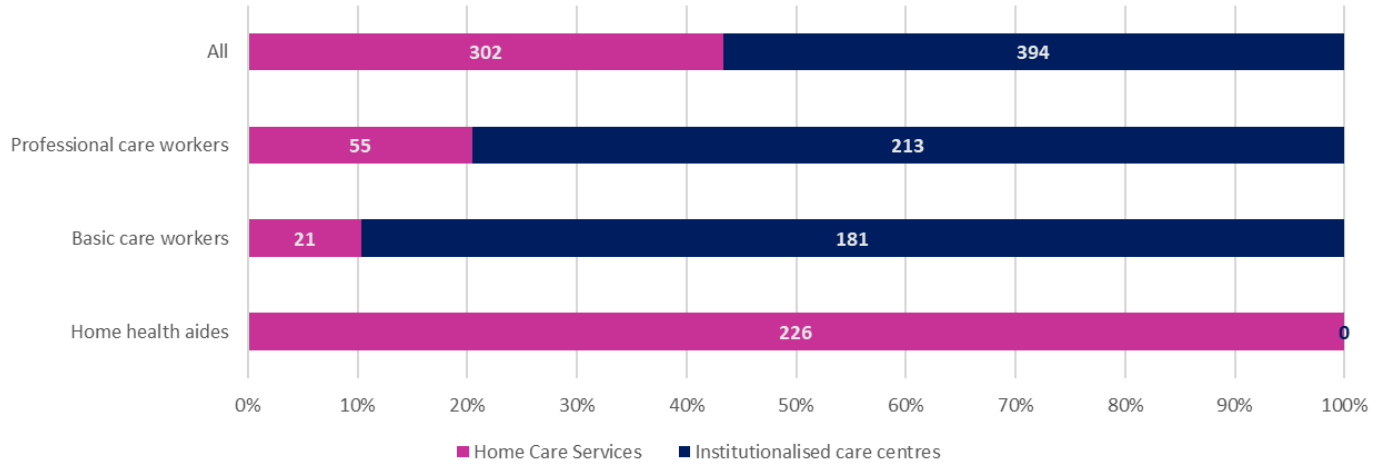


Figure 17. *Modality of home care*

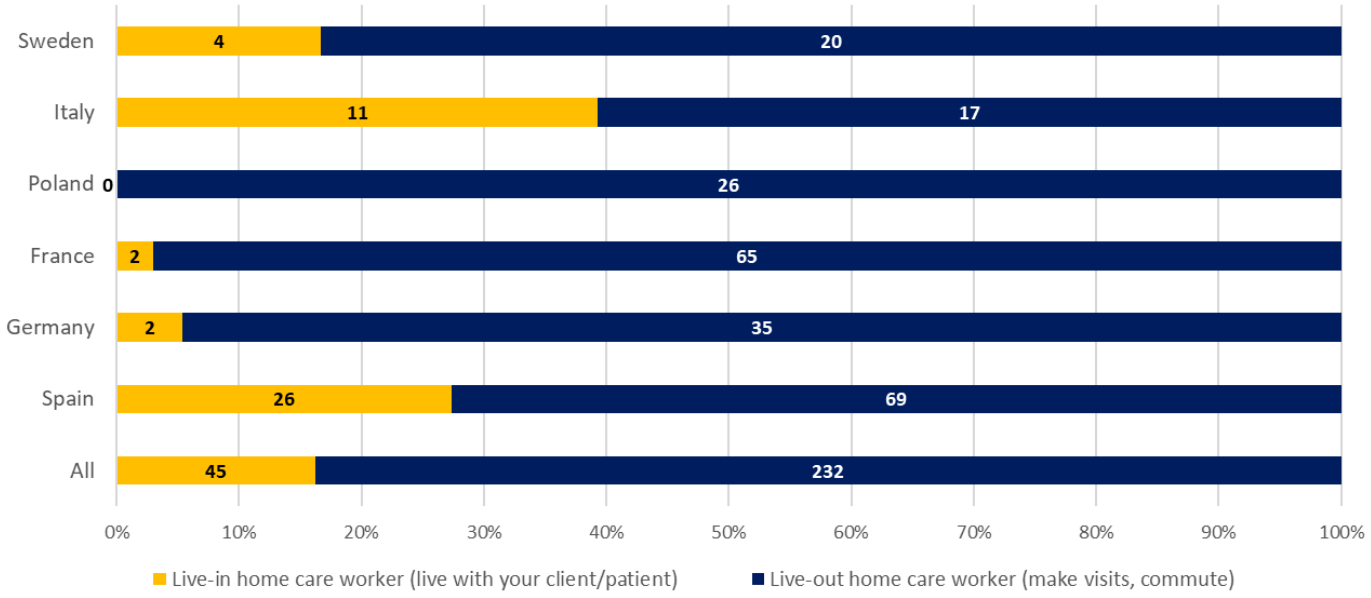


Figure 18. *Duration of stay of live-ins (days in one week)*

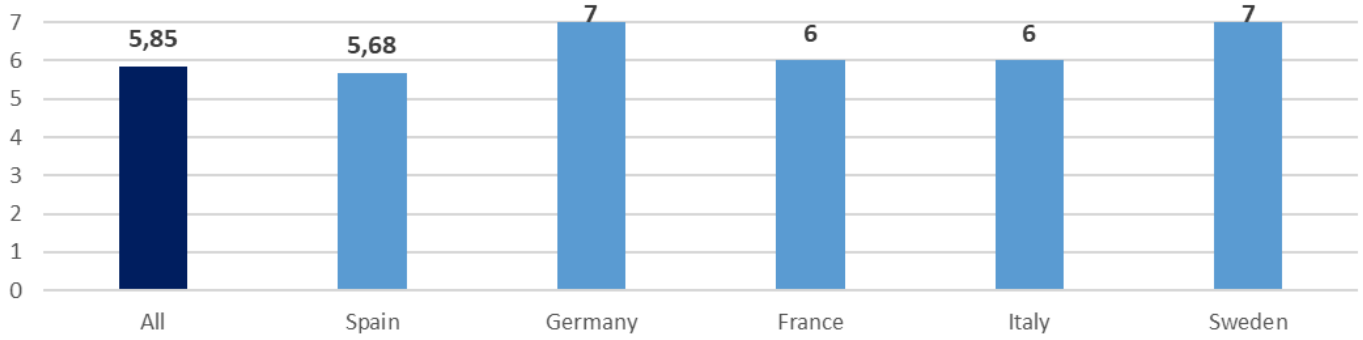
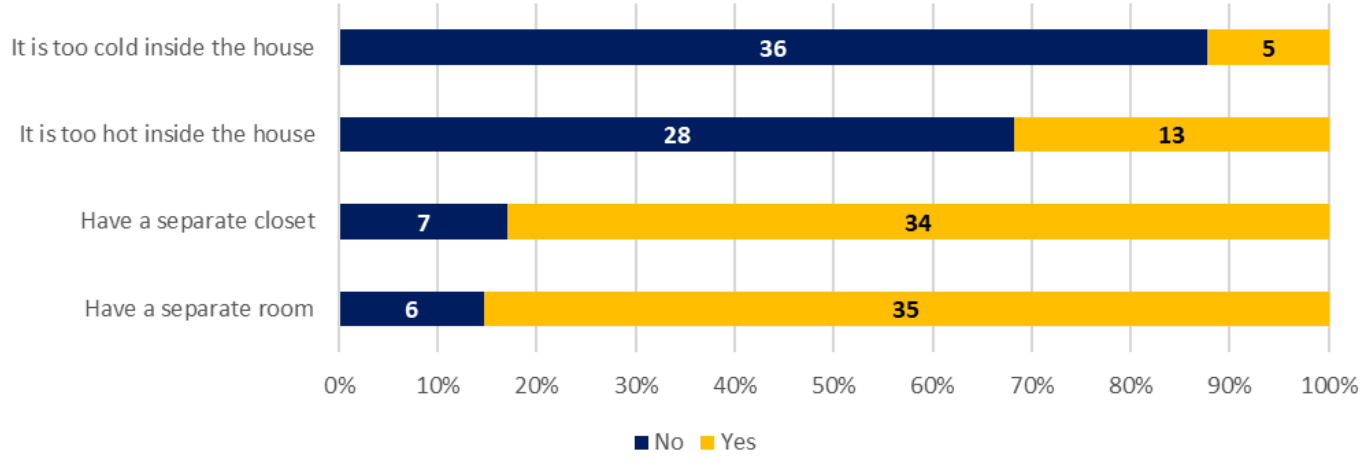


Figure 19. *Living conditions of live-in home care workers*



2.3.2. Contract Types and Employment Status

Most care workers were employed in the private sector (46.6%), followed by the public sector or non-profit organisations (42.2%). A smaller group (13.4%) were self-employed. Full-time contracts were the most common (60.8%), followed by part-time (28.4%) and hourly arrangements (10.8%). In terms of contract duration, 83.8% held indefinite contracts, 11.5% had temporary contracts, and 4.7% reported having no legal contract.

Shift work was reported by 28.9% of participants, while 47% worked fixed schedules and 24.1% had flexible hours. Shift work was most common among basic care workers (43.6%), while flexible hours were more common among home health aides (38.9%).

Figure 20. *Employment*

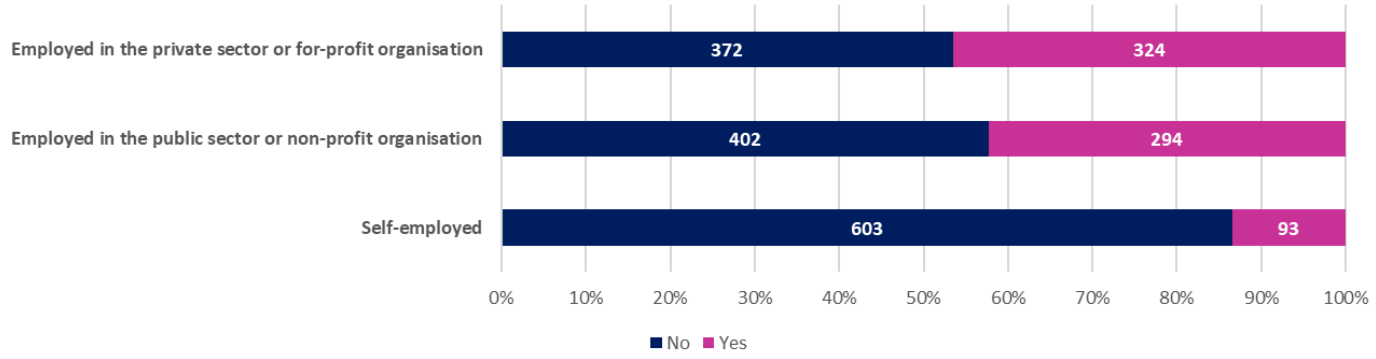


Figure 21. *Type of contract*

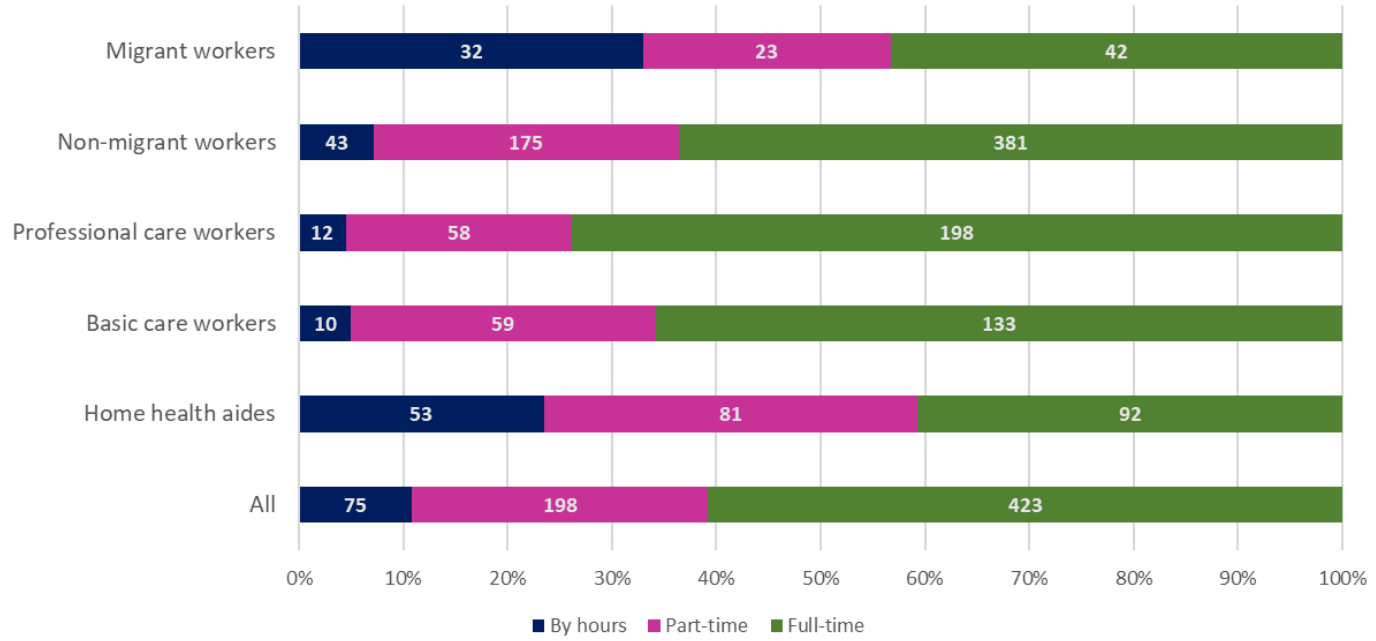


Figure 22. *Duration of contract*

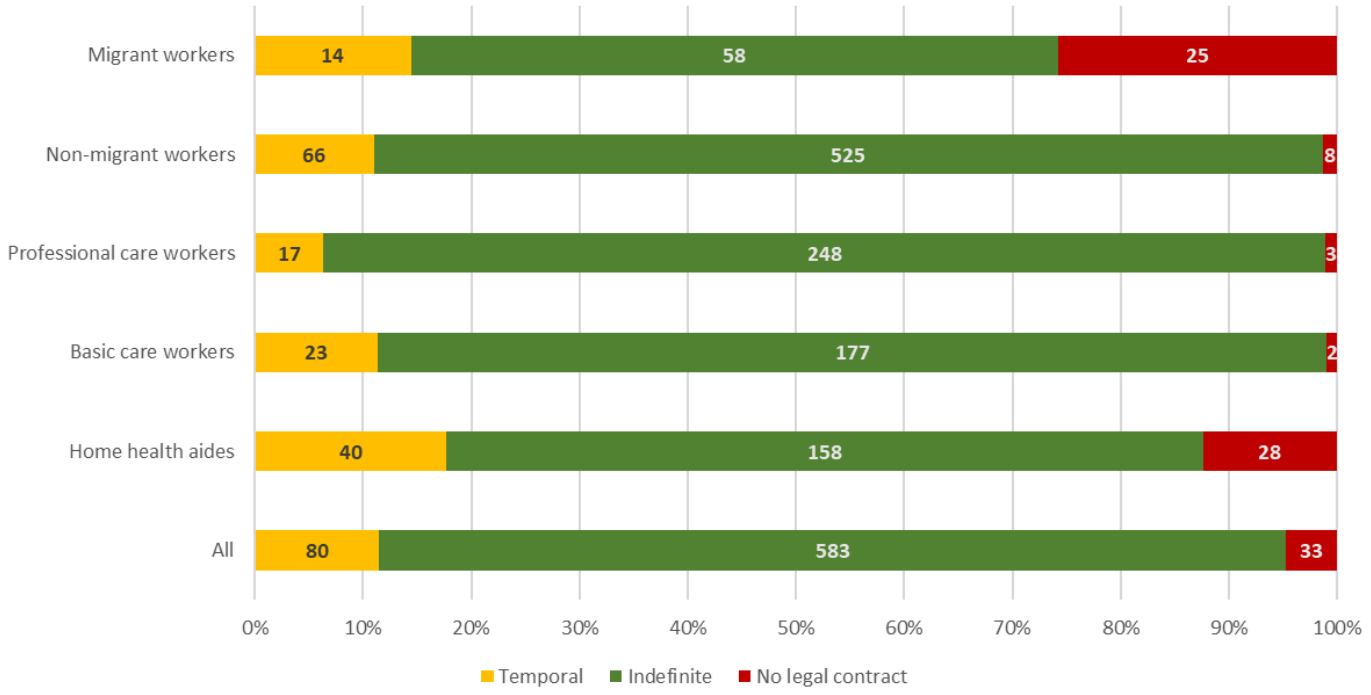
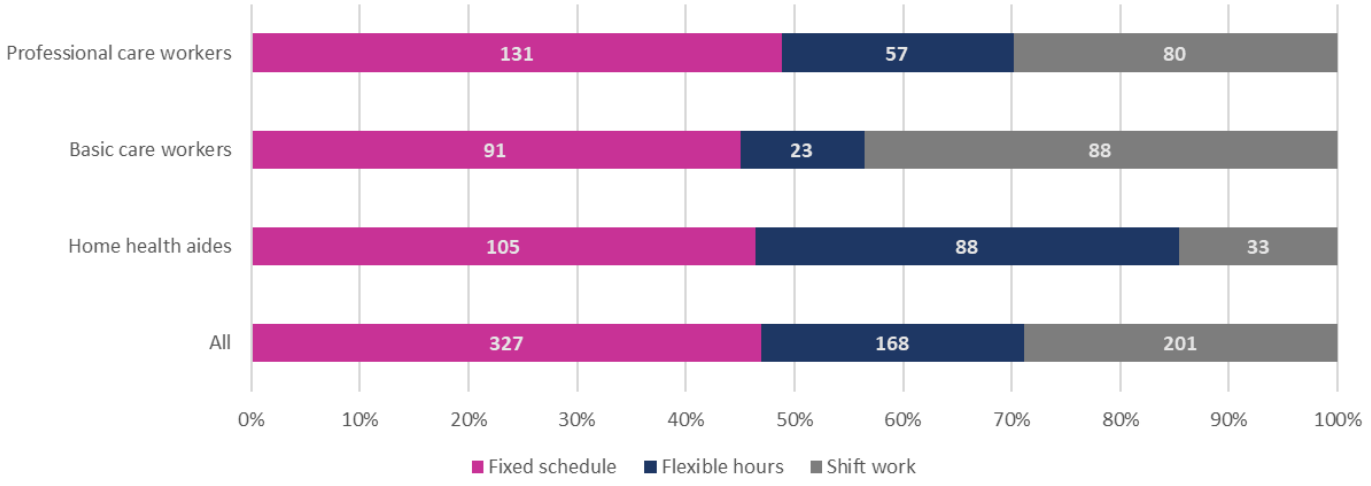


Figure 23. *Type of schedule*



2.3.3. Working Hours, Wages, and Number of Care Receivers

On average, participants worked 34.9 hours per week, with live-in home care workers reporting the longest schedules (49 hours/week) and live-out home care workers the shortest (29.8 hours/week). Monthly wages averaged €1,719.09 across the sample. Institutional care workers earned the most (€1,920.12), followed by live-out home care workers (€1,445.01) and live-in workers (€1,270). Migrant workers reported the lowest average wages (€1,321.15). Across countries, wages were highest in Sweden and Germany and lowest in Spain and Poland.

Home care workers attended to an average of 17.2 care receivers per week, but this varied sharply by modality: live-in workers reported an average of just 6.1 care receivers, while live-out workers cared for 19.5 care receivers.

Figure 24. *Hours worked in a week*

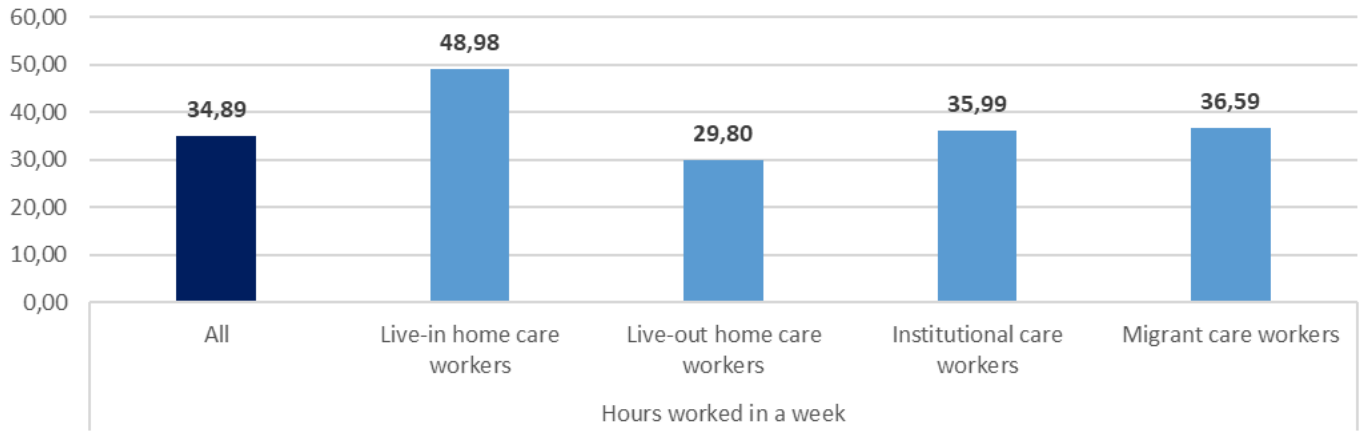


Figure 25. *Monthly wages (€)*

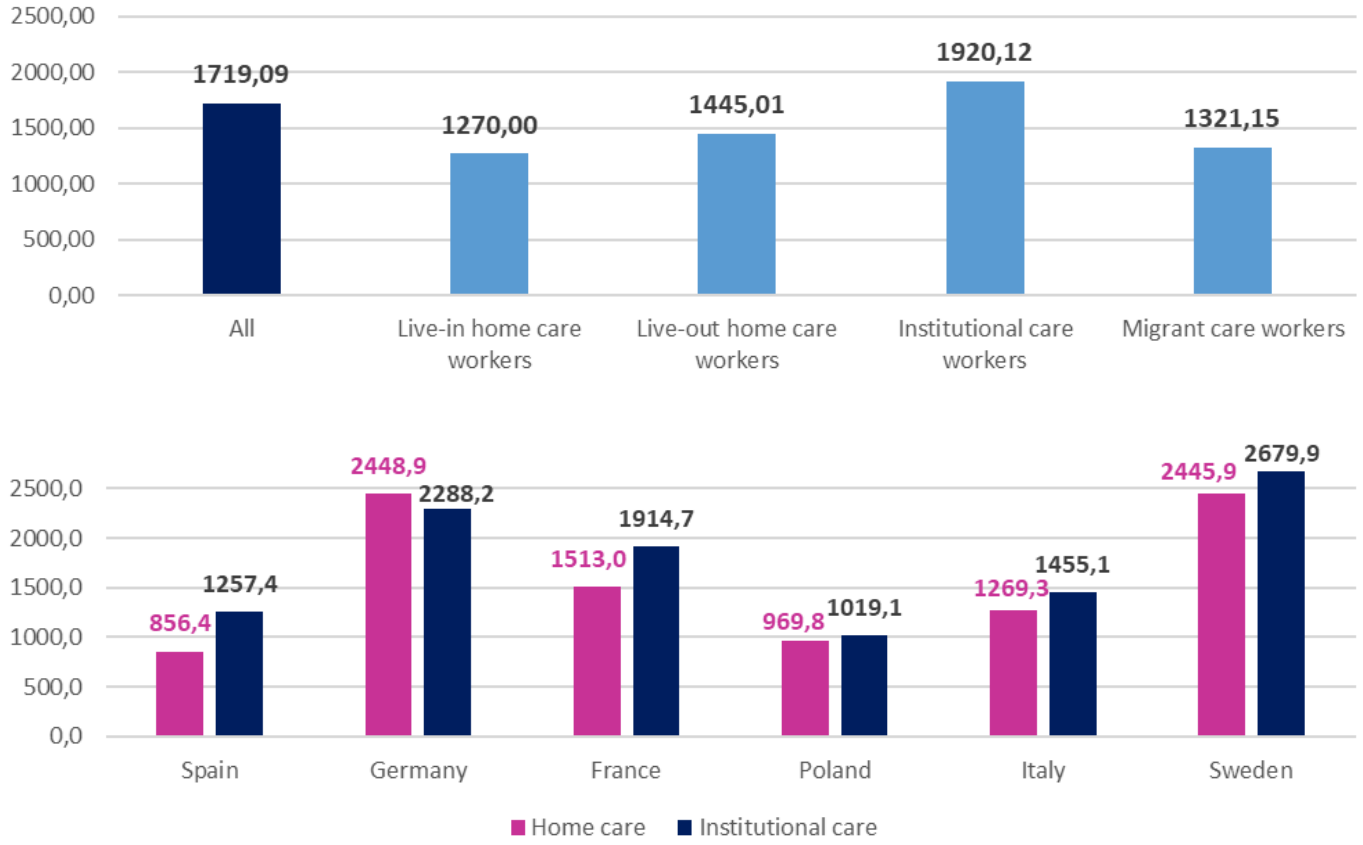
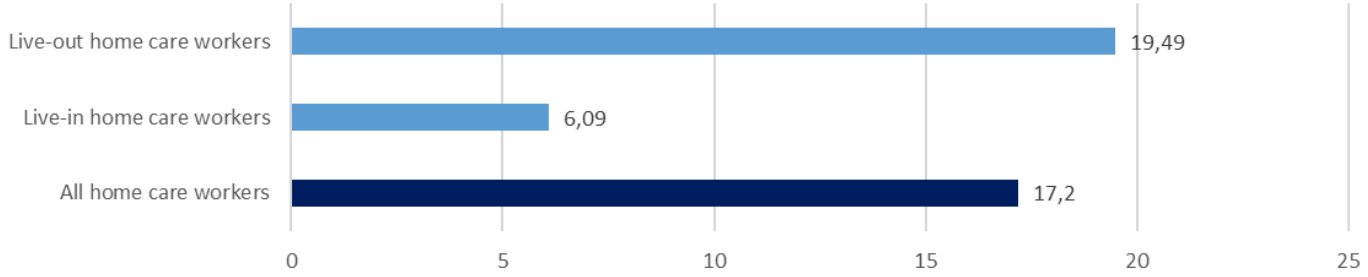


Figure 26. *Number of home care care receivers per week*



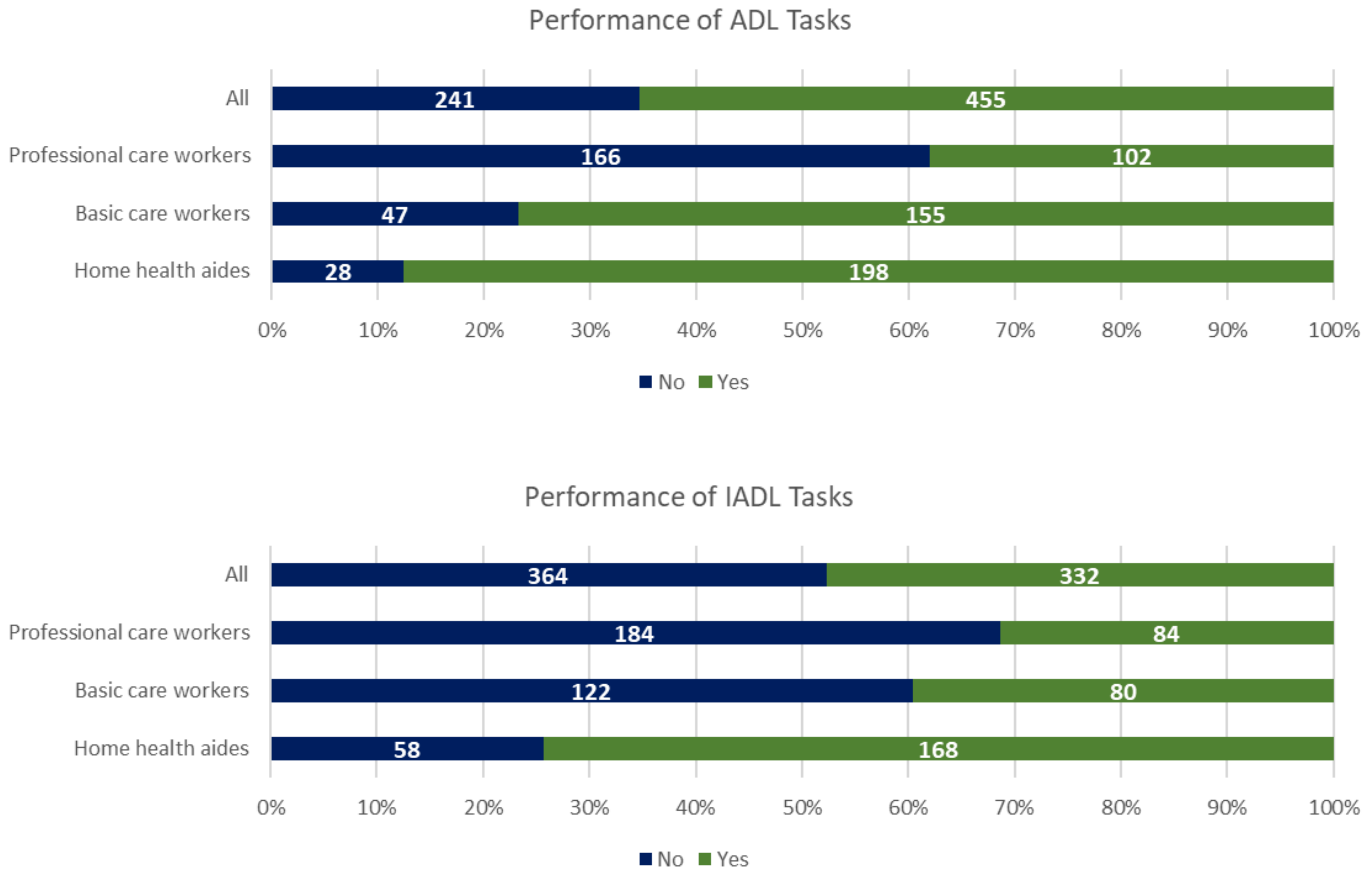
2.4. Nature of the Job

2.4.1. Care Tasks and Care Receivers Needs

Participants were most engaged in activities of daily living (ADL, 65.4%), followed by healthcare tasks (53.6%), while engagement in instrumental ADLs was less common (47.7%). Most professional care workers reported performing healthcare tasks (84.7%), while home health aides more often engaged in ADLs and instrumental ADLs.

Care receivers' health conditions varied widely. Most workers attended to care receivers with mobility issues (82.3%), mental health conditions (79.3%), or physical health issues such as chronic illnesses such as diabetes or heart failure (79.3%). Infectious diseases (30.2%) and obesity (63.2%) were also reported, though less frequently. Only 23.6% of workers reported attending to care receivers with no diagnosis or health issues.

Figure 27. *Type of tasks they perform*



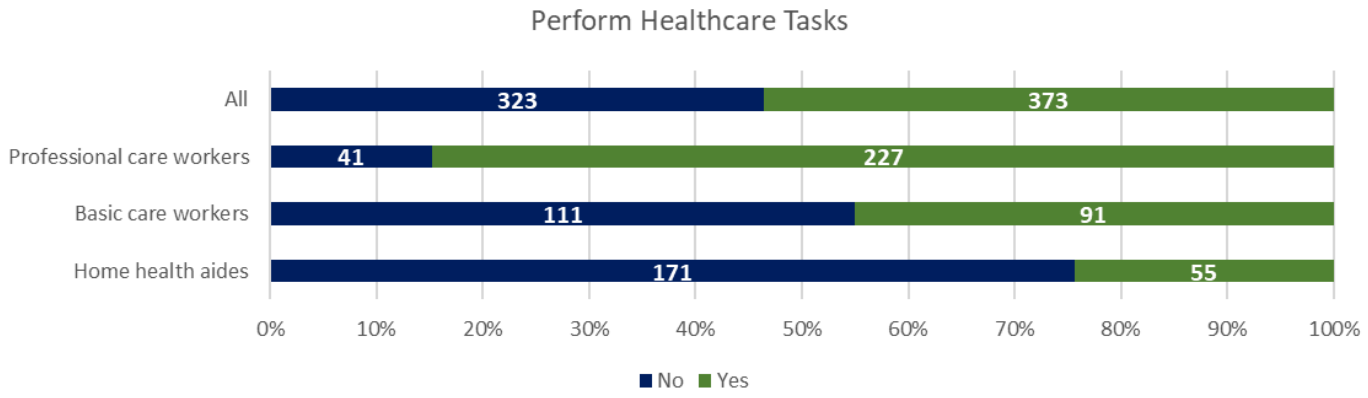
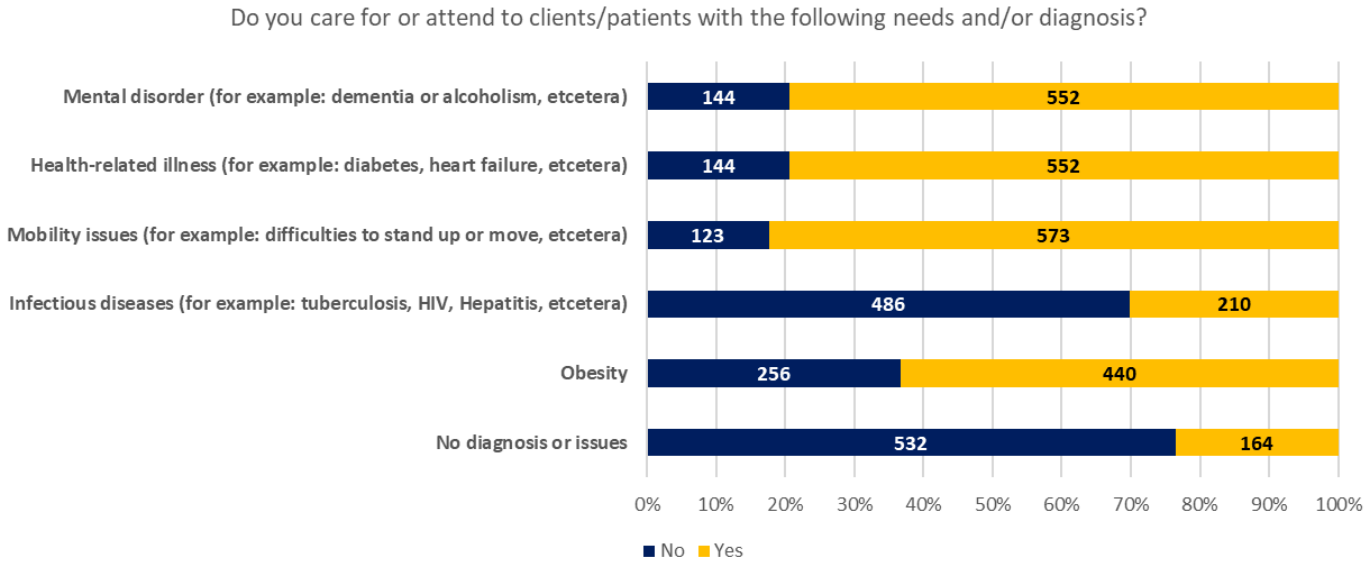


Figure 28. *Care receivers' health conditions*



2.4.2. Working Conditions and Support Structures

Over three-quarters of participants (76.3%) reported having a supervisor. However, this varied by group: 84.2% of basic care workers had a supervisor, compared to 81% of professional care workers and only 63.7% of home health aides. Most institutional care workers worked in teams (89.3%), whereas home health aides frequently worked alone or had colleagues who were not present in the same unit (70.2%).

Lifting equipment was more commonly available to professional and basic care workers (60.4% and 80.2%, respectively) than to home health aides (57.5%). Among home care workers, continuity of care was relatively high, with 44% providing care to the same care receivers for at least a year.

Figure 29. *Supervisor information*

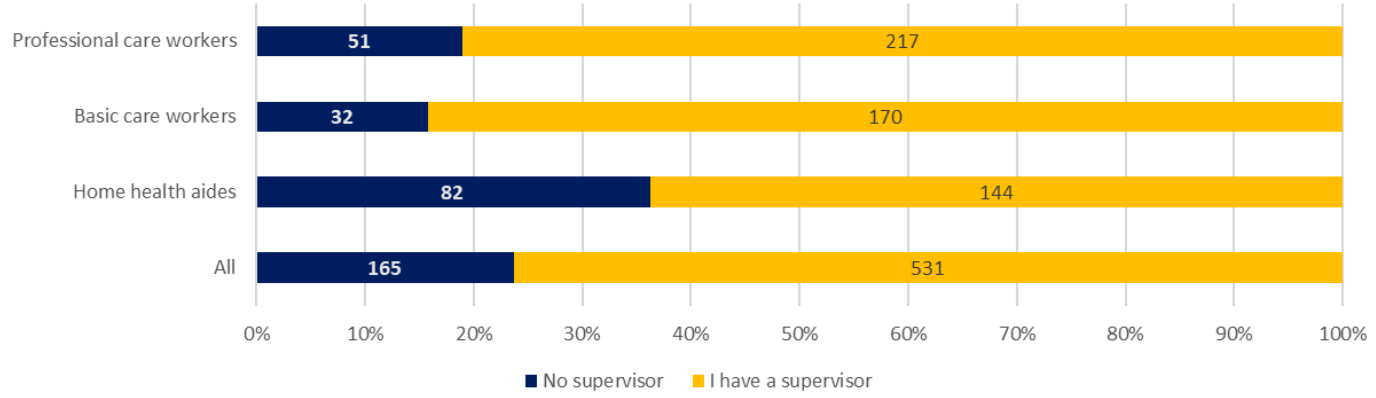


Figure 30. *Teamwork information*

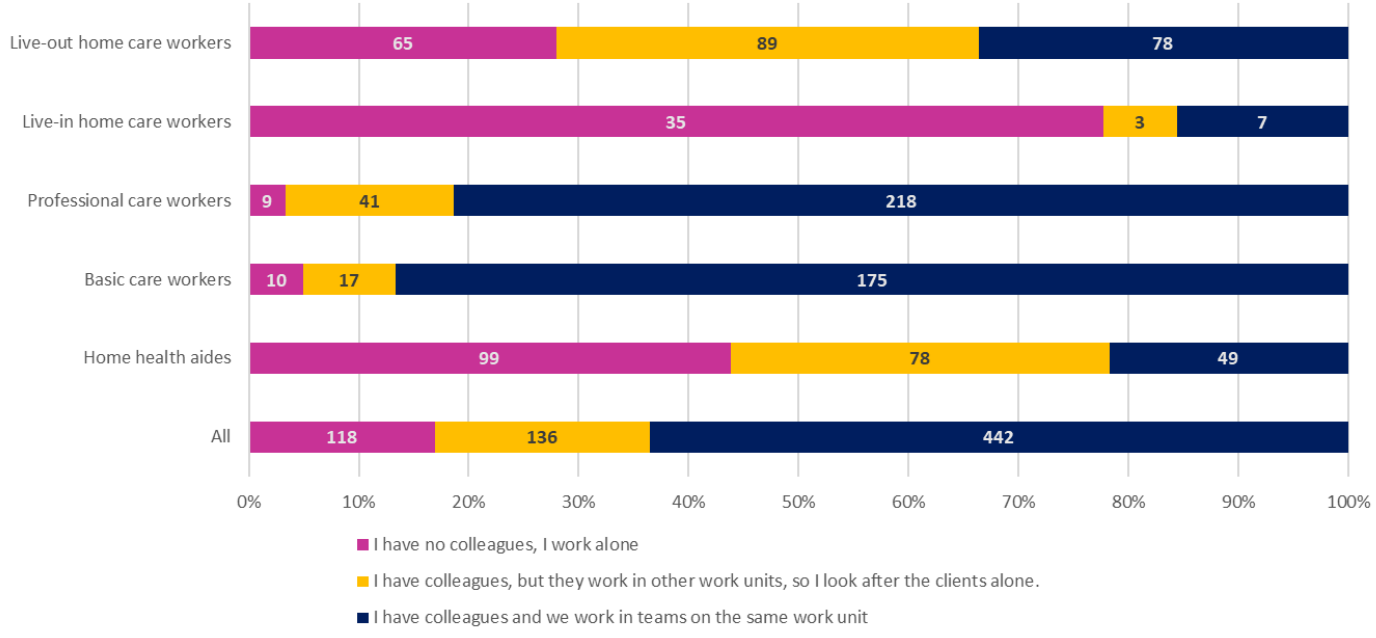


Figure 31. *Lifting equipment*

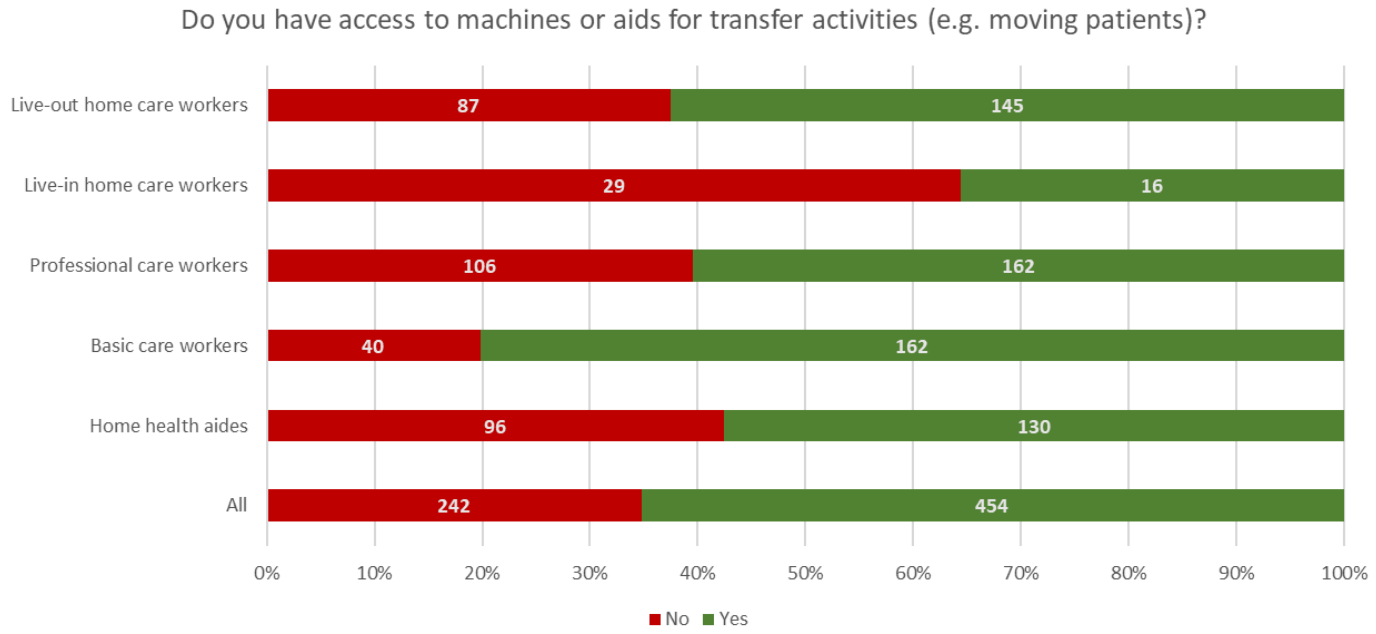
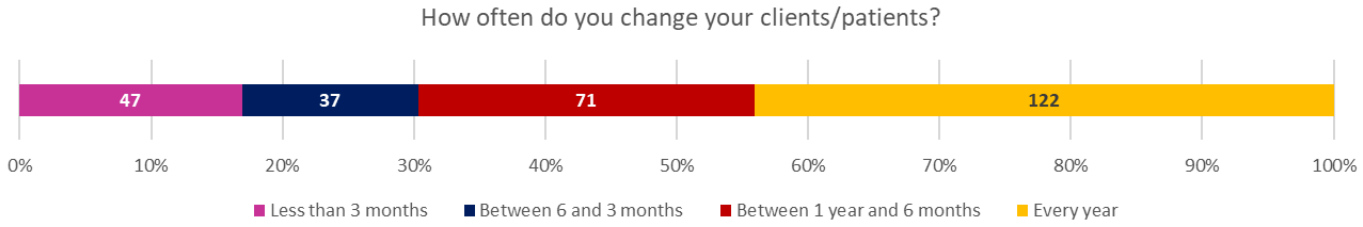


Figure 32. *Continuity of home care*



2.4.3. Transportation and Payment Methods

Most participants (62.2%) used their own cars to get to work, while 19.1% used public transport or carpooling. Only 18.7% walked or cycled.

Payments were primarily made via bank transfer or similar methods (93%). Cash payments were more common among migrant workers (31.2%) and home health aides (15.5%).

Figure 33. *Commute to work*

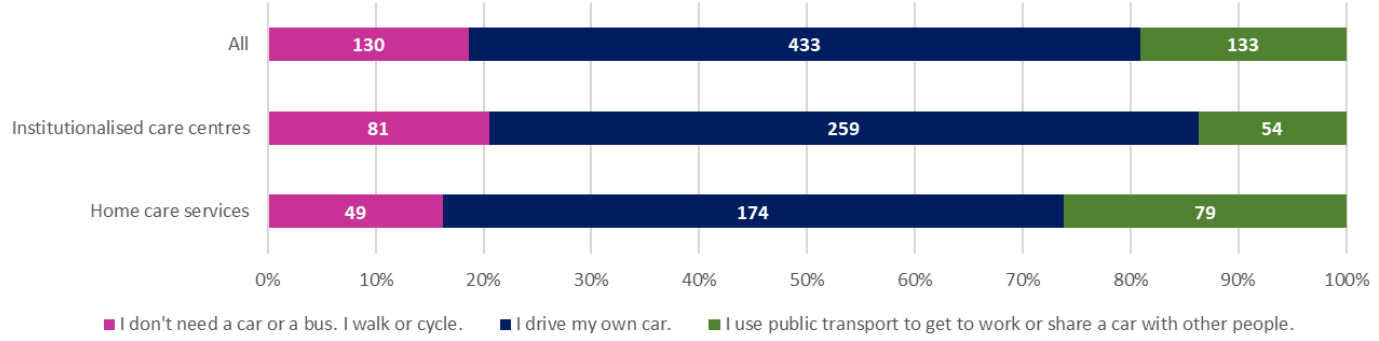
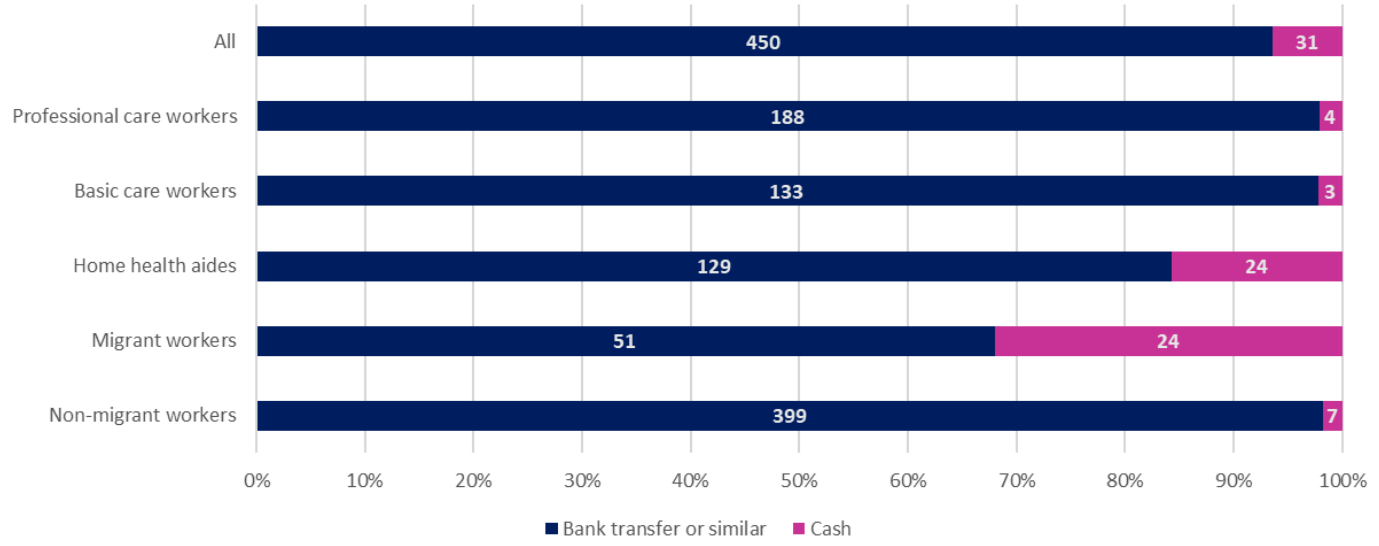


Figure 34. *Method of payment*



2.5. Awareness and Representation

2.5.1. Knowledge and Use of Benefits and Rewards

Overall knowledge of employment-related benefits was limited (Mean of 2.7 out of 9, SD = 2.35). The best-known benefit was paid vacation (63.8%), followed by paid sick leave (53.7%). Actual use of benefits was lower (Mean of 1.3 out of 9, SD = 1.69). Only 12.5% reported receiving performance bonuses, 10.6% had extra time off, and 34.1% had used paid vacation. Fewer than 10% reported using paid travel passes, or meal vouchers.

Figure 35. *Means of knowledge and use of benefits or employer rewards*

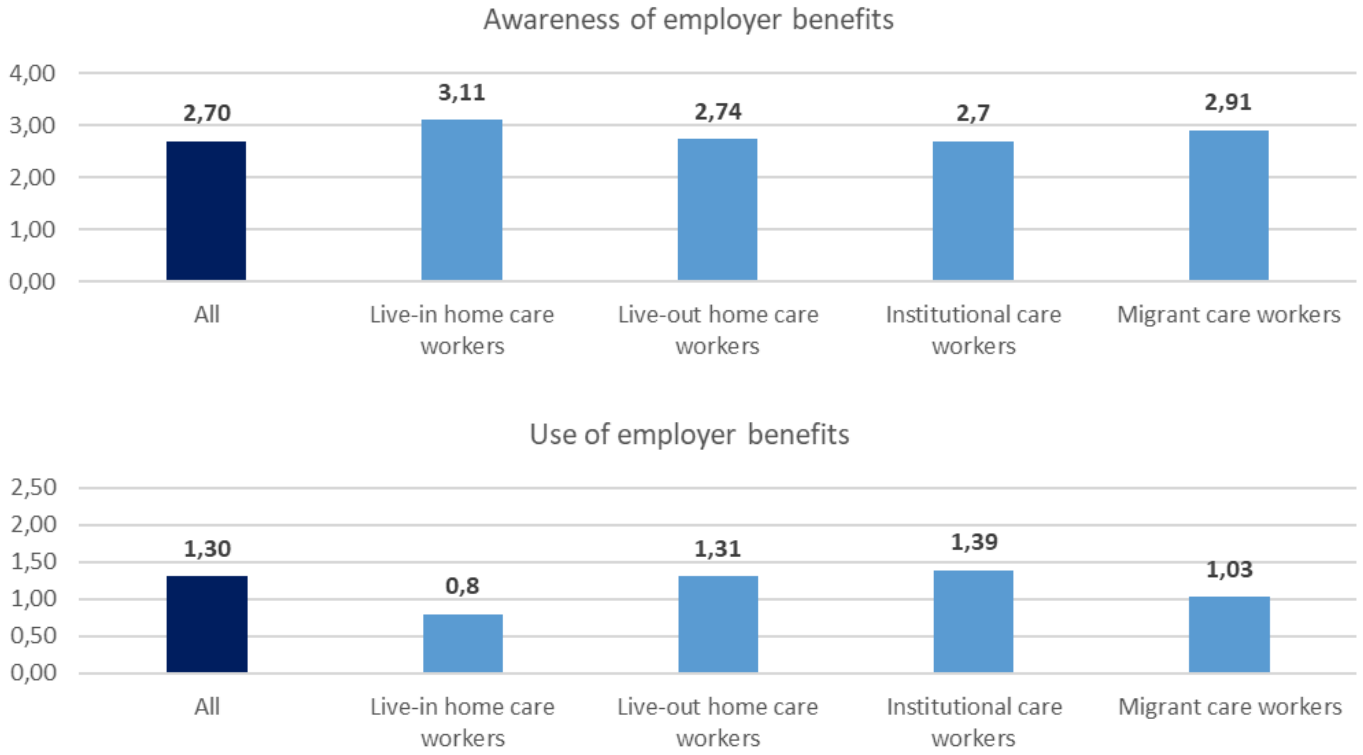


Figure 36. *Knowledge of rewards*

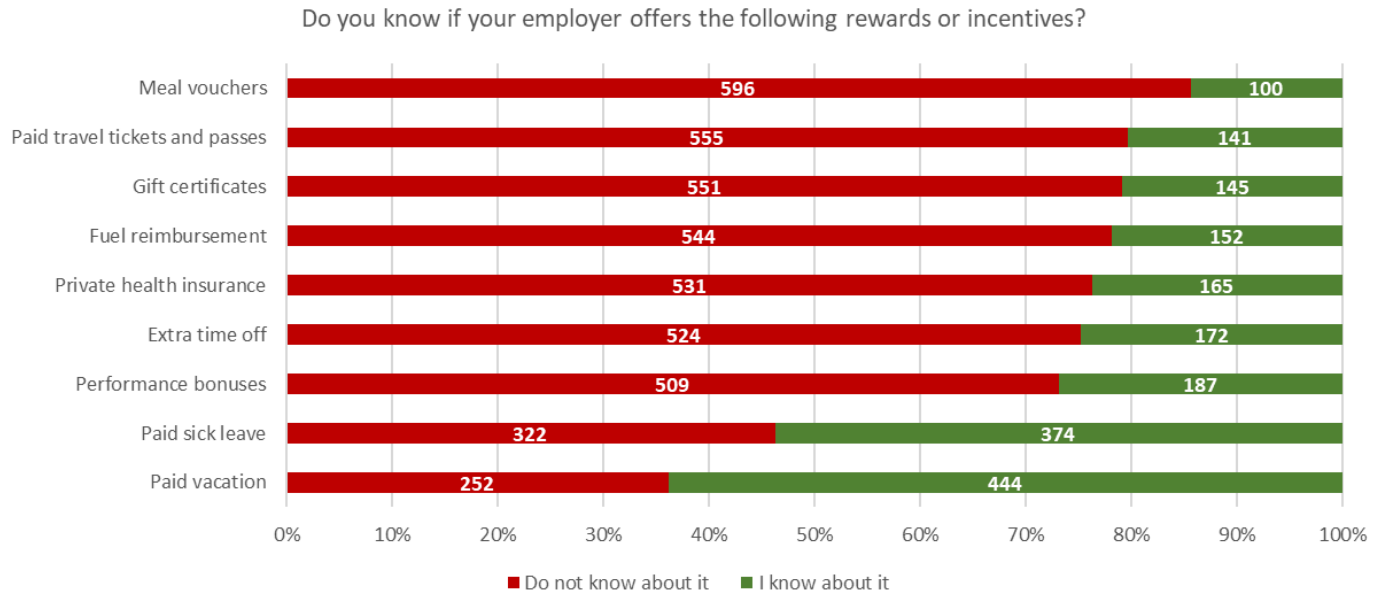
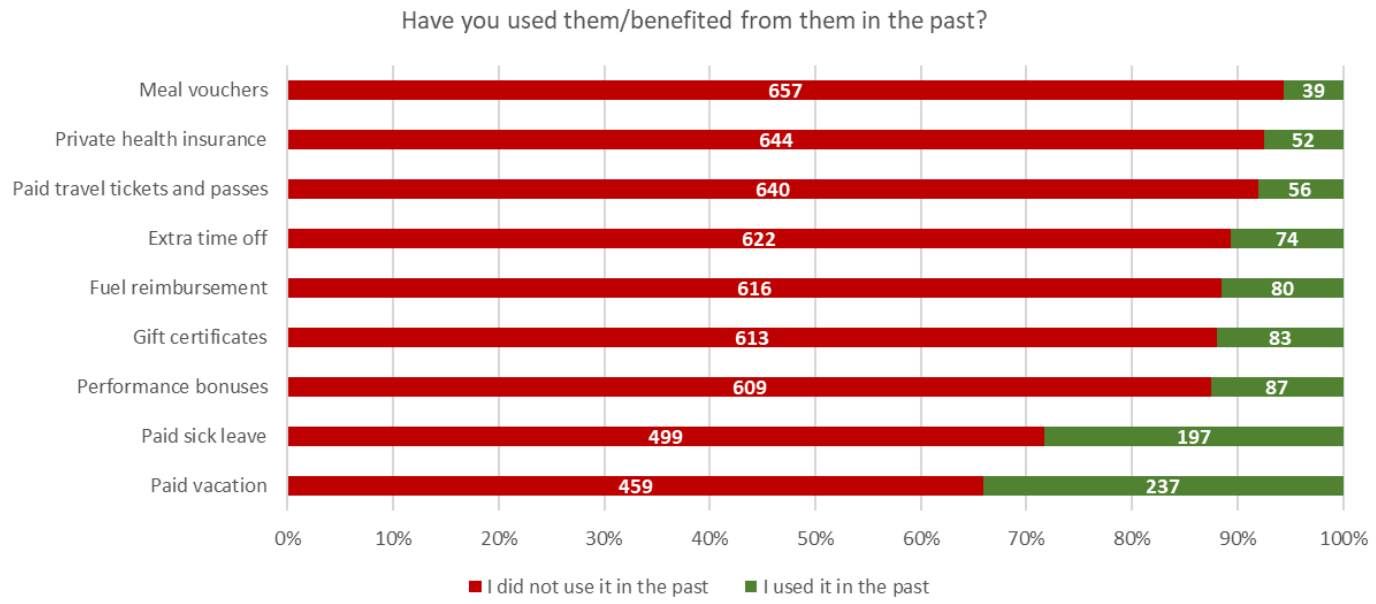


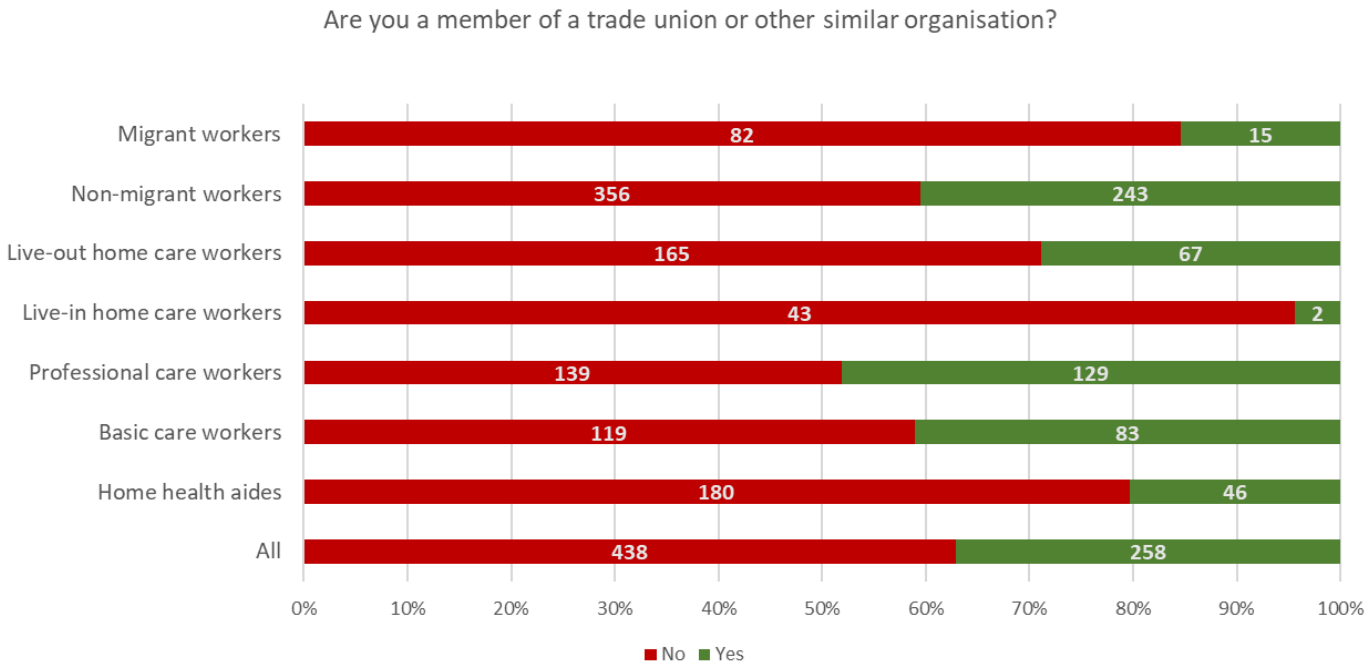
Figure 37. *Use of rewards*



2.5.2. Union Memberships

Slightly more than one-third of participants (37.1%) reported being union members. This proportion was highest among professional care workers (48.1%) and lowest among live-out home care workers (28.9%). Only 15.5% of migrant care workers were unionised. The least unionised group were live-in home care workers (only two participants, 4.4%).

Figure 38. *Trade union membership*



2.6. Group and Country Comparisons

2.6.1. Who Are the Three Target Groups?

Table 6. *Main characteristics - comparing the groups*

Conditions	Home health Aides	Basic Care Workers	Professional Care Workers
Setting	Home based care	Institutional care	Institutional care
Formal education in care services	Least likely (69%)	Most likely (89%)	83%
Percentage of migrant workers	Highest (29%)	8%	Lowest (6%)
Unionisation	Least likely (20%)	41%	Most likely (48%)
Teamwork	Least likely (22%)	Most likely (87%)	81%
Indefinite contracts	Least likely (70%)	88%	Most likely (93%)
No legal contract	Most likely (12%)	Least likely (1%)	1,1%
Most common tasks	Personal care tasks	Personal care tasks	Healthcare tasks

Key contrasts:

- **Training**: Basic care workers had the highest level of formal training in caregiving services.
- **Work settings**: Home health aides worked exclusively in people's homes, while basic and professional care workers worked primarily in institutions.
- **Migrant status**: Home health aides had the largest proportion of migrants, while professional care workers had the smallest.
- **Task profile**: ADLs and IADLs dominated the responsibilities of home health aides, while professional care workers were primarily responsible for healthcare tasks.
- **Supervision and teamwork:** Institutional workers (Targets B and C) were more likely to work in teams and under supervision, whereas home health aides worked alone.
- **Employment protections:** Professional care workers enjoyed the most secure employment conditions, including full-time, indefinite contracts and high levels of unionisation, while home health aides were more exposed to precarious employment.

2.6.2. Sample Composition by Country

Table 7. *Main characteristics - comparing the overall participants of each country*

Conditions	Spain	Germany	France	Poland	Italy	Sweden
Predominant group	Home health aides (74%)	Professional care workers (61%)	Home health aides (67%)	Professional care workers (57%)	Basic care workers (41%)	Professional care workers (58%)
Unionisation	No	Yes	No	No	No	Yes
Sector	Private	Public	Private	Public	Private	Public
Shift	Fixed hours	Shift work	Horario flexible	Shift work	Fixed hours	Fixed hours
Teamwork	Alone	Teamwork	Teamwork	Teamwork	Teamwork	Teamwork
Percentage of migrant workers	36,3%	5,8%	7,8%	0%	12,3%	9,6%

The following section presents the comparative results of the survey. To accurately interpret the findings, it is important to consider the descriptive characteristics of each national participant group. The composition of the overall participants varies considerably between countries. For instance, the Spanish and French participants have a high proportion of home care workers, whereas the Polish, Swedish and German participants are mostly made up of professional care workers in residential facilities. Therefore, these underlying sample characteristics must always be considered when interpreting the observed differences.

Chapter 3. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Groups

This chapter presents the results in two main sections. First, it summarises the findings from the general survey (cross-sectional data), establishing a baseline for the well-being of care workers and their perceptions of risk and protective factors. Then, using the longitudinal data from the weekly questionnaires, it analyses the dynamics of well-being over time, aiming to identify the factors that predict positive and negative states in care workers' well-being.

3.1. Well-Being Results

Table 8. *Main results of Wellbeing*

Outcome	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.73	0.41	226
	Target B	2.71	0.47	202
	Target C	2.69	0.49	268
	Mean	**2.71**	**0.41**	**696**
Perceived Exertion	Target A	6.41	2.14	226
	Target B	6.73	2.80	202
	Target C	5.80	2.94	268
	Mean	**6.27**	**2.69**	**696**
Turnover intentions	Target A	2.03	1.02	226
	Target B	2.21	1.20	202
	Target C	2.42	1.17	268
	Mean	**2.23**	**1.14**	**696**
Work-Private Life Conflict	Target A	2.64	0.96	226
	Target B	2.54	0.91	202
	Target C	2.73	0.84	268
	Mean	**2.64**	**0.91**	**696**
Work-Private Life Enrichment	Target A	3.53	0.71	226
	Target B	3.45	0.74	202
	Target C	3.43	0.73	268
	Mean	**3.47**	**0.73**	**696**
Happiness	Target A	7.13	1.74	226
	Target B	7.08	1.80	202
	Target C	7.01	1.69	268
	Mean	**7.07**	**1.74**	**696**
Flourishing	Target A	5.56	0.91	226
	Target B	5.52	0.96	202
	Target C	5.52	0.92	268
	Mean	**5.53**	**0.93**	**696**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

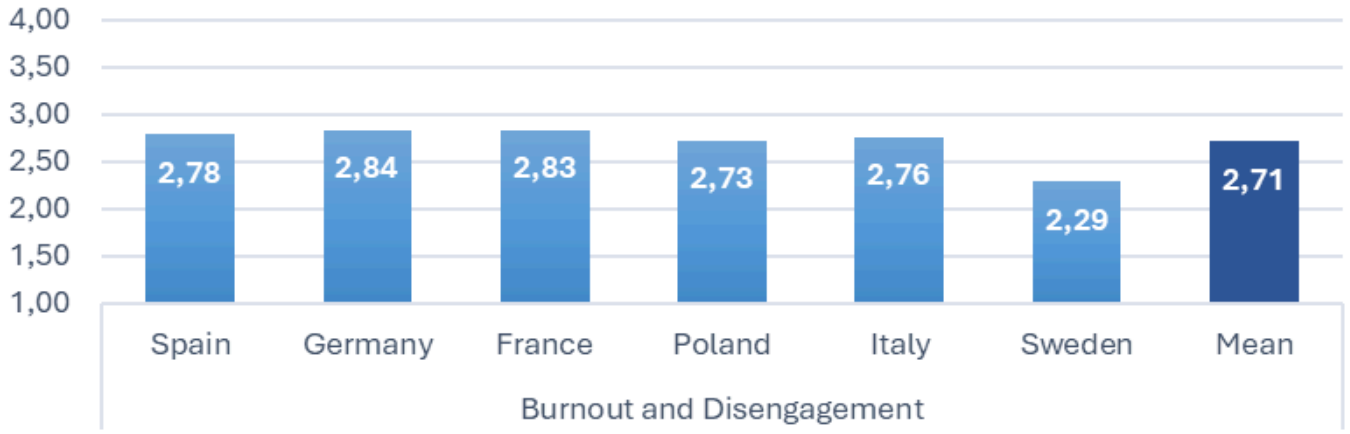
In this section, the well-being outcomes of care work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. The impact of work on personal life is also explored, and the section concludes with findings on employees' expressed desire to leave their job if given the opportunity.

3.1.1. Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average burnout score among care workers was 2.71 (SD = 0.46) out of 4, indicating a moderately high level of burnout. This suggests that participants frequently experienced emotional exhaustion and disengagement from their work, which are two central dimensions of burnout. There were no significant differences between home health aides, basic care workers and professional care workers, indicating that this experience was reported at similar levels across different roles and care settings.

Figure 39. *Cross-country burnout comparative results*



Significant differences in burnout were found between countries. Care workers in Sweden reported the lowest levels of burnout and differed significantly from all other countries. In contrast, Poland, Italy, Spain, France, and Germany showed no significant differences from one another and had similarly higher scores than Sweden. Taken together, these results suggest that care workers in Poland, Italy, Spain, France, and Germany experience similarly elevated levels of emotional exhaustion and disengagement—pointing to a shared experience of strain across care systems despite differences in employment conditions and institutional structures—whereas Sweden shows comparatively lower burnout.

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to

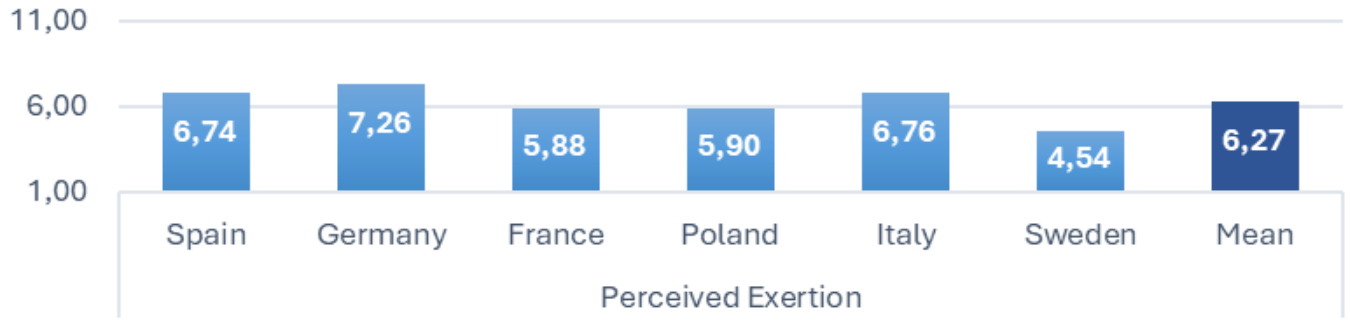
the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

The average perceived physical exertion score was 6.27 (SD = 2.69) out of 11, indicating a moderate to high level of physical effort experienced by care workers. Significant differences emerged between the groups: basic care workers reported the highest exertion and differed significantly from professional care workers, who reported lower levels. Home health aides scored in between and did not differ significantly from either of the other groups. While basic and professional care workers are predominantly employed in institutional settings, these results suggest that basic care workers may experience more intense physical demands. One possible explanation for this is the type of tasks they perform: basic care workers, who typically have intermediate qualifications, are more likely to be assigned physically demanding roles such as bathing, lifting and transferring care receivers. In contrast, professional care workers, who generally have higher qualifications, are more likely to be tasked with specialised medical or supervisory duties.

Figure 40. *Cross-target physical exertion comparative results*

Significant differences in perceived physical exertion were found between countries. Care workers in Germany reported the highest levels and differed significantly from France and Poland. Spain and Italy were in between, with scores that did not differ significantly from either France, Poland or Germany. Sweden reported the lowest levels and differed significantly from all other countries. These results suggest that care workers in Germany experience greater physical strain in their roles than those in France and Poland, with Spain and Italy at intermediate levels and Sweden reporting the lowest levels.

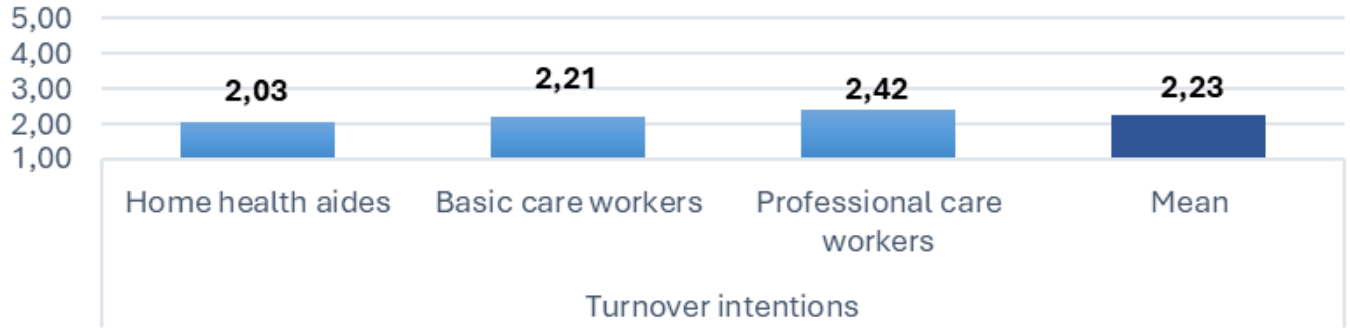
Figure 41. *Cross-country physical exertion comparative results*



Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

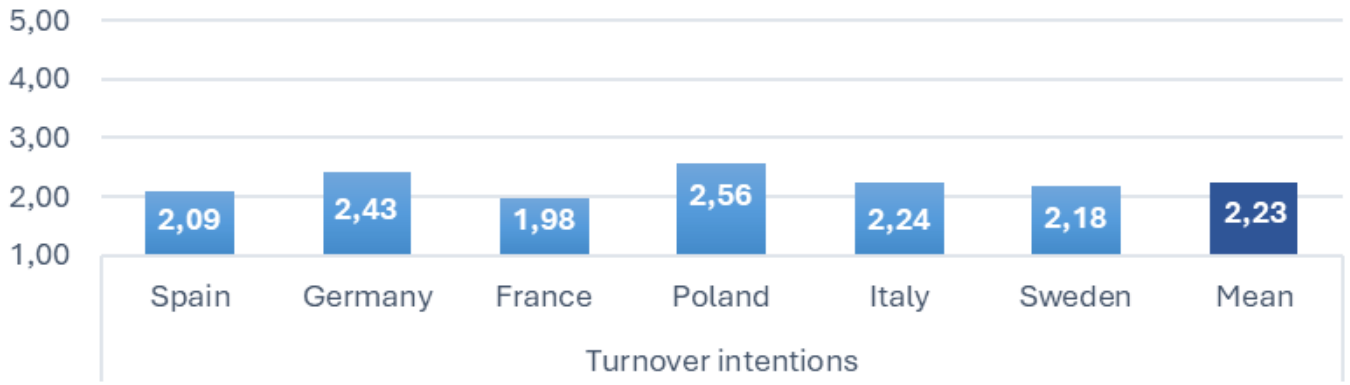
The average turnover intention score was 2.23 (SD = 1.14) on a 1-5 scale, indicating that care workers generally reported a relatively low to moderate desire to leave their current job. However, significant differences were found between the groups. Professional care workers expressed higher intention to leave than home health aides. Basic care workers were intermediate and did not differ significantly from either of the other groups.

Figure 42. *Cross-target turnover comparative results*



Significant differences in turnover intentions were found between countries. Care workers in Poland reported the highest intentions to leave their jobs, while those in France reported the lowest. Spain, Sweden, Italy, and Germany reported average scores that did not differ significantly from either France or Poland. These results suggest that Polish care workers are more likely to consider leaving their positions than those in France, while Spain, Sweden, Italy, and Germany show intermediate, statistically similar levels.

Figure 43. *Cross-country turnover comparative results*

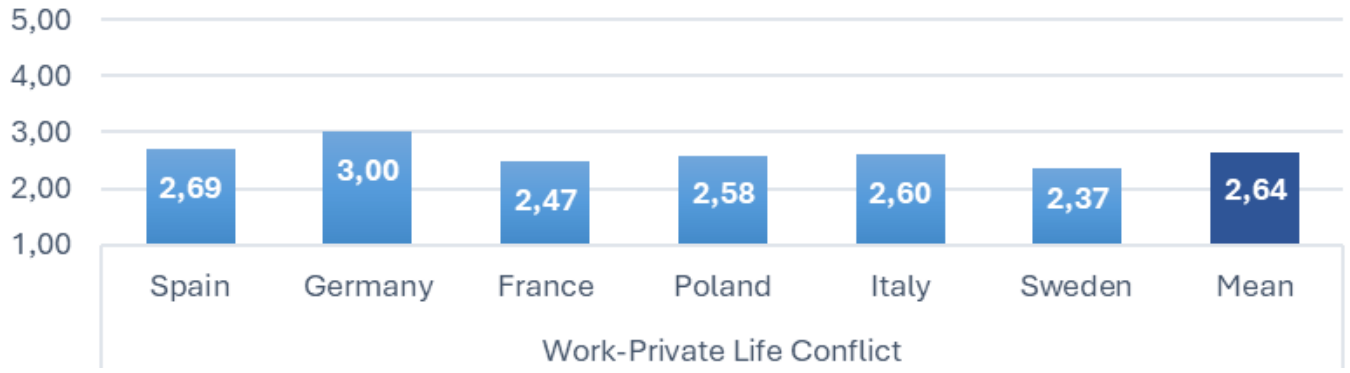


Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the demands of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The average score for work–private life conflict was 2.64 (SD = 0.91) on a 1-5 scale, indicating moderate interference between work and personal life. There were no significant differences between home health aides, basic care workers and professional care workers, suggesting comparable levels of work–private life conflict across roles and care settings.

Significant differences in work–private life conflict were observed between countries. Care workers in Germany reported the highest levels and differed significantly from those in Sweden, France, Poland, and Italy. Spain occupied an intermediate position and did not differ significantly from either Germany or the other countries. These results suggest that German care workers are more likely to report difficulties balancing work and private responsibilities than their counterparts in Sweden, France, Poland, and Italy, while Spain shows comparable intermediate levels.

Figure 44. *Cross-country work-private life conflict comparative results*



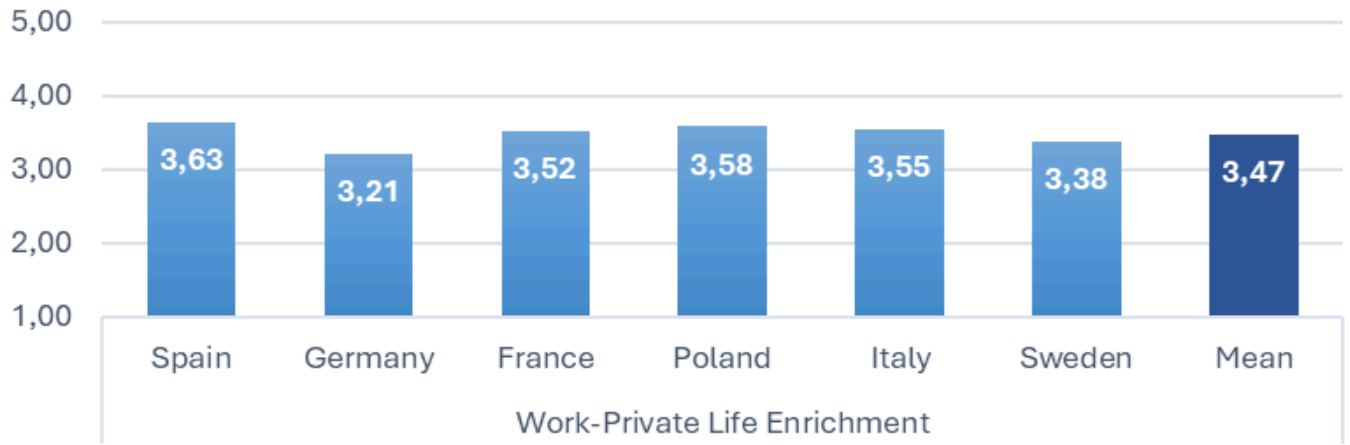
3.1.2. Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The average score for work-private life enrichment was 3.47 (SD = 0.73) out of 5. This suggests that care workers generally perceive a moderately high level of positive interaction between their work and personal lives. There were no significant differences between the target groups, suggesting that this positive exchange is experienced similarly by different types of care workers.

Significant differences in work-private life enrichment were found across countries. Care workers in Germany reported the lowest enrichment and differed significantly from those in Italy, Poland, and Spain. Sweden and France occupied intermediate positions and did not differ significantly from either Germany or the higher-scoring countries. These results suggest that German participants were less likely to view work as positively enriching their private life (and vice versa) than their counterparts in Italy, Poland, and Spain, while levels in Sweden and France were comparable to both sides.

Figure 45. *Cross-country work-private life enrichment comparative results*



Happiness results. This construct was designed to assess care workers' general levels of happiness with their lives. The variable was assessed using a single item: 'taken everything together, how happy are you with your life?'. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

The average happiness score among care workers was 7.07 (SD = 1.74) out of 10, indicating a relatively high overall level of satisfaction with life. This suggests that despite the challenges associated with care work, many participants felt positive about their lives in general. There were no significant differences between the three target groups, indicating that happiness was experienced at similar levels regardless of training level or care setting.

No significant differences in happiness were observed between countries. On average, care workers across countries reported similarly high levels of happiness, suggesting broadly comparable levels of overall life satisfaction across contexts.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The average flourishing score was 5.53 (SD = 0.93) out of a possible 7. This suggests that care workers generally reported a high level of psychological well-being, encompassing aspects such as optimism, purpose and personal growth. There were no significant differences between the various target groups, indicating that this sense of overall well-being was experienced in a similar way by all care workers.

No significant differences in flourishing were found between countries. On average, care workers in all six countries reported similarly high levels of overall psychological well-being, including aspects such as optimism, sense of purpose, and positive social relationships.

3.2. Risk Factors in the Care Sector

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 9. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	3.91	1.34	225
	Target B	3.76	1.50	202
	Target C	3.38	1.49	268
	Mean	**3.66**	**1.46**	**695**
Quantitative Demands	Target A	2.22	0.78	225
	Target B	2.68	0.85	202
	Target C	3.05	0.80	268
	Mean	**2.68**	**0.88**	**695**
Work Pace	Target A	3.20	0.97	225
	Target B	3.47	0.96	202
	Target C	3.52	0.83	268
	Mean	**3.40**	**0.92**	**695**
Tasks Beyond Care Workers' duties	Target A	2.73	1.33	225
	Target B	2.62	1.31	202
	Target C	2.92	1.25	268
	Mean	**2.77**	**1.30**	**695**
Emotional Demands	Target A	3.21	0.93	225
	Target B	3.57	0.83	202
	Target C	3.76	0.76	268
	Mean	**3.53**	**0.87**	**695**
Demands for Hiding Emotions	Target A	3.70	1.01	225
	Target B	3.88	0.82	202
	Target C	3.96	0.72	268
	Mean	**3.85**	**0.86**	**695**
Exposure to Workplace Violence	Target A	1.85	0.94	225
	Target B	2.25	1.14	202
	Target C	1.90	0.95	268
	Mean	**1.98**	**1.02**	**695**
Exposure to Discrimination	Target A	0.43	0.92	225
	Target B	0.29	0.82	202
	Target C	0.15	0.59	268
	Mean	**0.28**	**0.78**	**695**
Intragroup Conflict	Target A	2.02	0.76	225
	Target B	2.56	0.90	202
	Target C	2.70	0.80	268
	Mean	**2.44**	**0.87**	**695**

Continuation of Table 9.

Risk factors	Target	Mean	S.D.	N
Workplace Incivility	Target A	1.86	0.77	225
	Target B	2.16	0.85	202
	Target C	2.14	0.77	268
	Mean	**2.05**	**0.81**	**695**

3.2.1. Job-related Risk Factors

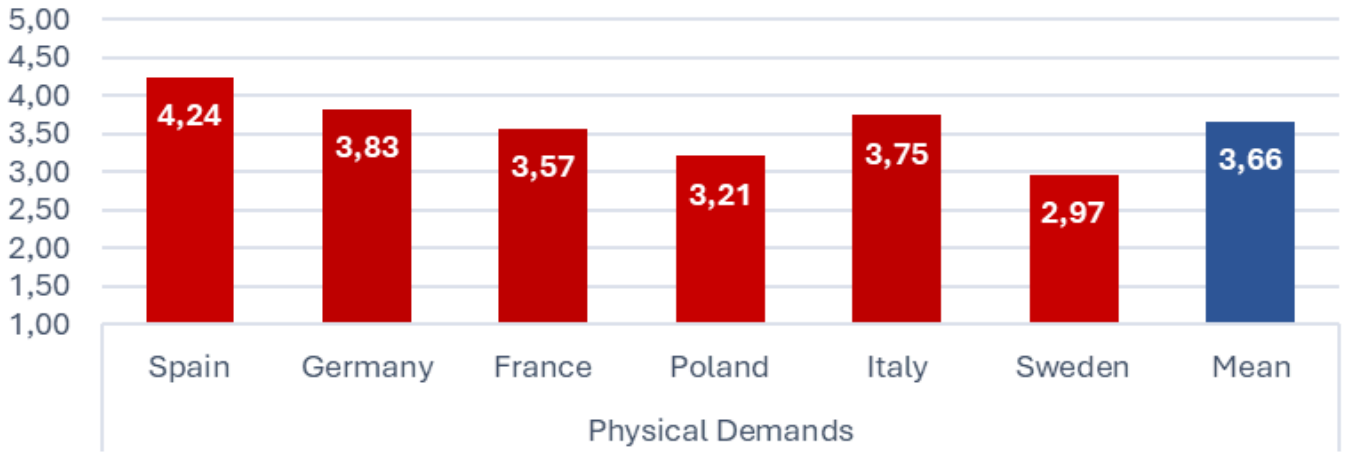
Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

The average score for physical demands was 3.66 (SD = 1.46) out of 5, indicating the regular occurrence of physically demanding tasks such as lifting, moving or supporting care receivers. Significant differences were found between target groups. Professional care workers reported the lowest physical demands and differed significantly from both basic care workers and home health aides. Basic care workers and home health aides did not differ significantly, with both groups reporting comparably higher physical demands.

Figure 46. *Cross-target physical demands comparative results*

Significant differences were found between countries. Care workers in Spain reported the highest levels of physical demands, while those in Sweden reported the lowest. France and Poland showed lower, similar levels, and Italy and Germany were intermediate. Spain differed significantly from Sweden, France, and Poland, but not from Italy or Germany.

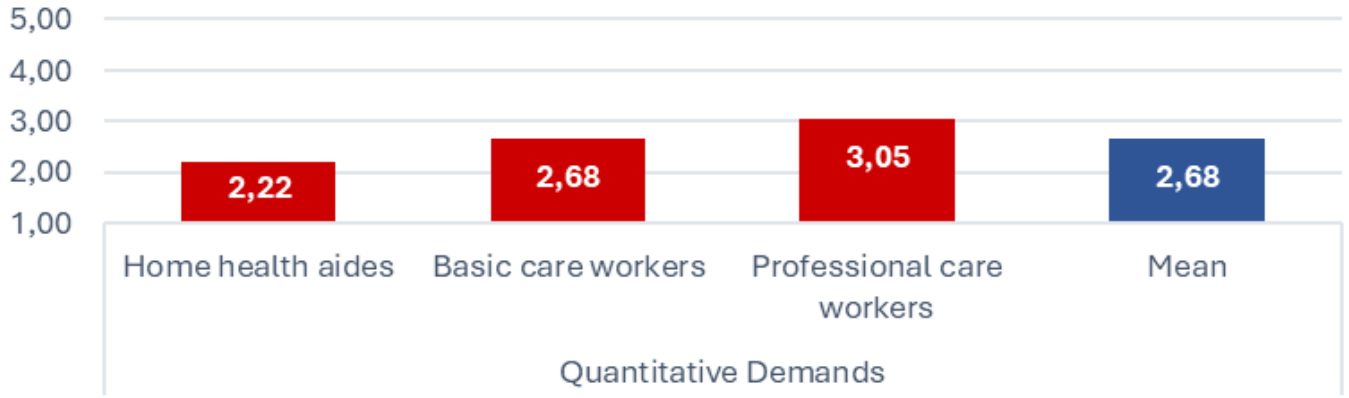
Figure 47. *Cross-country physical demands comparative results*



Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

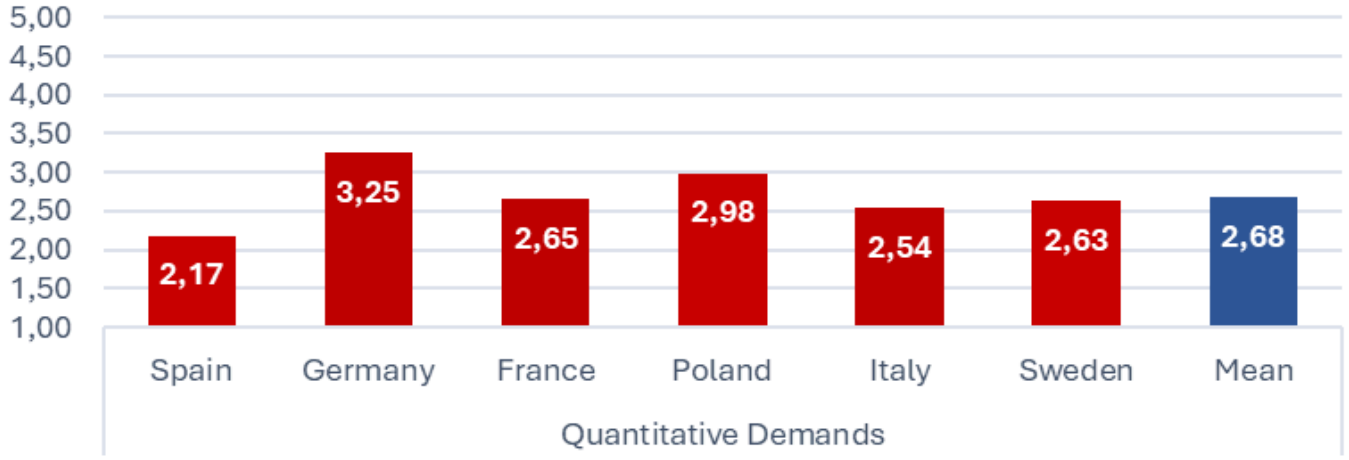
The average score for quantitative demands was 2.68 (SD = 0.88) on a scale from 1 to 5, indicating a moderate workload for care workers, i.e. the amount of work expected within a given timeframe. Significant differences were observed between the groups: professional care workers reported the highest levels of quantitative demands, home health aides the lowest, and basic care workers were intermediate—with all pairwise differences significant. This suggests that workload intensity varies across care roles, with more qualified staff likely bearing a heavier workload.

Figure 48. *Cross-target quantitative demands comparative results*



Significant differences were observed between countries. Care workers in Spain reported the lowest levels of quantitative demands, forming a distinct group, whereas Germany reported the highest, also forming a distinct group. Italy occupied a lower-intermediate position. Sweden and France were intermediate and did not differ significantly from either Italy or Poland, while Poland was upper-intermediate. These findings suggest the lowest time pressure and workload intensity in Spain and the highest in Germany, with the other countries falling in between.

Figure 49. *Cross-country quantitative demands comparative results*



Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

The average score for work pace demands was 3.40 (SD = 0.92) out of 5, indicating that care workers generally experienced a fast-paced environment. Significant differences were found between groups: basic and professional care workers reported higher levels of work pace demands, whereas home health aides reported significantly lower levels. This suggests that time pressure and work intensity vary depending on the care setting - institutional versus home.

Figure 50. *Cross-target work pace demands results*

Significant differences in work pace demands were found between countries. Care workers in Sweden reported the lowest levels and differed significantly from all other countries. By contrast, France, Italy, Spain, Poland, and Germany showed no significant differences from one another, with similarly higher levels than Sweden.

Figure 51. *Cross-country work pace demands results*

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

On a scale from 1 to 5, the average score for exposure to requests to perform tasks beyond formal job duties was 2.77 (SD = 1.30), indicating that care workers were asked fairly often to take on responsibilities outside their defined roles. Significant differences were found between groups: professional care workers reported the highest levels of such requests and differed significantly from basic care workers, while home health aides were intermediate and did not differ significantly from either group.

Figure 52. *Cross-target requests for tasks beyond care workers' duties comparative results*

Significant differences were observed between countries. Care workers in Italy reported the lowest levels of requests to perform tasks beyond their formal duties, whereas those in Germany reported the highest. The other countries occupied intermediate positions and did not differ significantly from either Italy or Germany. These findings suggest fewer such requests in Italy than in Germany, with the other countries showing comparable intermediate levels.

Figure 53. *Cross-country requests for tasks beyond care workers' duties comparative results*

3.2.2. Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job-related risk factor. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for emotional demands was 3.53 (SD = 0.87) on a scale from 1 to 5, indicating that care workers often experienced emotionally demanding situations in their work. Significant differences emerged between the groups: home health aides reported the lowest emotional demands, while basic and professional care workers reported similarly higher levels, with no significant difference between them.

Figure 54. *Cross-target emotional demands comparative results*

Significant differences emerged between countries. Care workers in France and Spain reported the lowest emotional demands and did not differ from each other. Poland reported the highest levels. Sweden and Italy showed intermediate levels, and Germany fell at upper-intermediate levels, not differing significantly from Sweden, Italy, or Poland. These findings suggest that emotional demands are significantly greater for care workers in Poland and Germany than for those in France and Spain.

Figure 55. *Cross-country emotional demands comparative results*

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

On a scale from 1 to 5, the average score for demands related to hiding emotions was 3.85 (SD = 0.86), indicating that care workers often felt the need to suppress or regulate their emotional responses in the workplace. Significant differences were found between the groups: professional care workers reported higher levels of this demand than home health aides, while basic care workers were intermediate and did not differ significantly from either group. This suggests that roles involving higher qualifications or more formal care settings may entail greater expectations of emotional control.

Figure 56. *Cross-target demands for hiding emotions comparative results*

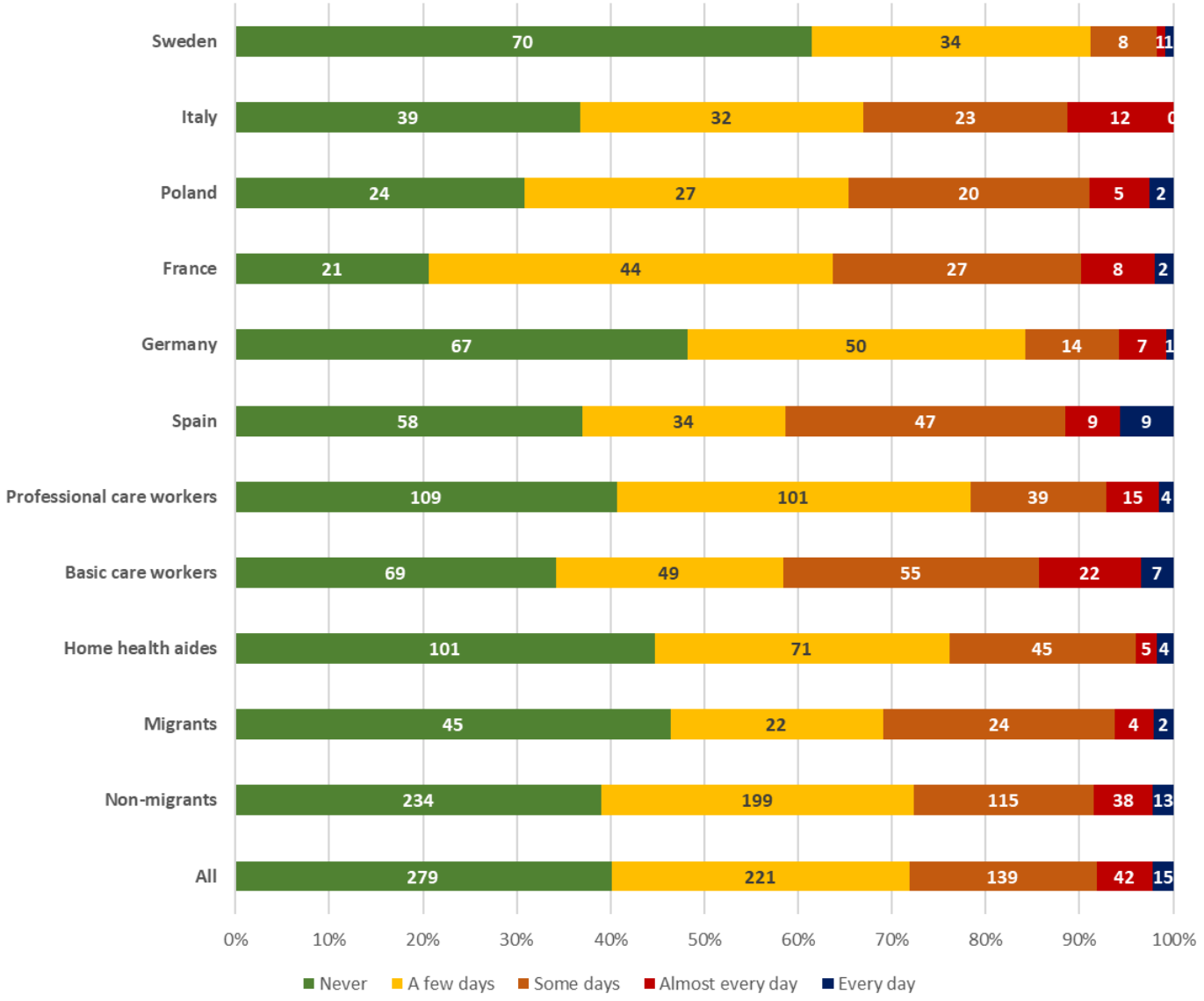
Significant differences were found between countries. Care workers in France, Poland, and Sweden reported higher levels of demand to hide their emotions, whereas those in Italy and Spain reported lower levels. Germany occupied an intermediate position and did not differ significantly from either group. These results suggest greater pressure to conceal emotions in France, Poland, and Sweden than in Italy and Spain.

Figure 57. *Cross-country demands for hiding emotions comparative results*

3.2.3. Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

Figure 58. *Responses to workplace violence item*



The average exposure to workplace violence score was 1.98 (SD = 1.02) out of 5, indicating that care workers occasionally experienced verbal or physical aggression from care receivers, family members or other individuals. Significant differences were observed between groups: basic care workers reported the highest levels of exposure, whereas home health aides and professional care workers reported significantly lower levels that were statistically similar.

Figure 59. *Cross-target exposure to workplace violence comparative results*

Significant differences were observed between countries. Spain and France reported the highest exposure to workplace violence, whereas Sweden reported the lowest. Germany, Italy, and Poland showed intermediate levels. These findings suggest exposure was higher in Spain and France than elsewhere, with Sweden at the lowest levels.

Figure 60. *Cross-country exposure to workplace violence comparative results*

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

Figure 61. *Exposure to discrimination variable results*

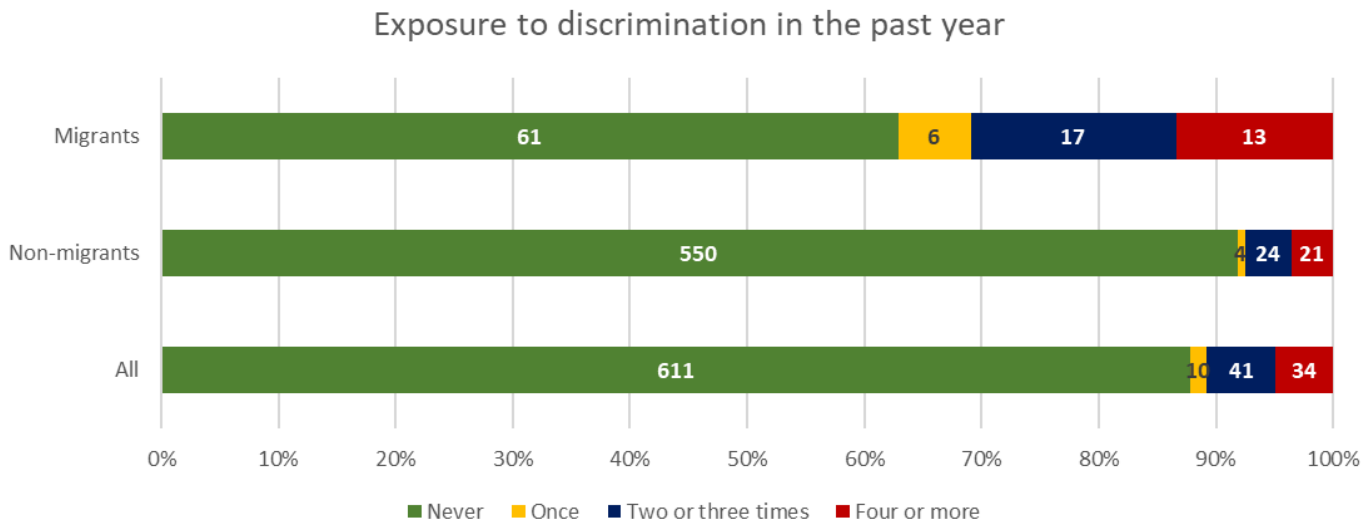
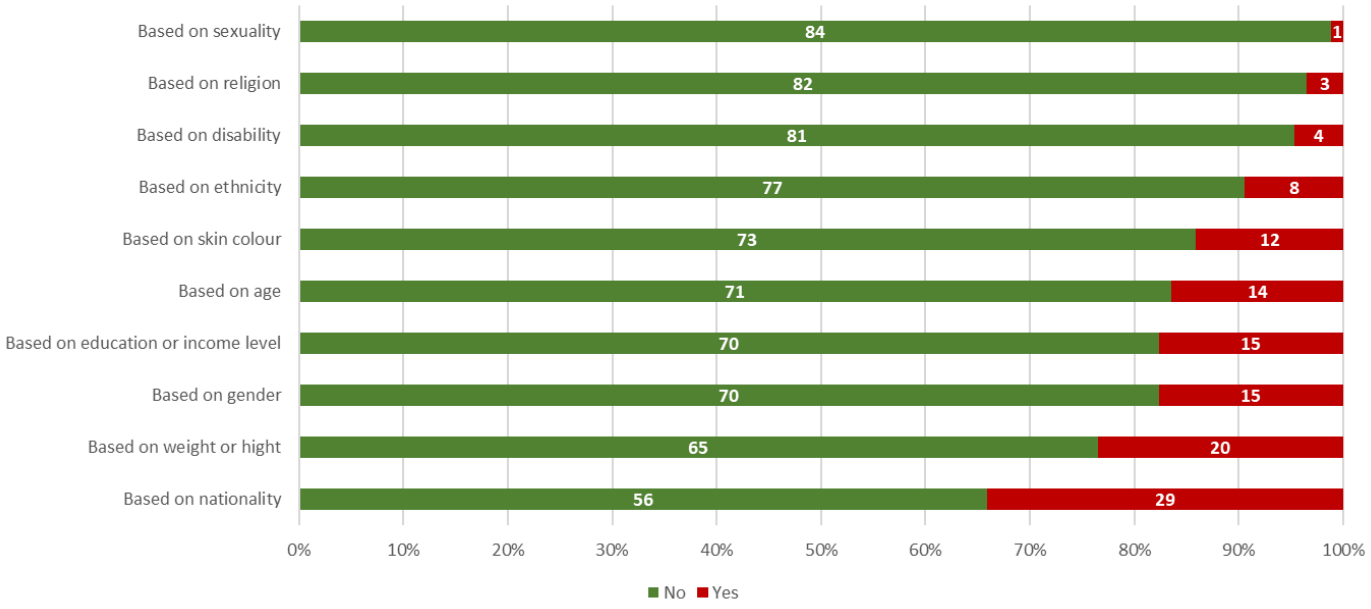


Figure 62. *Perceived motive of discrimination of those who experienced it*



A total of 12.21% of care workers reported experiencing discrimination in the workplace in the past year. The perceived motives, listed in order of frequency of mention, were: nationality; weight or height; education or income level; gender; skin colour; ethnicity; sexuality; disability; and religion. Migrant care workers were more likely to report such experiences than non-migrant care workers. The average exposure to discrimination score was 0.28 (SD = 0.78) on a 0–3 scale, indicating that incidents were infrequent but still occurred. Significant differences were observed between the groups. Home health aides reported the highest levels of exposure to discrimination, whereas professional care workers reported the lowest levels. This finding is consistent with the demographic composition of the sample, given that migrant workers were predominantly employed in home-based care roles.

Figure 63. *Cross-target exposure to discrimination results: averages per target*

No significant differences in discrimination were found between countries. On average, exposure levels were similar across countries.

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The average score for intragroup conflict was 2.44 (SD = 0.87) on a scale from 1 to 5, indicating moderate conflict frequency within care teams and with other workplace contacts. Significant differences were found between the groups: professional care workers reported the highest levels of intragroup conflict, while home health aides reported the lowest.

Figure 64. *Cross-target intragroup conflict results*

Significant differences were observed between countries. Germany and Poland reported the highest levels of intragroup conflict, whereas France reported the lowest. Sweden and Spain were lower–intermediate, and Italy was intermediate. This suggests that care workers in Germany reported significantly higher levels of intragroup conflict than those in France, with workers in the other countries falling in between.

Figure 65. *Cross-country intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for workplace incivility was 2.05 (SD = 0.81) out of 5, indicating that care workers occasionally experienced low-level disrespectful behaviour in their work environments. Significant differences were found between the groups: home health aides reported the lowest levels of incivility, whereas professional and basic care workers reported higher, statistically similar levels.

Figure 66. *Cross-target workplace incivility comparative results*

Significant differences emerged between countries. France reported the lowest levels of incivility in the workplace, whereas Poland reported the highest. Germany, Spain, and Italy showed intermediate levels. These results suggest that workplace incivility is significantly higher in Poland than in France, with other countries at intermediate levels.

Figure 67. *Cross-country workplace incivility comparative results*

3.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 10. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.95	0.91	226
	Target B	3.87	0.83	202
	Target C	3.83	0.83	268
	Mean	**3.88**	**0.86**	**696**
Variation of Work	Target A	2.73	0.88	226
	Target B	2.86	0.91	202
	Target C	3.25	0.89	268
	Mean	**2.97**	**0.92**	**696**
Control over Working Time	Target A	2.50	0.72	226
	Target B	2.74	0.67	202
	Target C	3.12	0.72	268
	Mean	**2.81**	**0.75**	**696**
Predictability	Target A	3.60	1.08	226
	Target B	3.51	1.00	202
	Target C	3.40	0.94	268
	Mean	**3.50**	**1.01**	**696**
Autonomy	Target A	3.04	0.69	226
	Target B	2.80	0.76	202
	Target C	2.97	0.70	268
	Mean	**2.94**	**0.72**	**696**
Meaning of Work	Target A	4.57	0.62	226
	Target B	4.58	0.66	202
	Target C	4.42	0.72	268
	Mean	**4.52**	**0.68**	**696**
Recognition	Target A	3.94	0.93	226
	Target B	3.80	1.04	202
	Target C	3.69	0.95	268
	Mean	**3.80**	**0.98**	**696**
Emotional Social Support	Target A	3.60	0.92	226
	Target B	3.40	1.04	202
	Target C	3.41	0.87	268
	Mean	**3.47**	**0.94**	**696**
Instrumental Social Support	Target A	2.49	0.87	226
	Target B	2.81	0.91	202
	Target C	2.88	0.89	268
	Mean	**2.73**	**0.90**	**696**

3.3.1. Job-related Protective Factors

Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

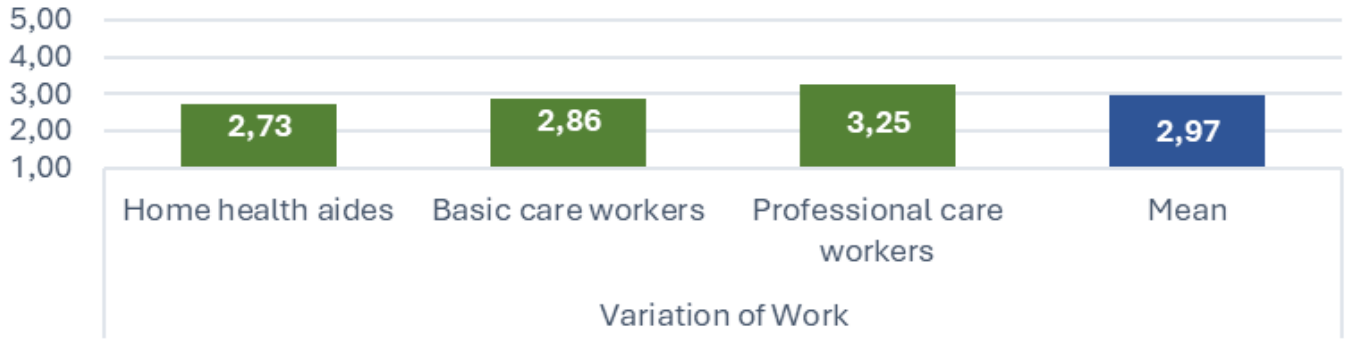
The average score for opportunities for development was 3.88 (SD = 0.86) out of 5, suggesting that care workers generally perceived ample opportunities to utilise and enhance their skills within their current roles. There were no significant differences between the groups, suggesting that these opportunities were perceived similarly across care settings and qualification levels.

There were no significant differences between countries in terms of the perceived opportunities for development. This suggests that the perception of opportunities for professional growth and skill advancement within the care sector is relatively consistent across national contexts.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

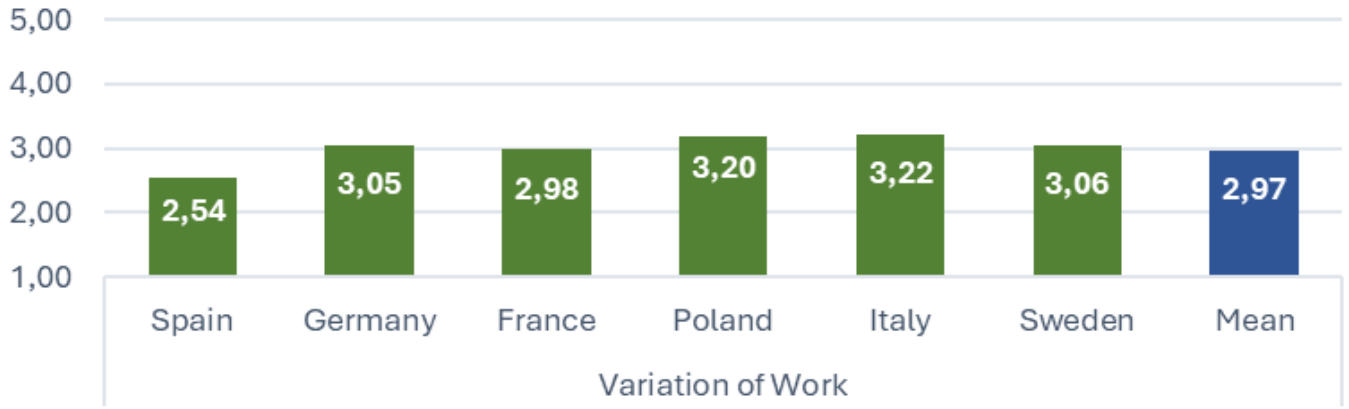
The average score for work variety was 2.97 (SD = 0.92) out of 5, indicating a moderate level of task diversity with some repetitive elements. Significant differences were observed between the groups: professional care workers reported the highest levels of task variety, whereas home health aides and basic care workers reported significantly lower, more similar levels. This pattern may reflect the broader range of responsibilities associated with more specialised roles.

Figure 68. *Cross-target variation of work comparative results*



Significant differences in reported task variation were found between countries. Care workers in Spain reported significantly lower levels of variation in their work than those in Germany, France, Italy,Poland, and Sweden, who all reported higher, and similar levels. This suggests that the tasks performed by Spanish care workers tend to be more repetitive, whereas care workers in the other countries experience a broader range of responsibilities.

Figure 69. *Cross-country variation of work comparative results*



Control over Working Time. The construct refers to care workers' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

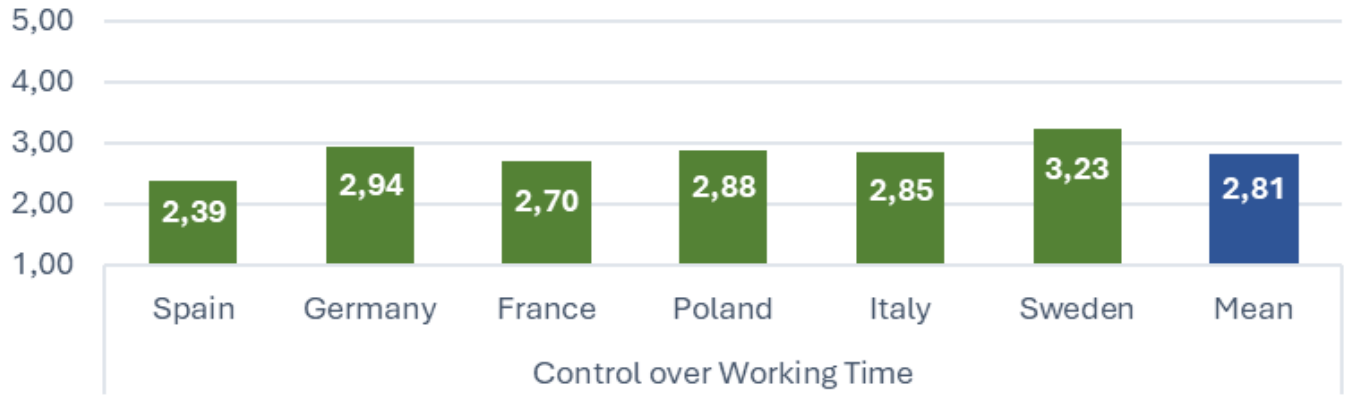
On a scale from 1 to 5, the average score for control over working time was 2.81 (SD = 0.75), indicating a moderate level of autonomy in managing work schedules, including start and end

times, breaks, and days off. Significant differences were found between groups: professional care workers reported the highest levels of control, whereas home health aides reported the lowest. This suggests that schedule flexibility is more limited in home-based care settings.

Figure 70. *Cross-target control over working time comparative results*

Significant differences in control over working time emerged between countries. Care workers in Spain reported significantly lower levels of control over their schedules and differed significantly from the others. Sweden reported the highest levels. France, Italy, Poland, and Germany showed intermediate levels with no significant differences among them. This suggests that Spanish care workers may have less flexibility or autonomy in organising their working hours, whereas Swedish care workers have greater control.

Figure 71. *Cross-country control over working time comparative results*



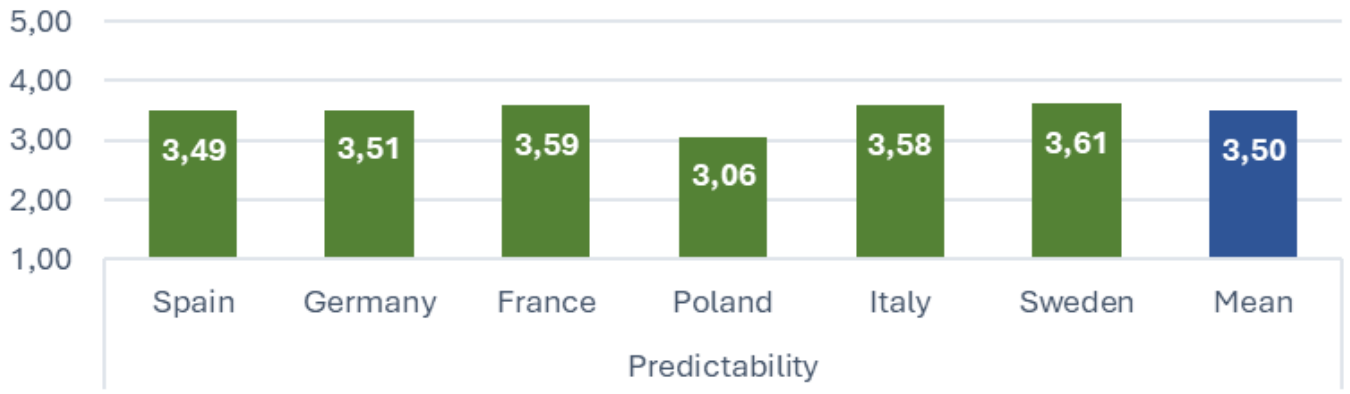
Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level

of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

On a scale from 1 to 5, the average score for predictability was 3.50 (SD = 1.01), indicating that care workers frequently felt they received timely and sufficient information to perform their tasks and adapt to changes at work. There were no significant differences between the groups, indicating that predictability was reported at similar levels across care settings and qualification levels.

Significant differences in the levels of job predictability reported by care workers were observed across countries. Care workers in Poland reported lower levels of job predictability than those in Spain, Germany, Italy, France, and Sweden, which did not differ significantly from one another. This suggests that Polish care workers may face greater uncertainty regarding their daily tasks, schedules and work routines than their counterparts in other countries, who reported more stable and foreseeable work environments.

Figure 72. *Cross-country predictability comparative results*



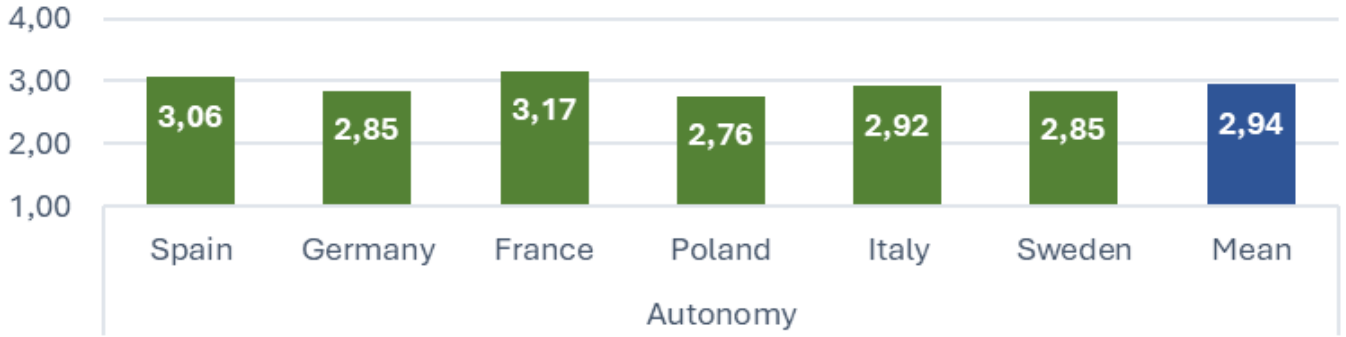
Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

On a scale from 1 to 5, care workers reported an average autonomy score of 2.94 (SD = 0.72). This indicates a moderate degree of freedom in how they perform their duties and organise their daily activities. Significant differences were found between groups: home health aides and professional care workers reported the highest levels of autonomy and did not differ significantly from each other, whereas basic care workers reported the lowest.

Figure 73. *Cross-target autonomy comparative results*

Significant differences in autonomy were observed between countries. France reported the highest levels. Poland, Sweden, and Germany clustered at the lower end with similar levels. Italy and Spain were intermediate and did not differ significantly from either France or the lower-end countries. These results suggest that care workers in France perceive their autonomy as significantly higher than care workers in Poland, Sweden, and Germany, with Italy and Spain in between.

Figure 74. *Cross-country autonomy comparative results*

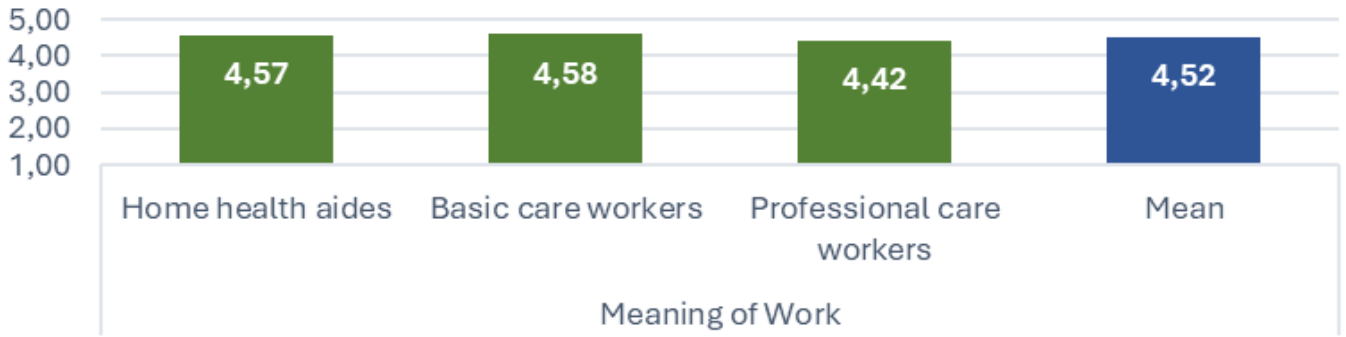


3.3.2. Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

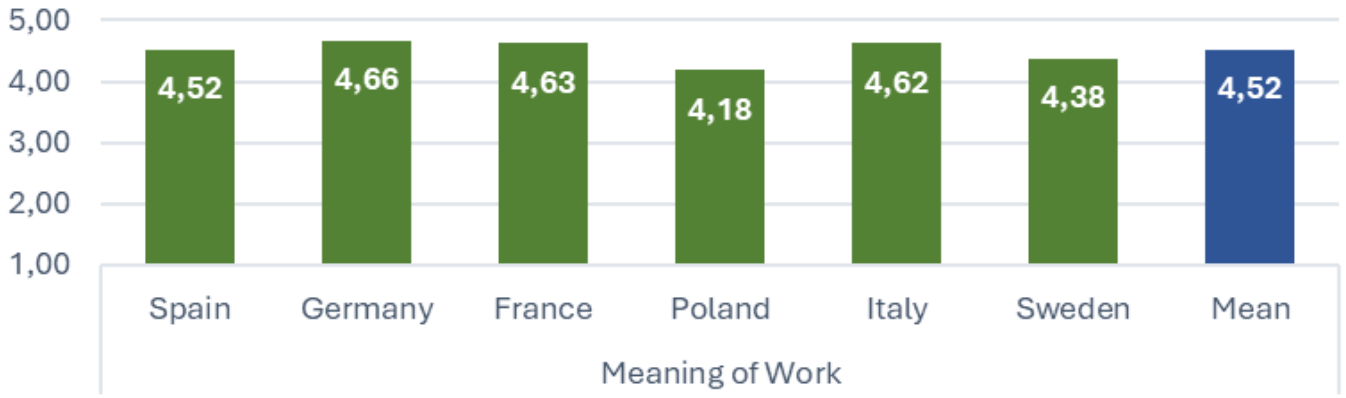
The average score for 'meaning of work' was 4.52 (SD = 0.68) out of 5, indicating that care workers strongly perceive their work as having value beyond financial compensation. Significant differences emerged between groups: basic care workers reported the highest levels of job meaning, whereas professional care workers reported the lowest.

Figure 75. *Cross-target meaning of work results*



Significant differences were observed between countries in terms of the meaning that care workers attribute to their work. Poland reported lower levels than Germany, France, Italy, and Spain. Sweden occupied an intermediate position and did not differ significantly from either Poland or the higher-scoring countries. These findings suggest that Polish care workers may experience less personal fulfilment or value from their professional contributions than workers in the other countries.

Figure 76. *Cross-country meaning of work comparative results*



3.3.3. Relational Protective Factors

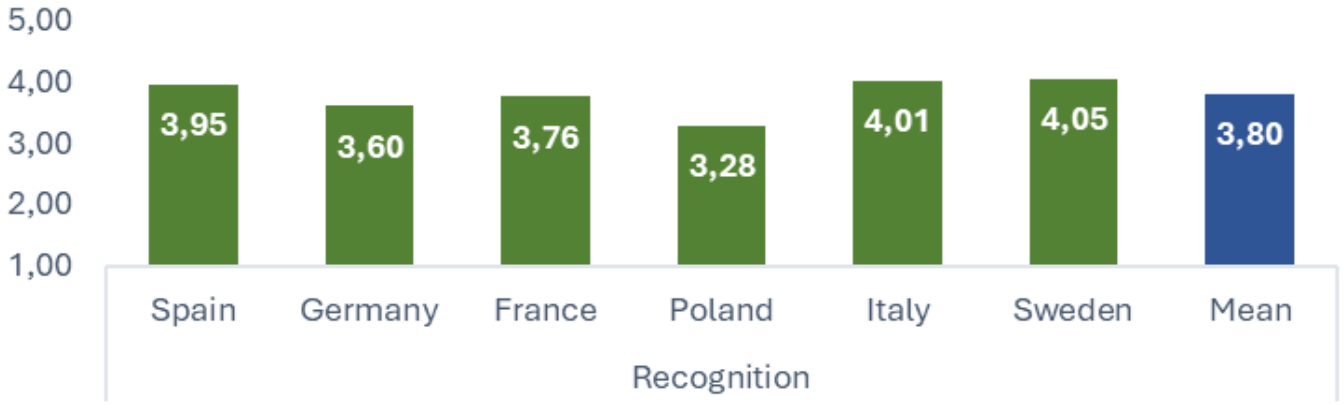
Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average recognition score was 3.80 (SD = 0.98) out of 5, indicating that care workers generally felt recognised and respected. However, significant differences emerged between groups: home health aides reported higher perceived recognition than professional care workers, while basic care workers were intermediate and did not differ significantly from either group.

Figure 77. *Cross-target recognition comparative results*

Significant differences in the levels of perceived recognition were found among care workers across countries. Poland reported the lowest levels. In contrast, France, Spain, and Italy formed a higher group, with Sweden at the upper end. Germany sat at an intermediate level—below Sweden and broadly similar to France, Spain, and Italy. These results suggest that care workers in Sweden feel the most recognised, followed by those in Italy, Spain, and France, with Germany at an intermediate level and Poland lowest.

Figure 78. *Cross-country recognition comparative results*



Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

On a scale from 1 to 5, care workers reported an average score of 3.47 (SD = 0.94) for emotional support and 2.73 (SD = 0.90) for instrumental support. No significant differences were observed between groups for emotional support; levels were broadly similar across targets. In contrast, instrumental support did show significant differences: professional and basic care workers reported higher levels of instrumental support than home health aides, who reported the lowest levels. These findings suggest that the nature of care settings and team structures - with institutional workers more often embedded in teams and home care workers more likely to work alone - may influence the kind of support care workers receive in their daily routines.

Figure 79. *Cross-target social support comparative results*

Significant differences in the levels of emotional support reported by care workers emerged when the data was analysed by country. Poland reported the lowest levels, whereas Germany, Sweden, Spain, France, and Italy reported higher and mutually similar levels. Overall, this indicates higher emotional support in Italy (and the other countries) than in Poland.

Reported levels of instrumental support varied significantly between countries. Compared to those in the other countries, care workers in France reported significantly lower levels of instrumental support. Sweden was at the highest end, while Poland, Spain, Germany, and Italy showed intermediate levels that did not differ significantly from one another. This suggests that French care workers may receive less practical help at work, that support is highest in Sweden, and that levels in Poland, Spain, Germany, and Italy are intermediate.

Figure 80. *Cross-country social support comparative results*

3.4. Summary: Main Differences Across Roles and Countries

Table 11. *Overall summary of prevalence results*

Dimension		Variable	Overall level	Cross-target differences	Cross-country differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate	No differences	DE, FR, ES, IT, PL>SE
		Physical Exertion	Moderate-High	B, A > A, C	DE, IT, ES > IT, ES, PL, FR > SE
		Turnover Intentions	Low-Moderate	C, B > B, A	PL, DE, IT, SE, ES > DE, IT, SE, ES, FR
		Work–Private Life Conflict	Moderate	No differences	DE, ES > ES, IT, PL, FR, SE
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences	ES, PL, IT, FR, SE > FR, SE, DE
		Happiness	High	No differences	No differences
		Flourishing	High	No differences	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate-High	A, B > C	ES, DE, IT > DE, IT, FR, PL > FR,PL, SE
		Quantitative Demands	Moderate	C > B > A	DE, PL > PL, FR, SE > FR, SE, IT > ES
		Work Pace Demands	Moderate-High	C, B > A	DE, PL, ES, IT, FR > PL, ES, IT, FR, SE
		Tasks Beyond Job Duties	Moderate	C > A, B	DE, PL, ES, FR, SE > PL, ES, FR, SE, IT
	Emotional risk factors	Emotional Demands	Moderate-High	C, B > A	PL, DE > DE, IT, SE> IT, SE, ES, FR
		Demands for Hiding Emotions	High	C, B > B, A	PL, FR, SE, DE > DE, ES, IT
	Relational risk factors	Exposure to Workplace Violence	Low	B > C, A	FR, ES, PL, IT > PL, IT, DE > DE, SE
		Exposure to Discrimination	Low	A, B > B, C	No differences
		Intragroup Conflict	Moderate	C , B > A	DE, PL > PL, IT ES > IT, ES, SE > ES, SE, FR
		Workplace Incivility	Low	B, C > A	PL, IT, ES, DE > IT, ES, DE, SE > ES, DE, SE, FR

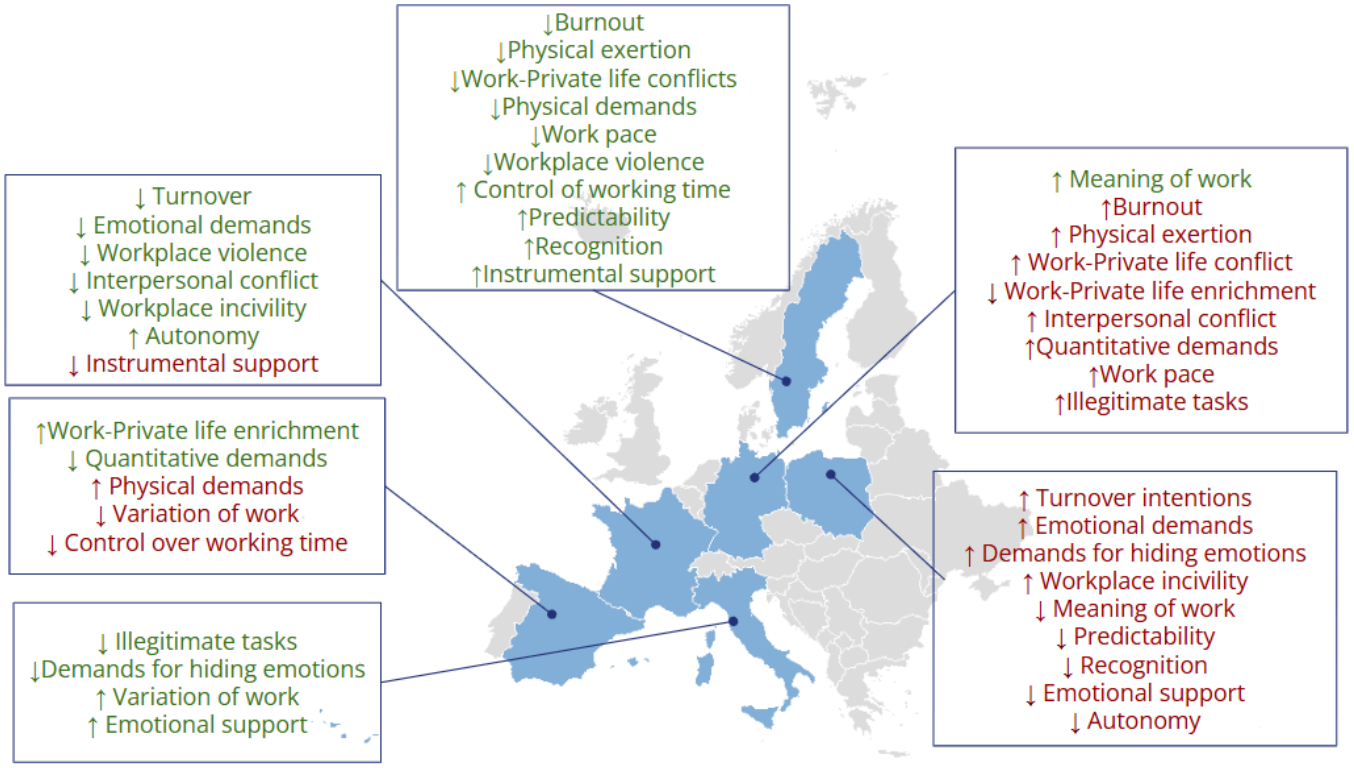
Continuation of Table 11.

Dimension		Variable	Overall level	Cross-target differences	Cross-country differences
Protective factors	***Job-related protective factors***	Possibilities for Development	Moderate-High	No differences	No differences
		Variation of Work	Moderate	C > B, A	IT, PL, SE, DE, FR > ES
		Control Over Time	Moderate	C > B > A	SE, DE > DE, PL, IT, FR > FR, ES
		Predictability	Moderate	No differences	SE, FR, IT, DE> ES, PL
		Autonomy	Moderate	A, C > B	FR, ES, IT > ES, IT, DE, SE, PL
	Emotional protective factors	Meaning of Work	High	B > A > C	DE, FR, IT, ES, SE > SE, PL
	Relational protective factors	Recognition	Moderate-High	A > B > C	SE, IT, ES, FR > IT,ES, FR, DE > DE, PL
		Emotional Support	Moderate	No differences	IT, FR, ES, SE, DE > DE, PL
		Instrumental Support	Moderate	C, B > A	SE, IT > IT, DE, ES, PL > FR

Figure 81. *Significant differences on the prevalences between groups*

***Note*: '↓' indicates that the group had statistically significantly lower levels of said outcome/risk/protective factors than the other two groups, while '↑' indicates significantly higher levels. Green and red colours indicate whether this difference represents that the group is at a better or worse position compared to the other groups.**

Figure 82. *Significant differences on the prevalences between overall samples in each country*



***Note*: Remember that home health aides represent the majority of the participants from Spain (74%) and France; (67%) professional care workers represent the majority of the participants from Germany (61%), Sweden (58%), and Poland (57%); while the major target group in Italy are basic care workers (41%).**

The significant differences in outcomes across countries, as shown in the tables, could be attributed to the varying composition of their care worker samples. Specifically, the participants in Spain and France are predominantly made up of home health aides (74% and 67%, respectively), while those in Germany, Sweden, and Poland are largely professional care workers (61%, 58%, and 57% respectively). In contrast, Italy's main target group is basic care workers (41%). The national discrepancies that are apparent can be attributed to the differing representation of these different professional categories in each country's participant group, given their distinct characteristics and work experiences.

Focusing solely on the comparison between the three professional groups, the key conclusion is that professional care workers consistently report the most strained profile compared to home health aides and basic care workers. Specifically, they experience significantly higher quantitative demands and more illegitimate tasks, coupled with lower meaning and recognition (despite more control over working time, greater task variation, and lower physical demands). This suggests that, despite their professional designation, this group combines the highest demands with the weakest resources.

Chapter 4. Identifying Predictors: Which Factors Really Make a Difference Week to Week?

4.1. Negative Well-Being Indicators

This section presents an analysis of the factors that predict the health and well-being of care workers. The analysis then examines which risk and protective factors are most relevant in explaining positive and negative changes in workers' well-being. To this end, a repeated-measures analysis was conducted using longitudinal data from weekly questionnaires. This approach enables the identification of the most significant predictors of each well-being outcome. Overall, the results suggest that risk factors are linked to an increase in negative health indicators, including burnout, intention to leave the job, work-private life conflict and perceived physical exertion. Risk factors are also linked to decreases in positive indicators, including happiness, work-private life enrichment, and flourishing. By contrast, protective factors are consistently associated with reductions in negative outcomes and increases in positive well-being indicators.

Burnout. The weekly questionnaire measured burnout as a two-dimensional construct: disengagement and exhaustion. Levels of disengagement and exhaustion remained consistent throughout the four-week data collection period, with a few exceptions. Disengagement was higher in the fourth week for the overall participants. The longitudinal data reveal which factors act as significant and consistent predictors for each target group over the four-week period.

Table 12. *Repeated-measures significant coefficients of the effect of predictors on Disengagement*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	0.058	-	-
Work pace	0.063	-	-
Illegitimate tasks	0.062	-	0.046
Emotional demands	0.108	-	-
Hiding emotions	0.093	-	0.056
Workplace violence	-	-	-
Relational intragroup conflict	0.022	0.059	-
Task intragroup conflict	0.047	-	0.090
Workplace incivility	0.117	0.056	0.072
Development	-0.097	-0.118	-0.068
Autonomy	-0.080	-0.078	-0.030
Predictability	-0.037	-0.105	-
Emotional support	-0.059	-	-0.027
Instrumental support	-0.039	-	-0.049

Note: these values represent the effect of each predictor variable on the dependent variable (disengagement). The number indicates how much the dependent variable increases (if the sign is positive) or decreases (if the sign is negative) when the predictor variable increases by 1 point. For example, the value for autonomy in the Target A (-0.080) indicates that a 1-point increase on the autonomy scale is associated with a 0.080-point decrease on the disengagement scale (i.e. as one increases, the other decreases - a negative relationship). Only predictors that reached statistical significance for the group are presented in the table.

Table 13. *Repeated-measures significant coefficients of the effect of predictors on Exhaustion*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	0.136	0.111	0.149
Work pace	0.156	0.142	0.124
Illegitimate tasks	0.087	-	0.111
Emotional demands	0.130	0.105	0.107
Hiding emotions	0.127	0.050	0.103
Workplace violence	0.075	-	0.087
Relational intragroup conflict	0.155	0.124	0.191
Task intragroup conflict	0.138	-	0.167
Workplace incivility	0.223	0.138	0.162
Development	–0.087	–0.830	–
Autonomy	–0.172	–	–0.099
Predictability	–0.085	–0.115	–0.091
Emotional support	–0.099	–0.093	–0.086
Instrumental support	-	-	–0.052

A repeated-measures mixed-effects analysis of the disengagement outcome showed that several risk factors were significantly and consistently associated with higher disengagement, with patterns differing by group. Among home health aides, higher quantitative demands, faster work pace, illegitimate tasks, emotional demands, hiding emotions, both relational and task intragroup conflict, and workplace incivility predicted greater disengagement. Among basic care workers, disengagement increased with relational conflict and workplace incivility. Among professional care workers, illegitimate tasks, hiding emotions, task conflict and workplace incivility were significant. Workplace violence did not show a reliable effect in any group. Although the precise mix of predictors varied by group, effects were stable across the four-week period, and incivility emerged as a consistent risk factor in all groups. Regarding protective factors, opportunities for development and autonomy were associated with lower disengagement in all groups. Predictability was protective among home health aides and basic care workers but not among professional care workers. Emotional and instrumental support were protective among home health aides and professional care workers, with no effects among basic care workers. Overall, disengagement tended to rise with workload, conflict and incivility—most markedly among home health aides—while supportive, predictable and empowering conditions generally buffered disengagement.

The analysis of the exhaustion outcome showed that several risk factors were significantly and consistently associated with higher exhaustion, with patterns differing by group. Across all groups, higher quantitative demands, faster work pace, greater emotional demands, hiding emotions, relational intragroup conflict, and workplace incivility were linked to increased exhaustion—capturing both workload pressure and a strained interpersonal climate. Among home health aides and professional care workers, illegitimate tasks, task intragroup conflict, and workplace violence also predicted higher exhaustion; these effects were not evident among basic care workers. Effects were stable across the four-week period in general. Regarding protective factors, predictability and emotional support were associated with lower exhaustion in all three groups. Development was protective among home health aides and basic care workers, while autonomy was protective among home health aides and professional care workers. Instrumental support was protective only among professional care workers. Overall, exhaustion rose with workload, emotion regulation demands and conflict, whereas predictable, supportive and empowering conditions helped to buffer strain.

Physical Exertion. A repeated-measures analysis indicates that perceived physical exertion among care workers is significantly associated with various risk factors across all target groups. Levels of physical strain remained consistent throughout the four-week data collection period.

Table 14. *Repeated-measures significant coefficients of the effect of predictors on Physical Exertion*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	0.677	0.603	1.104
Work pace	0.875	1.010	1.072
Illegitimate tasks	0.236	0.153	0.684
Emotional demands	0.799	0.609	0.892
Hiding emotions	0.608	0.262	0.880
Workplace violence	0.350	0.838	0.809
Relational intragroup conflict	-	0.757	0.978
Task intragroup conflict	-	-	0.650
Workplace incivility	0.349	0.636	0.910
Development	-	–	0.309
Autonomy	-0,480	–	-0,488
Predictability	-	-0.351	-
Emotional support	-	–	-
Instrumental support	-	–	0.453

A repeated-measures mixed-effects analysis of physical exertion showed that several risk factors were significantly and consistently associated with higher exertion, with patterns differing by group. Across all three groups, higher quantitative demands, faster work pace, more illegitimate tasks, greater emotional demands, hiding emotions, workplace violence, and workplace incivility were linked to increased exertion. Conflict effects varied: among basic care workers and among professional care workers, relational intragroup conflict predicted higher exertion, while task intragroup conflict was significant only among professional care workers. Effects were stable across the four-week period.

Regarding protective factors, autonomy was associated with lower exertion among home health aides and among professional care workers, whereas predictability reduced exertion among basic care workers only. Rather than operating as a buffer, development was positively related to exertion among professional care workers (the greater the opportunities for development, the greater the physical exertion). Instrumental support also showed a positive association with exertion in this group, and emotional support showed no clear effects for any group. Overall, physical exertion rose with workload, emotional regulation demands and a strained social climate, while only selected protective resources—particularly autonomy and predictability—were linked to reduced exertion.

Turnover Intentions. Levels of turnover intentions remained consistent throughout the four-week data collection period, with a few exceptions - It was higher in the fourth week for the overall sample.

Table 15. *Repeated-measures significant coefficients of the effect of predictors on Turnover Intentions*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	0.183	0.186	0.303
Work pace	0.166	0.191	0.213
Illegitimate tasks	0.173	0.122	0.152
Emotional demands	0.267	0.142	0.225
Hiding emotions	0.170	0.075	0.250
Workplace violence	0.186	0.185	0.164
Relational intragroup conflict	0.234	0.357	0.376
Task intragroup conflict	0.395	0.254	0.348
Workplace incivility	0.365	0.308	0.394
Development	-0.205	-0.201	-0.196
Autonomy	-0.254	-0.210	-0.182
Predictability	-0.089	-0.151	-0.226
Emotional support	-0.099	-	-0.133
Instrumental support	-	-	-

A repeated-measures mixed-effects analysis of turnover intentions showed strong and consistent associations with risk factors across groups. Among home health aides, basic care workers, and professional care workers, higher quantitative demands, faster work pace, illegitimate tasks, emotional demands, hiding emotions, workplace violence, relational intragroup conflict, task intragroup conflict, and workplace incivility were all linked to higher turnover intentions. Effects were stable across the four-week period.

Regarding protective factors, opportunities for development, autonomy, and predictability were associated with lower turnover intentions in all three groups. Emotional support was additionally protective among home health aides and professional care workers, while instrumental support showed no clear effect. Overall, turnover intentions increased with the accumulation of risk factors—workload pressure, emotional strain, and a strained interpersonal climate—whereas protective factors that foster skill growth, control, and foreseeability helped to buffer quitting intentions.

Work-life conflict. Levels of work-private life conflict varied throughout the four-week data collection period; they were lowest in the fourth week.

Table 16. *Repeated-measures significant coefficients of the effect of predictors on W-L Conflict*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	0.199	0.311	0.430
Work pace	0.204	0.306	0.344
Illegitimate tasks	0.210	0.286	0.293
Emotional demands	0.305	0.200	0.352
Hiding emotions	0,231	0,170	0,413
Workplace violence	0.215	0.299	0.209
Relational intragroup conflict	0.345	0.244	0.475
Task intragroup conflict	0.265	0.208	0.381
Workplace incivility	0.488	0.228	0.439
Development	-	-	-
Autonomy	-0.270	-0.184	-0.188
Predictability	-0.138	-0.044	-0.200
Emotional support	–0.174	-	–0.127
Instrumental support	-	0.084	-

A repeated-measures mixed-effects analysis of work–private life conflict showed significant, positive associations with risk factors across groups. Among home health aides, basic care workers, and professional care workers, higher quantitative demands, faster work pace, illegitimate tasks, emotional demands, hiding emotions, workplace violence, relational intragroup conflict, task intragroup conflict, and workplace incivility were each linked to greater work–private life conflict. These effects were generally stable over the four-week period, underscoring the combined impact of workload pressure, emotion regulation demands, and strained interpersonal dynamics.

Regarding protective factors, autonomy and predictability were associated with lower work–private life conflict in all three groups. Emotional support was protective among home health aides and professional care workers, with no clear effect among basic care workers. Development showed no significant association. Instrumental support was not protective; instead, it was positively related to conflict among basic care workers only. Overall, work-private conflict rose with the accumulation of risk factors, whereas autonomy and predictability consistently buffered interference between work and private life.

4.2. Positive Well-Being Indicators

Work-life enrichment. Levels of work-life enrichment remained consistent throughout the four-week data collection period.

Table 17. *Repeated-measures significant coefficients of the effect of predictors on W-L Enrichment*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	-0.141	-0.124	-0.118
Work pace	-0.020	-0.077	-
Illegitimate tasks	-0.072	0.013	-0.134
Emotional demands	-0.133	-	-0.114
Hiding emotions	-	-	-
Workplace violence	-	-	-0.175
Relational intragroup conflict	-0.145	-0.197	-0.158
Task intragroup conflict	-	-0.108	-0.158
Workplace incivility	-0.329	-0.192	-0.164
Development	0.196	0.385	0.319
Autonomy	0.299	0.065	0.290
Predictability	0.060	0.172	0.283
Emotional support	0.096	0.079	0.269
Instrumental support	0.080	-	0.121

A repeated-measures mixed-effects analysis of work–private life enrichment showed significant and largely consistent patterns across groups. Enrichment decreased with several risk factors: higher quantitative demands, illegitimate tasks, relational intragroup conflict and workplace incivility were detrimental across all three groups. Task intragroup conflict reduced enrichment among basic care workers and professional care workers, and workplace violence was associated with lower enrichment among professional care workers. Work pace lowered enrichment among home health aides and basic care workers, while emotional demands were a significant detractor for home health aides and professional care workers. Hiding emotions showed no effect.

By contrast, protective factors were consistent across groups. Opportunities for development, autonomy, predictability and emotional support were each associated with higher enrichment in all groups, while instrumental support was beneficial among home health aides and professional care workers. Overall, enrichment rose in supportive, predictable and empowering conditions and fell where workload pressure and strained interpersonal dynamics were greater.

Happiness. The results of the repeated-measures model indicate that the happiness of care workers is significantly associated with a wide range of risk and protective factors. Levels of happiness remained consistent throughout the four-week data collection period.

Table 18. *Repeated-measures significant coefficients of the effect of predictors on Happiness*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	–0.152	–0.417	–0.441
Work pace	–0,234	–0,421	–0,264
Illegitimate tasks	–0.224	–0.323	–0.354
Emotional demands	–0,306	–0,399	–0,391
Hiding emotions	–0,264	–0,298	–0,472
Workplace violence	-0,195	-0,324	-0,342
Relational intragroup conflict	–0.242	–0.477	–0.576
Task intragroup conflict	-	–0.339	–0.489
Workplace incivility	-0.490	-0.469	-0.488
Development	0,348	0,225	0.078
Autonomy	0.155	0.520	0.211
Predictability	0.202	0.256	0.160
Emotional support	0.177	0.286	0.193
Instrumental support	0.082	-	-

A repeated-measures mixed-effects analysis of happiness showed significant and consistent patterns across groups. Happiness decreased with risk factors: higher quantitative demands, faster work pace, illegitimate tasks, emotional demands, hiding emotions, workplace violence, relational intragroup conflict and workplace incivility were each linked to lower happiness among home health aides, basic care workers and professional care workers. Task intragroup conflict was additionally detrimental among basic care workers and professional care workers only. Together, these findings indicate that workload pressure, emotional strain and strained interpersonal dynamics undermine life satisfaction.

By contrast, protective factors were positively associated with happiness. Opportunities for development, autonomy, predictability and emotional support related to higher happiness in all three groups. Instrumental support showed a positive association among home health aides only. Overall, happiness was lower where risk factors accumulated and higher in supportive and predictable work environments.

Flourishing. Levels of flourishing remained consistent throughout the four-week data collection period.

Table 19. *Repeated-measures significant coefficients of the effect of predictors on Flourishing*

Risk and protective factors	Group		
	Target A	Target B	Target C
Quantitative demands	-0.130	-0.102	-0.071
Work pace	-	-	-0.065
Illegitimate tasks	-0.036	-	-0.086
Emotional demands	-	-	-0.059
Hiding emotions	-	-	-0.081
Workplace violence	-	-	-0.080
Relational intragroup conflict	-0.109	-0.149	-0.130
Task intragroup conflict	-0.110	-0.148	-0.118
Workplace incivility	-0.200	-0.169	-0.126
Development	0.114	0.145	0.115
Autonomy	0.207	0.146	0.102
Predictability	0.066	0.153	0.120
Emotional support	0.112	0.167	0.152
Instrumental support	-	0.102	0.025

A repeated-measures mixed-effects analysis of flourishing showed clear and consistent patterns across groups. Flourishing decreased with risk factors: higher quantitative demands, relational intragroup conflict, task intragroup conflict and workplace incivility were detrimental among home health aides, basic care workers and professional care workers. Work pace lowered flourishing among professional care workers only; illegitimate tasks reduced flourishing among home health aides and professional care workers; and emotional demands, hiding emotions and workplace violence were detrimental among professional care workers. Effects were consistent across the four-week period.

By contrast, protective factors were broadly beneficial. Opportunities for development, autonomy, predictability and emotional support were each associated with higher flourishing in all three groups, while instrumental support showed additional benefits among basic care workers and professional care workers. Overall, flourishing rose in supportive, predictable and empowering work contexts, and fell where workload and interpersonal frictions were greater.

4.3. Summary: What Should We Reduce and What Should We Strengthen?

Overall, risk and protective factors were found to be significant predictors of well-being among care workers. To identify the key indicators specific to each occupational group, the factors that consistently predicted negative and positive well-being outcomes were pinpointed.

Table 20. *Key predictors for negative well-being indicators*

	Home health Aides	Basic Care Workers	Professional Care Workers
Risk factors	Quantitative demands	Relational conflict	Illegitimate tasks
	Work pace	**Workplace incivility**	Demands for hiding emotions
	Illegitimate tasks		Task conflict
	Emotional demands		**Workplace incivility**
	Demands for hiding emotions		
	Workplace incivility		
Protective factors	Autonomy	Predictability	Autonomy

Note: Risk and protective factors that were significant predictors for all negative indicators of well-being are presented in the table. These represent risk and protective factors. In bold, those that were significant for all three groups are highlighted.

Table 21. *Key predictors for positive well-being indicators*

	Home health Aides	Basic Care Workers	Professional Care Workers
Risk factors	**Quantitative demands**	**Quantitative demands**	**Quantitative demands**
	Illegitimate tasks	**Relational conflict**	Illegitimate tasks
	Relational conflict	Task conflict	Emotional demands
	Workplace incivility	**Workplace incivility**	Workplace violence
			Relational conflict
			Task conflict
			Workplace incivility
Protective factors	**Possibilities for development**	**Possibilities for development**	**Possibilities for development**
	Autonomy	**Autonomy**	**Autonomy**
	Predictability	**Predictability**	**Predictability**
	Emotional support	**Emotional support**	**Emotional support**

Note: Risk and protective factors that were significant predictors for all positive indicators of well-being are presented in the table. These represent risk and protective factors. In bold, those that were significant for all three groups are highlighted.

Upon analysing the key predictors of well-being, it appeared that three risk factors and four protective factors were significant across all three occupational groups, influencing negative or positive well-being:

Upon analysing the key predictors of well-being, it appeared that three risk factors and four protective factors were significant across all three occupational groups, influencing negative or positive well-being:

- The universal risk factors were **quantitative demands, relational conflict** (related to personality clashes) and **workplace incivility**.
- The universal protective factors were **possibilities for development**, **autonomy**, **predictability** and **emotional support**.

PART 2. LISTENING TO CARE WORKERS: Understanding Risks, Protective Factors and Coping Pathways

Chapter 5. How the Voices of Care Workers Were Collected

5.1. Reaching Participants for the Focus Groups

A similar process to the quantitative study was used to recruit participants. Participants were contacted through associations, nursing homes and other care-oriented organisations. A convenience sample was approached. Therefore, people voluntarily participate in the study.

Each focus group aimed to have between 7 and 10 people, with 10 participants invited in case someone was absent. Once the meeting was convened, it was held regardless of the number of participants, as the organisational circumstances of each country and organisation were different. Participants in each focus group were homogeneous, that is, they did not belong to different hierarchical levels or different positions in the group or society. At the same time, they were diverse so that they could provide us with as much information as possible on the topics to be discussed. It was ensured that the discussion groups were not biassed by any variable due to the recruitment process, i.e., that information favourable or unfavourable to any topic was not sought a priori. The meetings were organised about 7-10 days in advance and a reminder was made a couple of days before.

Data were collected through 33 focus groups conducted in different countries: France (8), 4 groups for Target A and 4 groups for Target B and C; Germany (5), 2 groups for Target A and 3 for Target B and C; Italy (6), 2 groups for Target A and 4 for Target B and C; Poland (5), all groups belonged to Target B and C and Spain (9), 6 groups for Target A and 3 groups for Target B and C. The index below shows the sociodemographic distribution of the different discussion groups by country and target. The presentation is in accordance with the chronological order in which the interviews were conducted in each country.

Table 22. *Focus groups index*

Country	Name of FG	Target	N	Gender		Age average	Country of origin	Modality
				F	M			
France	FG 1 FR B	B	6	5	1	43.16	Cameroon and France	Face-to-face
	FG 2 FR A	A	8	5	3	49.14	France	Face-to-face
	FG 3 FR B	B	5	5	0	42	Cameroon and France	Face-to-face
	FG 4 FR A	A	9	9	0	42.75	France	Face-to-face
	FG 5 FR C	C	5	5	0	37	France	Face-to-face
	FG 6 FR A	A	8	8	0	49.25	France	Face-to-face
	FG 7 FR AC	A (5) C (5)	10	8	2	35	France	Face-to-face
	FG 8 FR C	C	6	6	0	28.6	France	Face-to-face
Germany	FG 1 DE A	A	4	3	1	51.25	Poland	Online
	FG 2 DE A	A	5	4	1	49.8	Poland	Online
	FG 3 DE B	B	4	4	0	37.25	Germany, Macedonia, Poland	Face-to-face
	FG 4 DE C	C	2	2	0	30	Albania and Germany	Face-to-face
	FG 5 DE C	C	6	6	0	46	Germany	Face-to-face
Italy	FG 1 IT B	B	3	2	1	46.33	Italy	Face-to-face
	FG 2 IT B	B	2	1	1	48.5	Cameroon and Italy	Face-to-face

Country	Name of FG	Target		N	Gender		Age average	Country of origin	Modality
					F	M			
	FG 3 IT A	A		8	7	1	51	Brasil, Cuba, Moldavia, Morocco, Peru and Romania	Face-to-face
	FG 4 IT B	B		2	1	1	44	Italy	Face-to-face
	FG 5 IT A	A		9	9	0	48.66	Cameroon, Ecuador, Italy, Peru and Romania	Face-to-face
	FG 6 IT C	C		8	7	1	40.62	Switzerland and Italy	Face-to-face
Poland	FG 1 PL C	C		3	3	0	36	Poland	Online
	FG 2 PL BC	B (3)	C (3)	6	6	0	39.83	Poland	Face-to-face
	FG 3 PL BC	B (3)	C (4)	7	7	0	40.28	Poland	Face-to-face
	FG 4 PL BC	B (4)	C (3)	7	7	0	43	Poland	Face-to-face
	FG 5 PL BC	B (2)	C (6)	8	7	1	45.12	Poland	Face-to-face
Spain	FG 1 ES A	A		7	7	0	50.29	Spain	Online
	FG 2 ES A	A		9	9	0	40.73	Spain	Face-to-face
	FG 3 ES A	A		6	6	0	46.92	Spain	Face-to-face
	FG 4 ES A	A		8	8	0	30.5	Spain	Online
	FG 5 ES A	A		9	8	1	41.33	Colombia, Morocco, Nicaragua and Peru	Online
	FG 6 ES BC	B	C	10	8	2	40	Spain	Face-to-face

Country	Name of FG	Target		N	Gender		Age average	Country of origin	Modality
					F	M			
		(5)	(5)						
	FG 7 ES BC	B (5)	C (4)	9	6	3	43.11	Spain	Face-to-face
	FG 8 ES BC	B (5)	C (2)	7	7	0	44.71	Spain	Online
	FG 9 ES A	A		8	8	0	46.12	Colombia, Honduras, Nicaragua, Paraguay and Spain	Face-to-face

5.2. From Questions to Conversation: Conducting the Groups

All focus groups followed the instructions given in the training session for conducting the meeting. A pleasant place with no distractions and interruptions was assured. Before the discussion, participants were asked to sign the informed consent and about the possibility to record the session only to transcript their interventions. Anonymity and confidentiality was explained.

5.2.1. What Was Asked: Discussion Guide and Key Topics

- Presentation of the participants.
- Brief explanation of the work the participants do, what are the main difficulties they face in their daily work.
- Brief explanation of how work affects their personal life, their well-being. What are the main challenges?
- A short explanation of the personal and social resources available to them.
- A general assessment of how the participants' working conditions could be improved.

After the focus group participants were asked if they would like to receive information about the project and the conclusions drawn from the data they provided.

5.2.2. Qualitative Analysis Approach

A thematic analysis was conducted[14]. The recordings were transcribed in two stages: first, via the Trint program, chosen for its data protection features; then, the transcripts were manually reviewed, and those in a language other than Spanish were translated into English using the back-translation method as outlined[15].

Atlas.ti version 9 was used to analyze the transcripts, generating codes deductively through the JD-R theory model[16] and inductively through information from the discussion groups. Bingham's 5-step coding guide[17] was applied, which controls for researcher bias in code interpretation and assignment. This is a mixed coding method[18] Three researchers were involved in the code review, analysis, and refinement process in accordance with the aforementioned guidelines.

[14] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

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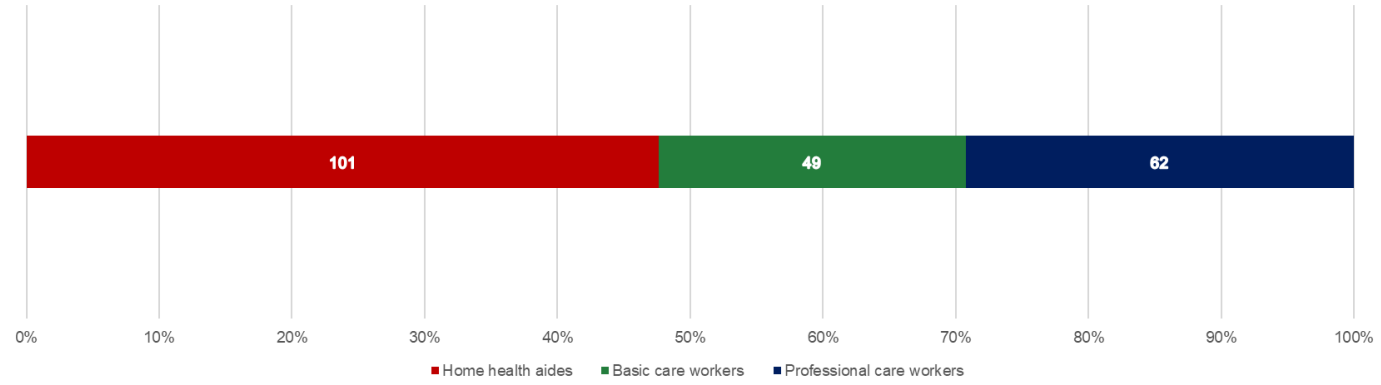
[17] Bingham, A. (2023). From Data Management to Actionable Findings: A Five-Phase Process of Qualitative Data Analysis. *International Journal of Qualitative Methods, 22.* https://doi.org/10.1177/16094069231183620.

[18] Anguera, M. T., Portell, P., Hernández-Mendo, A., Sánchez-Algarra, P., and Jonsson, G. K. (2021). Diachronic analysis of qualitative data. In A.J. Onwuegbuzie and B. Johnson (Eds.), *Reviewer's Guide for Mixed Methods Research Analysis* (pp. 125-138). London: Routledge.

Chapter 6. Who Took Part in the Focus Groups

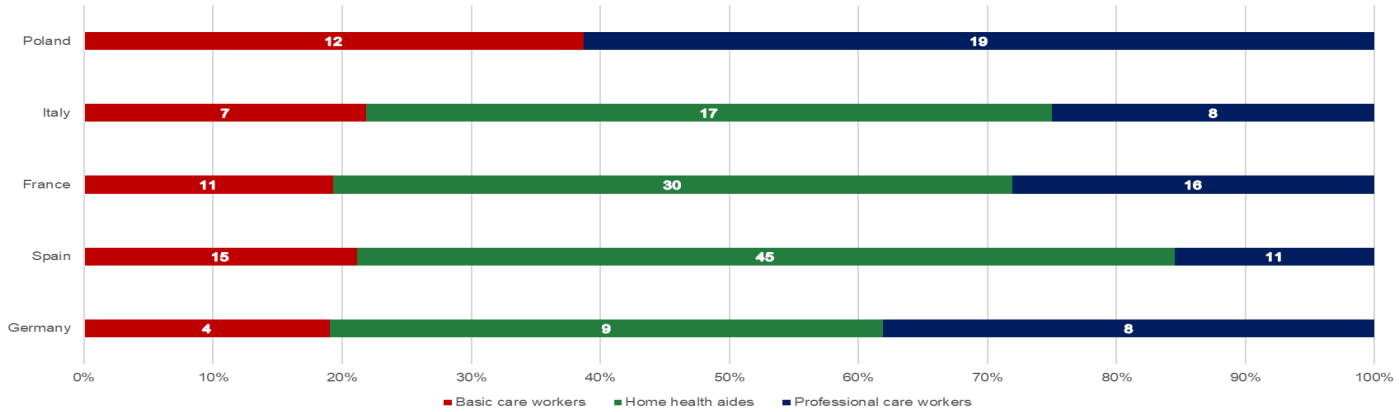
This qualitative study draws on data from 212 care workers across five European countries: Spain, Germany, France, Poland, and Italy. Participants were engaged in various types of care work, including home-based care and institutional settings. The sample comprised 101 home health aides (Target A), 49 basic care workers (Target B) and 62 professional care workers (Target C). Among home health aides who answered their work modality 39.3 % were live-in home care workers while 60.7 % were live-out home care workers.

Figure 83. *Targets*



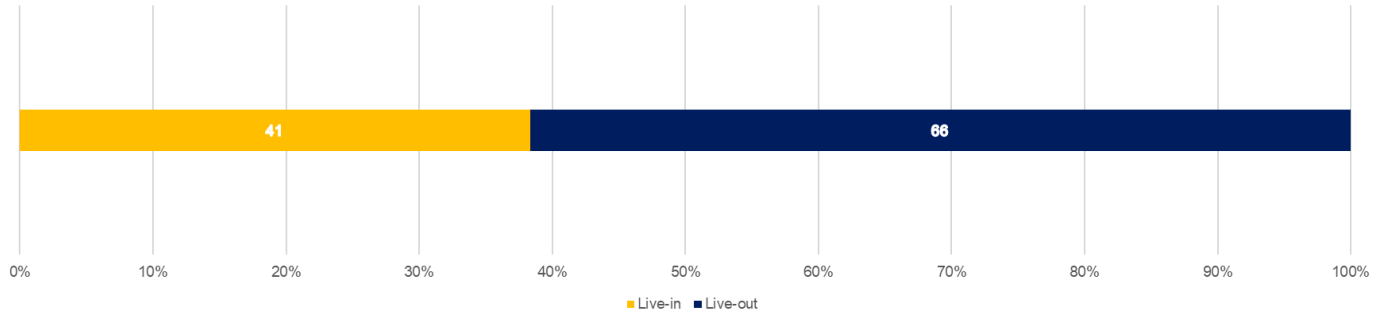
Note: **Home health aides** (target A), **Basic care workers** (target B), **Professional care workers** (target C).

Figure 84. *Targets per country*



Note: **Home health aides** (target A), **Basic care workers** (target B), **Professional care workers** (target C).

Figure 85. *Modality of home care*



6.1. Gender

Participants were predominantly female (90.5%), with only 9.5% identifying as men. By target, gender distribution is similar to the overall sample. Among home health aides, 9% identify themselves as men and 89.3% as women; among basic care workers 10.3% were men and 89.7% women; among professional care workers 9.7% were men and 90.3% women. Related to the country, Poland reports 3.3% men and 96.7% women; Italy shows 15.7% men and 84.3% women; France presents 10.5% men and 89.5% women; Spain 8.5% men and 91.5% women and Germany whose gender distribution is the same as the overall one.

Figure 86. *Gender*

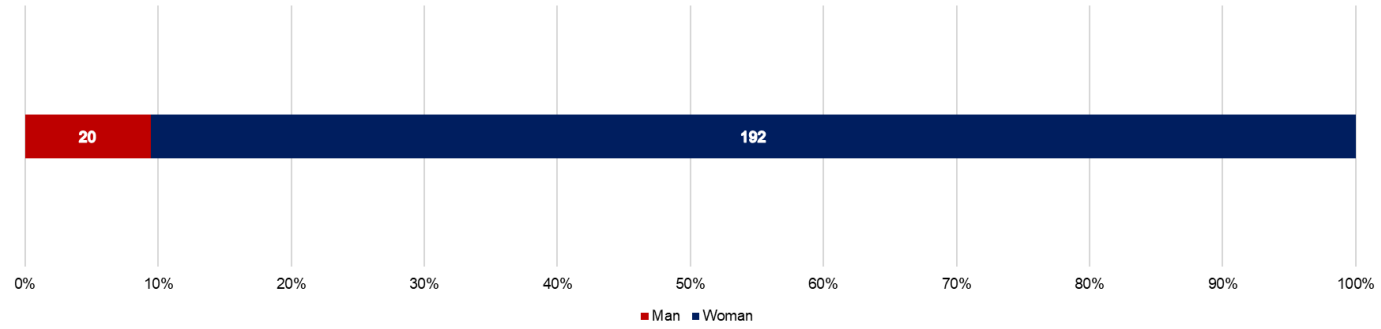


Figure 87. *Gender per target*

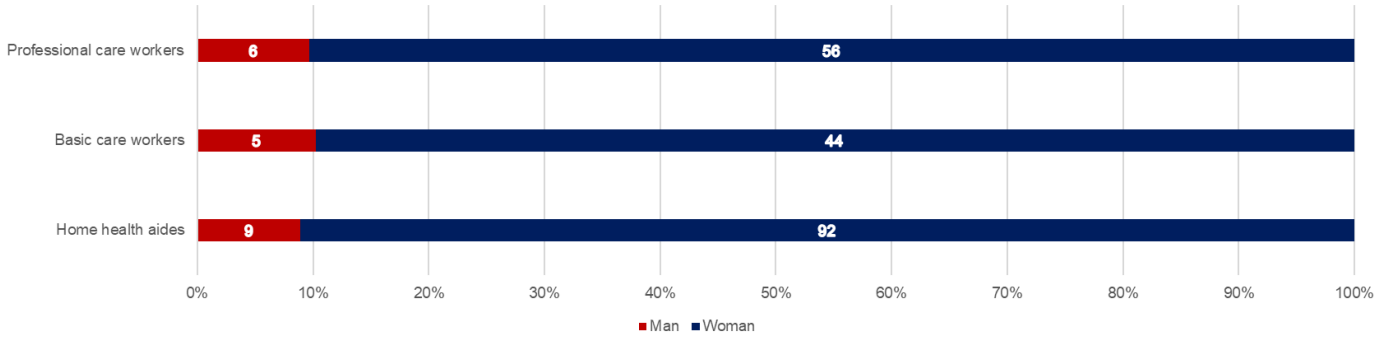
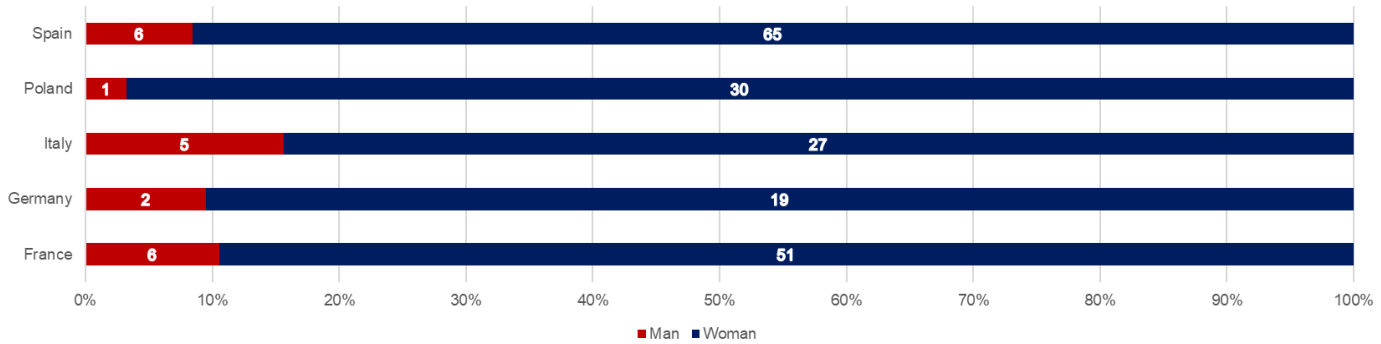


Figure 88. *Gender per country*



6.2. Age

The average age across the sample was 42.6 years. When categorised into age groups 24% of participants were aged 18-34, 44.8% were 50-64, and 30.6% were middle-aged adults aged 50-64. Only 0.6% were 65 or older. It's important to notice that there is only 1 person older than 65 who belongs to the professional care workers group. Per country, Italy shows a distribution that differs from the others, with a higher proportion of adults and middle-aged-adults, and a notably lower proportion of younger adults.

Figure 89. *Age*

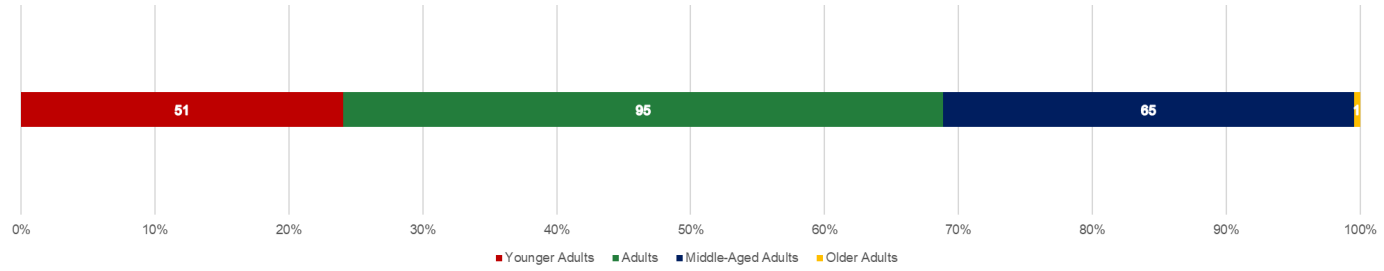


Figure 90. *Age per target*

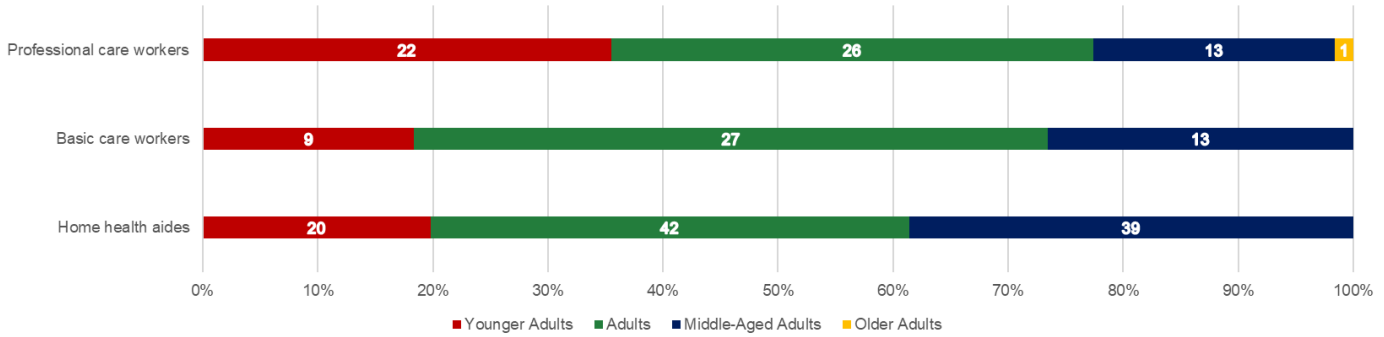
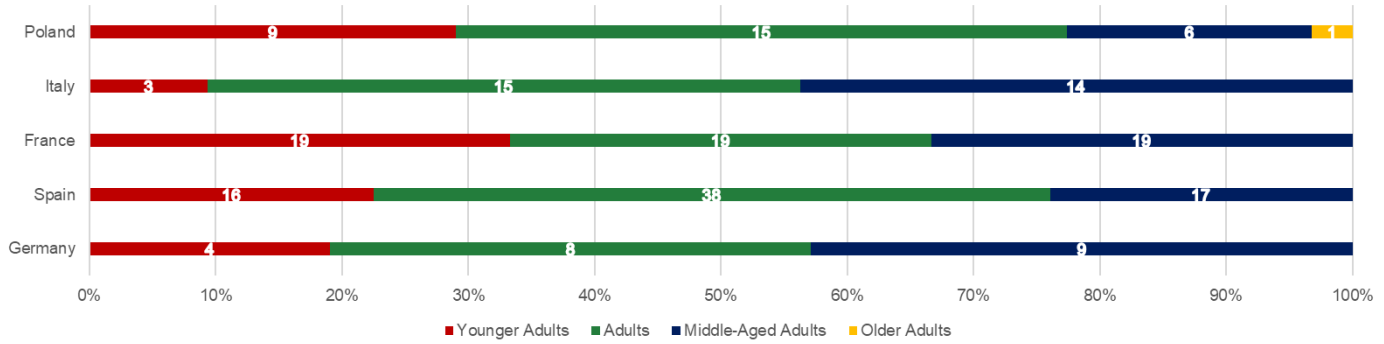


Figure 91. *Age per country*



6.3. Education

In terms of education 30.6% of the overall sample reported no training related to care activity, 15.09% attended at least a short course, 19.81% had a technician diploma in care sector and 34.5% had university studies. Home health aides had the lowest level of education, followed by basic care workers and finally the professional care workers whose majority had university attendance.

Figure 92. *Education*

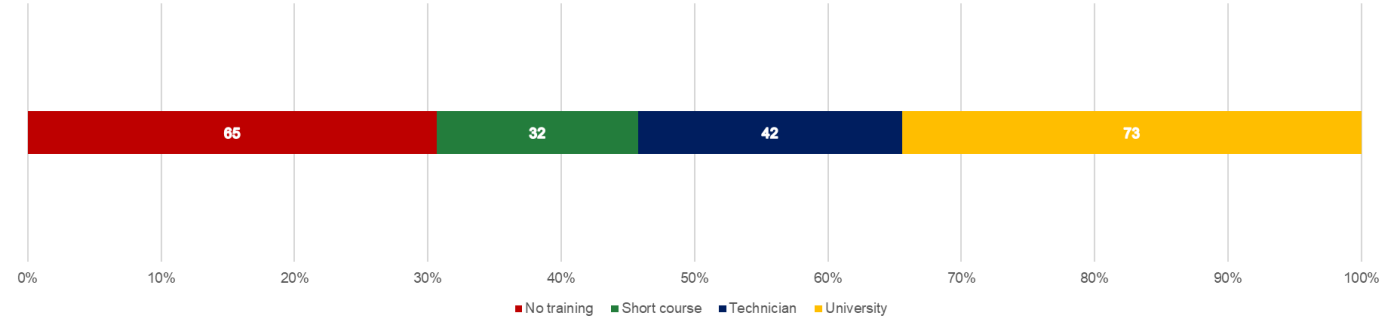


Figure 93. *Education per target*

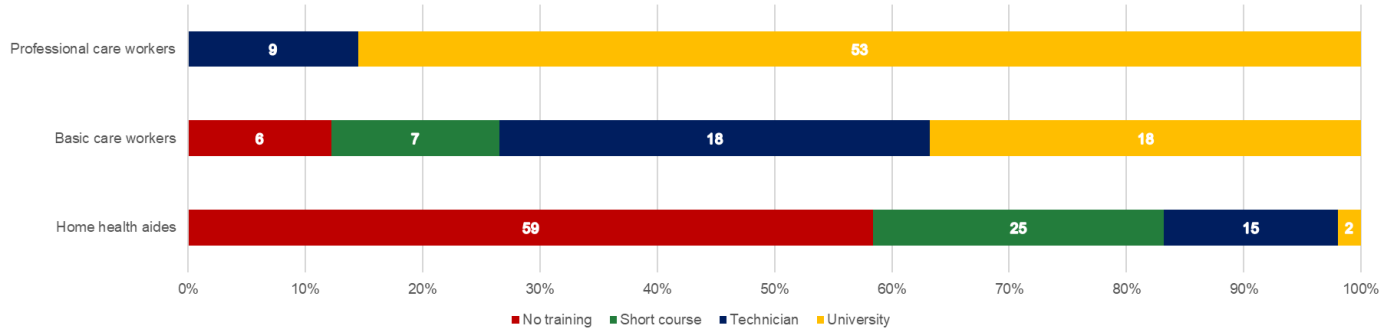
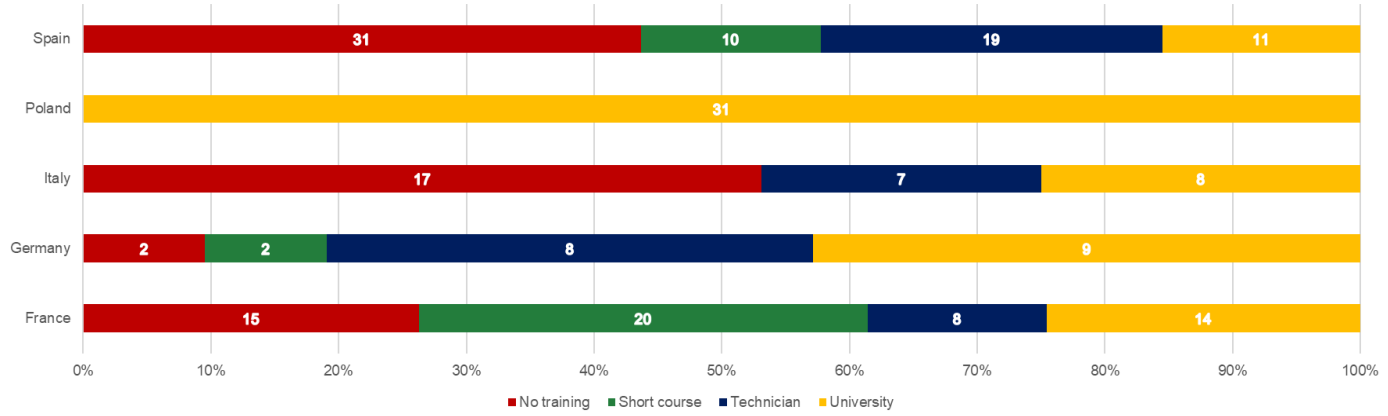


Figure 94. *Education per country*



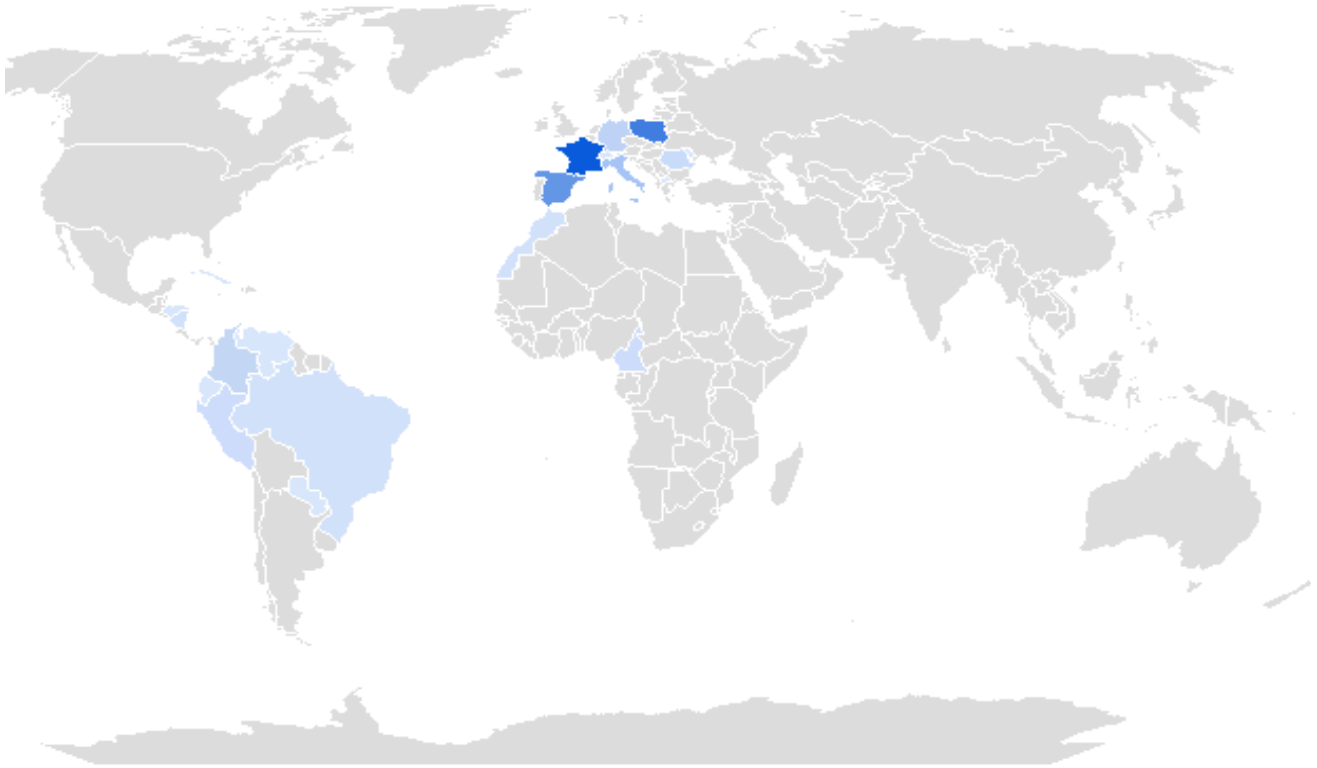
6.4. Nationality and Country of Origin

Most participants held the nationality of one of the countries in which the survey was conducted, with the largest groups being French (29.5%), Polish (22.1%), Spanish (16.8%), , Italian (7.9%), and German (4.2%). Nevertheless, some participants were foreign-born: 19.5% were born outside of their employment country. The most common countries of origin among migrant workers were countries of origin included Peru, Colombia, Nicaragua, Venezuela, Honduras, and several others across Latin America, Eastern Europe, and Africa.

Table 23. *Nationality*

Country	Participants	Percentage
France	56	29.5
Poland	42	22.1
Spain	32	16.8
Italy	15	7.9
Germany	8	4.2
Colombia	7	3.7
Romania	5	2.7
Cameroon	4	2.1
Peru	4	2.1
Nicaragua	3	1.5
Brazil	2	1
Morocco	2	1
Albany	1	0.5
Cuba	1	0.5
Ecuador	1	0.5
Honduras	1	0.5
Macedonia	1	0,5
Moldova	1	0.5
Paraguay	1	0.5
Switzerland	1	0.5
Venezuela	1	0.5
Total	190	100

Figure 95. *Country of origin*



Chapter 7. Care Workers' Voices: Giving Meaning to Risk, Protection, and Coping

The following section presents the key aspects identified in the focus groups. Drawing on participants' personal experiences, the aim is to describe the specific content of the different risk and protective factors, as well as their impact on individual well-being. These factors often do not appear in isolation; rather, everyday life involves the interaction of several of them. Since our objective is to explore in depth the experiences of each of the groups included in this study, the following qualitative results are presented according to each target group. Target A encompasses Home Care Workers, also known as home health aides, whereas targets B and C belong to basic and professional care workers. For a better understanding of the information, the results are presented by differentiating risk and protective factors by target. A Sankey diagram provides information on the frequency of codes identified according to each group. This section explains the categories and subcategories, along with quotations that support the descriptions.

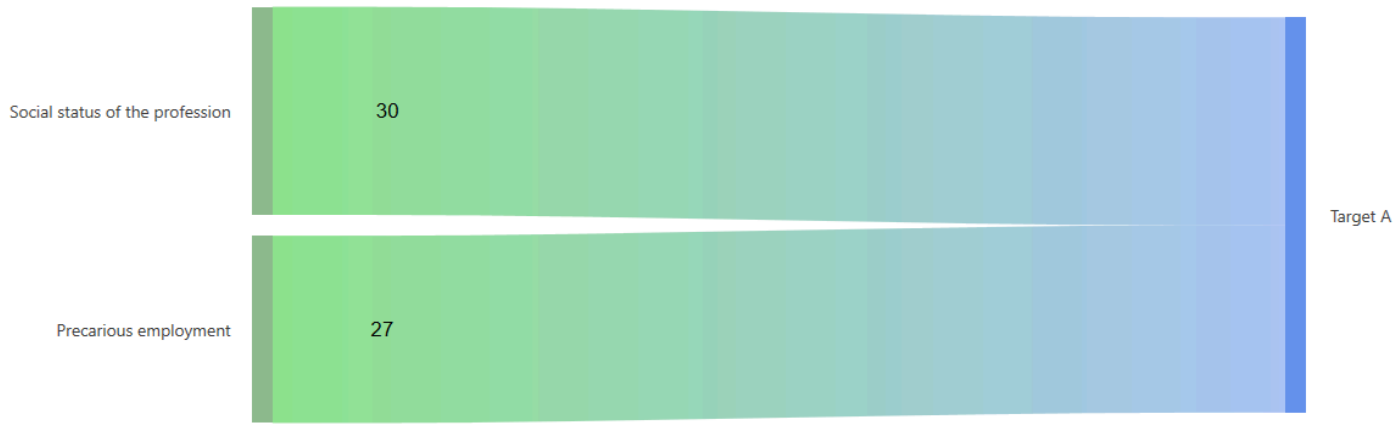
7.1. Home-based Care

The results presented below refer to care professionals who provide support in domestic or outpatient settings—often without formal training—to older adults, people with illnesses, or others requiring assistance at home.

7.1.1. Risk Factors

Context Risk Factors

Figure 96. *Context risk factors at home care workers group*



Social Status of the Profession. Home care workers describe a persistent experience of social and institutional devaluation, marked by symbolic invisibility, role confusion, and the absence of formal recognition—all of which undermine their professional status and identity.

Social undervaluation and role confusion. The testimonies reveal a deep sense of social, institutional, and symbolic undervaluation of home care work. Workers report that their role is frequently confused with domestic cleaning tasks, reinforcing stigmas such as being seen as mere "maids" or cleaners, which undermines the professional recognition of their actual function: caring for vulnerable individuals with complex physical and emotional needs. As one participant put it: *"They already see the mop coming in."* (FG1 ES Target A).

Professional invisibility and lack of recognition. This devaluation manifests on multiple levels. Symbolically, many workers express feeling invisible to institutions, care receivers, and their families. Structurally, they highlight the lack of formal recognition, legal status (in the case of migrant caregivers), and a distinct professional category. Added to this is the absence of unions, collective representation or strong associations to amplify their voices. One participant stated bluntly: *"We don't have any kind of rank... we don't have status. We are nothing."* (FG5 ES Target A).

Post-pandemic invisibility and personal dignity. The COVID-19 pandemic, though it briefly made their role more visible, did not lead to lasting change. Workers reported that they quickly returned to being invisible: *"During COVID we were heroes, and now we're invisible again."* (FG2 FR Target A). The lack of recognition also impacts personal dignity: many feel they are treated as disposable and interchangeable, despite taking on emotionally and physically demanding responsibilities. A migrant worker summarised it as: *"I would enjoy the job if at least I were treated like a human being."* (FG1 DE Target A).

Impact on recruitment and professional identity. The low professional status has structural consequences: it discourages training, hinders generational renewal, and perpetuates a cycle of precariousness, abandonment, and demoralisation. In the words of one participant: *"Young people don't last with these working hours. Also because of the lack of recognition."* (FG2 FR Target A). As a result, professional identity relies primarily on the ethical and emotional commitment of the workers themselves—many of whom feel that their personal motivation is the only thing giving meaning to a job that the system neither dignifies nor values.

Overall, the low social status of home care work—anchored in structural invisibility, symbolic devaluation, and lack of formal recognition—has significant consequences for professional identity, workforce sustainability, and emotional well-being. Despite their commitment, many workers feel reduced to invisible, replaceable figures. Without systemic changes to dignify and legitimise this profession, its future remains uncertain, and those who remain in it must continue to draw on personal values to sustain their motivation.

Precarious Employment. Precarious employment is one of the main issues in home care work and manifests in three interrelated dimensions: contractual insecurity, economic insecurity, and low wages. This situation particularly affects migrant workers and those hired through temporary placement systems, resulting in less stability, limited access to employment rights, and greater exposure to unfavorable working conditions. Altogether, this has a cumulative impact on both physical and emotional health, stemming from ongoing uncertainty and prolonged precariousness.

Contractual insecurity. Many home care workers face high levels of job instability. Contracts are often temporary or short-term, with uncertain renewals and no guarantees of continuity. This situation creates constant concern and makes it difficult to plan for the future: : *"There are people who start working for 6 months, then go in and don't stop, and there are people who finish and have to wait 6 months again to start working"* (FG4 ES Target A); *"Sometimes you don't even get a contract... I ask for one and they don't give it to me"* (FG9 ES Target A).

Undocumented migrant workers are in an even more vulnerable position: they accept jobs without a contract or under unclear conditions, often lacking sufficient information about the tasks or the person they will be caring for, which increases their exposure to abuse. One live-in home care worker reflected on how formalisation changes the experience: *"You go through very hard times when you're not regularised... they skimp on food, they want to give you leftovers... but when I formalised and had a contract, everything changed"* (FG5 ES Target A).

Differences are also evident within the formal system. Workers on permanent contracts enjoy greater stability and access to rights, while those hired from temporary placement lists face continuous reassignments marked by last-minute changes and uncertainty. As explained in one group: *"All of us here are from the substitute list... it's not the same as having a permanent position"* (FG4 ES Target A).

This contractual insecurity, affecting both the formal and informal sectors, can contribute to emotional distress and the sustained precarisation of care work: *"I have stress here at home, I go to work, I have stress... the company just thinks of money. They*

don't care that at some point we'll burn out. Last year, five of my colleagues burned out and changed sectors… I'm at the edge of burnout myself" (FG1 DE Target A).

Economic instability is a constant feature of home care work, although it takes different forms depending on the type of employment arrangement. When employment is managed through companies or formal services, workers frequently face changes in assignments, schedules, or service duration—often communicated with little notice. This makes it difficult to predict monthly income, especially when time lost due to hospitalisation, absence, or family decisions is not compensated. As one participant explained, *"If the care receiver goes to the doctor and you don't work that day, you don't get paid"* (FG4 ES Target A).

Delayed payments, deductions for unmet hours, and inconsistent application of overtime rules further deepen this insecurity: *"One month you work the same hours and earn 600€, the next month with the same care receivers and hours, you earn 800€"* (FG2 ES Target A); *"You don't even know how much you're going to get paid at the end of the month… Every month is different"* (FG4 ES Target A). Some workers even face deductions when care receivers cancel appointments or take holidays: *"If the care receiver is hospitalised, I don't get paid… And at the end of the month I've been working but I don't get my full salary"* (FG4 ES Target A).

In direct employment by families, especially in informal arrangements, this instability is even greater. Migrant workers without legal status report accepting jobs without contracts and with unclear conditions, which prevents them from claiming their rights or even receiving basic guarantees like food or payment on time. *"We've all gone through hard moments when you're not formalised—like when they cut your food or give you leftovers"* (FG5 ES Target A).

This financial uncertainty—marked by irregular payments, unpaid hours, and unpredictable wages—adds to workers' daily strain, as reflected in their repeated concerns about income and stability.

Low pay. Even when employment offers some stability, wages are widely perceived as insufficient given the physical and emotional demands of care work. Many participants highlighted that they earn the same—or even less—than other workers performing simpler tasks under similar conditions: *"We don't earn anything special here… and in another organisation, for example, it's even less, but you're doing exactly the same work, with the same conditions"* (FG4 ES Target A).

In live-in care, some workers reported extreme situations of long working hours and constant availability for very low pay: "*Working 54 hours a week and having 1200 euros a*

month is very little" (FG5 IT Target A); or even being on call 24 hours a day for 1500 euros, with no distinction between rest time and work: *"In the contract it was not this, I had 1500 euro and I worked 24 hours a day, when I say 24 hours a day it means that to be called at night maybe 4 or 5 times a night"* (FG5 IT Target A).

This perceived injustice generates frustration and demotivation, reinforcing the structural undervaluation of care work—especially in domestic settings without formal supervision.

The multidimensional precariousness described by home care workers—combining contractual insecurity, economic instability, and persistently low pay—shapes a fragile and uncertain professional reality. These conditions contribute not only to material vulnerability, but also to emotional strain, demotivation, and a sense of being undervalued. While some workers manage to access more stable arrangements, for many the experience of care work remains marked by unpredictability and imbalance, reinforcing the structural fragility of the sector.

Organisational Risk Factors

Figure 97. *Organisational risk factors at home care workers group*

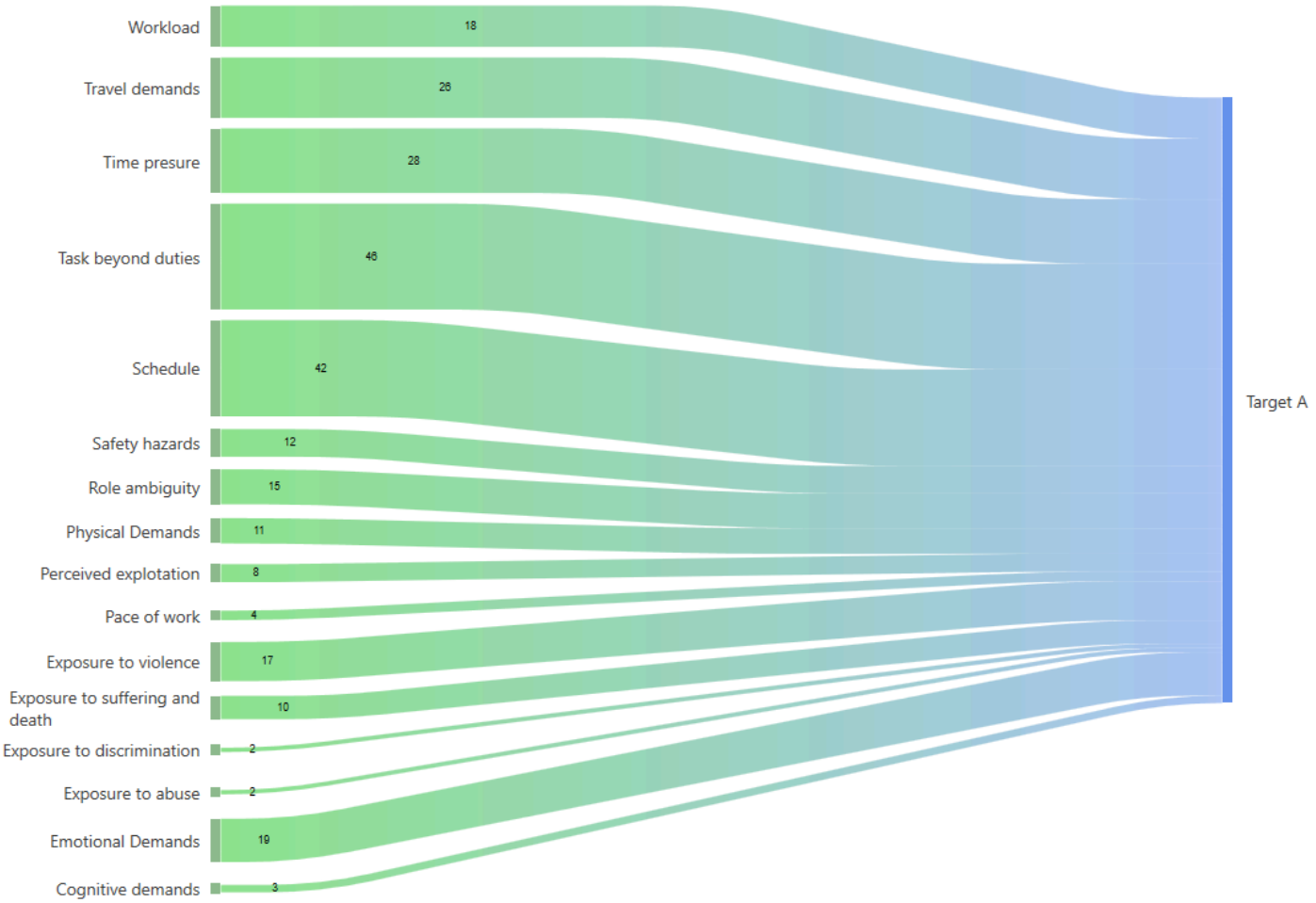
Staff Shortage. Lack of staff in the home care sector is experienced as a structural burden that directly affects work pace, stress levels, and the quality of care provided. Workers report an increase in responsibilities without a corresponding reinforcement of human resources, which forces them to reorganise tasks on the go, work under constant pressure, and reduce the time available for individualised care. This situation leads to frustration, emotional exhaustion, and a clear sense of professional deterioration: *"Before, we had more time and fewer responsibilities. Now, with staff shortages, we have to do more in less time, which increases our stress."* (FG2 FR Target A). The lack of institutional foresight, especially during holiday periods, and the lack of coordination between teams reinforce this perception of

disorganisation and overload. Overall, staff shortages not only prevent the delivery of quality care but also jeopardize workers' well-being and the sustainability of the system.

Lack of Funding. Many participants pointed out that limited service funding restricts the amount of time available for each care receiver, which compromises the quality of care. This situation leads to frustration among workers, who feel they cannot carry out their work properly. As one participant expressed: *"There are people who need more time at home, and we're running out of time to provide quality support, care or work."* (FG4 FR Target A).

Job-related Risk Factors

Figure 98. *Job-related risk factors at home care workers group*



Physical Demands. Home care work is physically demanding, particularly due to the manual handling of dependent individuals in environments with limited technical support. Participants describe daily tasks that involve significant strain, often performed without adequate resources or assistance.

Manual handling of people without adequate support. Home care work involves a considerable physical burden, mainly due to the manual handling of older people or those with reduced mobility, often in contexts where technical aids such as hoists are lacking. As one caregiver explained, *"I have to carry her weight myself, whether to get her into the shower, take her to the toilet, or for any other movement I have to do with her"* (FG5 ES Target A). This situation leads to musculoskeletal injuries, chronic pain —especially in the lower back— and persistent fatigue. *"We use the body, because my back hurts at the end of the day"* (FG4 FR Target A).

Limited use of technical equipment. Although technical equipment exists to reduce these risks, its use is not always guaranteed — either due to lack of availability or to organisational routines that prioritize speed or the habit of "doing things as always" over safety. In some cases, the need for assistance is downplayed based on subjective perceptions, as one participant noted: *"He says it's not necessary to use a hoist because she doesn't weigh much... but I do feel it"* (FG5 ES Target A).

Underestimation of physical strain as an occupational risk. This tendency to undervalue the physical effort required in care work reinforces the idea that such strain is just "part of the job," rather than a recognised occupational risk. As another caregiver stressed, *"This is not a 25 kg box of oranges... it's a person weighing 100 kilos, and you have to move them carefully"* (FG1 ES Target A). These assumptions hinder the recognition of physical demands and delay the implementation of effective preventive measures.

Individual responsibility for risk prevention. Taken together, these conditions create a physically demanding work environment where risk prevention depends largely on individual workers, with little structural protection. As another worker concluded, *"I forgot, the biggest problem in my team is posture and back pain. Carrying the elderly... it can take its toll on your body"* (FG4 FR Target A).

The testimonies point to a normalisation of physical strain, where pain and fatigue are viewed as inherent to the job rather than as preventable occupational risks. The lack of technical aids, structural prevention measures, and institutional recognition shifts the burden of safety onto individual workers, reinforcing a cycle of exposure, injury, and long-term harm.

Safety Hazards. Home care workers describe a wide range of personal safety hazards, which can be grouped into three subcategories:

> Biological exposure. During the pandemic, many professionals worked without proper protective equipment, relying on improvised methods to protect themselves from infection. One worker recalled: *"I made masks out of my daughters' disposable bibs. (...) We doused ourselves in alcohol, and if you had lit a match, we would've gone up like the Fallas in Valencia."* (FG1 ES Target A).
>
> Exposure to fire hazards. Several aides were assigned to homes where family members of the care receiver were consuming drugs or alcohol, creating real danger. One participant explained: *"The grandson was smoking joints in front of me with my mask on, right in the middle of the pandemic (...). I walked out of there completely high."* (FG1 ES Target A). These conditions often forced workers to leave the home during their shifts, preventing them from completing their tasks and increasing emotional strain.
>
> Other environmental conditions. Workers also face risks related to the location, state, or context of the home. Some homes lack phone coverage or pose latent threats, such as aggressive individuals or unsanitary conditions. One aide recounted: *"I got a call from coordination: 'Pack a small bag with her clothes and medication, but make sure the son doesn't see you,' because he didn't want her to be taken away (...). If that man had come in drunk and seen me packing his things, he could've done something to me."* (FG1 ES Target A).

These accounts reveal a systematic lack of risk assessment in home care settings, and insufficient organisational measures to ensure the safety of workers. The pressure to maintain services even in hostile or unsafe environments reinforces a broader feeling of structural vulnerability and neglect.

Travel-related Demands. Travel between care receivers is a core yet often overlooked component of home care work. Participants describe it as a source of daily strain, shaped by inefficient planning, unpaid time, and the physical and logistical challenges of constant commuting.

> Cumulative burden of travel between care receivers. Transport-related demands represent a constant and largely unacknowledged burden for home care workers. Participants highlight the strain caused by inefficient scheduling, long or poorly planned routes, and the cumulative impact of frequent travel between care receivers. These journeys, often unpaid or insufficiently compensated, extend working hours and add to physical fatigue: *"I have to work six hours, but I end up doing seven or eight—and*

no one pays me" (FG1 ES Target A). Some workers report walking long distances across demanding terrains or commuting between distant neighborhoods: *"I've been walking around this town for fifteen years... and the hills are exhausting"* (FG1 ES Target A).

Unplanned travel and schedule changes. The pressure increases when schedules change at the last minute or when unexpected errands are added, making it harder to organise work and rest times: *"Last-minute changes to schedules. Problems related to the organisation of work, such as travel between interventions, can also be a source of fatigue"* (FG6 FR Target A).

Working in unfamiliar or hard-to-reach areas. Some participants also point out the difficulty of working in unfamiliar areas or in places with poor access, which complicates daily logistics: *"Sometimes I find myself in another sector where I don't know the care receivers... or it's in the forest and you can't get a signal"* (FG4 FR Target A).

Personal costs and responsibility for transport. Using personal or company cars implies additional costs and responsibilities, especially in terms of fuel, maintenance, or dealing with work-related wear and tear: *"It's expensive, and we're already on a low salary, so we have to cope with the wear and tear on the car"* (FG2 FR Target A). For several workers, this continuous commuting also consumes personal time and reduces opportunities for rest or family life: *"I spend an awful lot of time on the road... it takes up all my free time"* (FG7 FR Target A and C).

Effects on well-being and daily exhaustion. Beyond the physical and organisational impact, travel demands also take a toll on workers' well-being. The combination of long commutes, irregular hours, and constant schedule changes leads to exhaustion that extends beyond working hours: *"The constant commuting and irregular working hours can be exhausting, and I completely agree that it affects my energy outside work too"* (FG7 FR Target A and C).

Travel-related demands add a layer of complexity to home care that intensifies fatigue and reduces opportunities for rest and recovery. The cumulative effect of poorly compensated commuting, unpredictable scheduling, and the use of personal resources not only impacts physical well-being but also encroaches on workers' personal time and overall quality of life.

Workload Pressures. Workload intensification is a recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.

Increased workload due to staff shortages. Home care workers face a demanding workload that extends beyond basic care tasks, often performed with limited resources and support. Many participants highlight how their responsibilities multiply when colleagues are absent or on leave, forcing them to assume additional tasks without reinforcement: *"For example, last Saturday there were only three care assistants instead of five. We had to reorganise our day and deal with the pressure"* (FG6 FR Target A); *"They tell you: 'I need you to do this, you have to do it, I don't have anyone else,' and you get home at nine o'clock at night saying, I can't take it anymore"* (FG4 ES Target A).

Accumulation of responsibilities and administrative overload. Beyond direct care, the accumulation of responsibilities—such as medication management, health monitoring, paperwork, or unforeseen situations—adds a continuous strain. As one participant pointed out, *"In my role, the stress of responsibility and the workload can be overwhelming"* (FG7 FR Target A and C). Professionals also report having to quickly adapt to the diverse profiles of the people they care for, managing very different cases such as aggression, depression, or cognitive decline. One participant explains: *"you have one person in the morning with a very difficult character [...] then you have another with Alzheimer's [...] another one has a deep depression [...] you have to adapt, cheer her up... At 9:00 p.m., when I get home [...] my head can't process anymore."* (FG2 ES Target A). On the other hand, administrative and training duties are often postponed or neglected because of this overload: *"I'm responsible for the person's well-being, the paperwork, plus my training, which I'm putting aside because it's too much at the moment"* (FG4 FR Target A).

Emotional strain linked to workload pressure. The lack of staff support also increases emotional demands, sometimes leading to guilt or frustration. Workers report feeling morally obliged to respond to every request, even at the cost of their well-being: *"You feel obliged to do everything, but you end up wearing yourself out"* (FG2 FR Target A). Some also reflect on the emotional toll of trying to sustain this pace: *"I was mentally very tired in the evenings because I had a lot of administrative stuff to deal with for my job"* (FG4 FR Target A).

The combination of intensified responsibilities, administrative burdens, and emotional strain creates unsustainable conditions for many home care workers. In the absence of adequate reinforcement, workload pressure becomes a chronic source of stress that compromises both well-being and the capacity to deliver quality care.

Work Pace. In home care, the pace of work is less structured than in residential care, which allows for more personalised attention but also creates imbalances and disorganisation. Some participants, based on their own experience, highlight the difference with residential settings, where —according to them— tasks are more systematised and time is allocated

equally among residents: *"In a nursing home, each staff member does their job... everything is structured and organised"* (FG4 ES Target A). In contrast, in home care, time management depends on the specific situation in each household, sometimes requiring several hours with a single person and, other times, rushing from one visit to another: *"In home care, you might spend three hours with one person and then have to run with the next one"* (FG4 ES Target A).

Care workers emphasize the importance of adapting their rhythm to the needs of older people, whose lives slow down with age and who require caregivers to adjust accordingly. As one participant expressed, *"We have to go at their pace, not ours... everything is more delicate, more gentle, more slow"* (FG5 ES Target A). However, this demand for patience and attunement often clashes with organisational pressures or unrealistic schedules, forcing workers to rush despite knowing that some patients need more time: *"Sometimes we have to move as quickly as possible, but we know that some patients need more time"* (FG8 FR Target C). This constant tension between quality care and time constraints leads to frustration and professional discomfort.

Time Pressure. Time pressure is one of the main structural demands faced by home care workers. These professionals are required to perform multiple tasks within very short periods, with no possibility to adjust the allocated time to the actual needs of the people they care for. On top of this, they must rush between homes and often take on tasks beyond their professional role, such as household chores.

The lack of staff, poor work planning, and the inability to extend pre-set visit times lead to a daily routine marked by a constant feeling of being rushed. This dynamic generates high levels of stress, frustration, and emotional exhaustion, and erodes the vocational meaning of care. As one worker put it: *"We don't have enough time to do our job properly. For example, half an hour to get someone up, feed them and dress them is a very short time. When the person needs more time, we're forced to rush things. This can be particularly stressful, especially at weekends, when you're alone with the patients."* (FG2 FR Target A). Insufficient time not only undermines the quality of care but also has a negative impact on workers' physical and emotional health, weakening the sustainability and dignity of home care work.

Schedule Demands. Schedule organisation in home care is a constant source of strain. Split, extended, and irregular shifts complicate rest, family life, and personal well-being. As one worker explained: *"Reconciling work and private life. It's a bit complicated, even though we work in shifts because we finish quite late and start earlier at 7.30am-12pm and 4pm-8.30pm."* (FG7 FR Target A and C). Others describe spending the entire day outside the home, often with unpaid idle time between visits: *"I leave at 8 a.m. and get back at 7:30 p.m.... with lots of gaps in between"* (FG1 ES Target A).

This situation worsens with unplanned coverage demands and understaffing, leading to exhausting days: *"You're working 11–12 hours every day... and you come home saying: I can't take it anymore"* (FG4 ES Target A). The pressure escalates when on-call duties or emergency shifts accumulate over time: *"After two weeks like that, your body doesn't hold up"* (FG4 ES Target A).

Workers also highlight instability caused by last-minute schedule changes and unpaid waiting times between visits: *"I've had to wait an hour or two in the car... and obviously, I didn't get paid"* (FG4 ES Target A). Others report being assigned extra shifts without prior agreement: *"Sometimes they don't even ask... they just assume you'll cover"* (FG4 ES Target A).

Live-in care workers face even harsher situations, like continuous shifts with frequent night calls: *"I worked 24 hours a day... they would call me four or five times a night"* (FG5 IT Target A).

Ultimately, these scheduling practices damage family life, mental health, and job satisfaction. One participant shared: *"The irregular hours disrupt my life... it's partly because of this that I separated from my husband"* (FG7 FR Target A and C).

Tasks Beyond Duties. Home care workers frequently report being asked to perform tasks that fall outside their formal responsibilities. These include household chores, care for other family members, or even medical procedures—demands that are not only inappropriate but often accepted under pressure, exposing workers to conflict and professional risk.

> **Household tasks outside the scope of care work.** The expectation that home care workers perform tasks beyond duties is a widespread issue. This includes deep cleaning, gardening, caring for other family members, or even carrying out unauthorised medical procedures. Such tasks often emerge in contexts where role boundaries are poorly defined, and families hold expectations that blur the purpose of care work. As one participant described, *"Let me give you an example, on 24 December, family dinner at home and when you arrive the next day you find a mountain of dishes in the kitchen... They ask you to pick it up when it's not our job at all. But you have to fight with them not to do it"* (FG1 ES Target A).
>
> **Role misuse and overstepping by family members.** This situation is aggravated by family members assuming that caregivers are available for all kinds of household chores, regardless of their assigned duties: *"They see you enter and say: 'The cleaner is here'... you explain it again and again, but they don't get it"* (FG1 ES Target A). Some workers even find themselves cleaning after live-in staff or relatives who were not part of their responsibility: *"When the live-in left, I was the one who had to clean the room after three months... that wasn't my job"* (FG1 ES Target A).

Emotional pressure to comply with extra tasks. Moreover, caregivers often feel emotionally pressured into accepting these tasks—either out of fear of conflict, to avoid being labeled as uncooperative, or because colleagues have previously accepted similar requests. As one worker expressed, *"If another caregiver has done everything the family wanted for months, when I refuse, I'm seen as the bad one"* (FG4 ES Target A). This is a source of conflict between colleagues in the case of substitutions or changes in care providers. When one caregiver agrees to perform tasks beyond their duties, it ends up impacting the other caregivers and generating conflict.

Performing medical tasks without proper authorisation. The pressure to perform duties outside their scope also extends to clinical situations, including wound care, administering medication, or managing medical devices without proper training or authorisation. *"We end up doing things we shouldn't be doing, like dressing ulcers... if I don't do it, no one will, but that's not my job"* (FG4 ES Target A). This forced flexibility not only puts caregivers at risk of legal and health consequences but also leaves them vulnerable to family pressure and potential blame in case of complications: *"If the company doesn't stand behind you, there's serious criminal liability... even for things like compression stockings or dressings"* (FG2 DE Target A).

The repeated expectation to perform tasks beyond formal duties—whether domestic or clinical—contributes to the erosion of professional boundaries in home care. This not only increases unacknowledged workload but also exposes workers to legal and emotional risks, weakening their ability to assert role limits and maintain a clear professional identity.

Role Ambiguity. Home care workers often encounter discrepancies between what is stated in their contracts and the actual conditions of the job. Unclear information about patients' needs, care expectations, and work conditions gives rise to role ambiguity, which complicates daily tasks and weakens the boundaries of professional responsibility.

Mismatch between contractual information and actual care needs. Role ambiguity emerges consistently from the beginning of the employment relationship through the daily execution of tasks. Workers often report that contracts provide misleading information about the level of autonomy of care receivers, resulting in unexpected overload when encountering high-dependency cases that were not disclosed beforehand: *"They give you a contract for a self-sufficient person, and when you arrive, you see that the person is not really self-sufficient"* (FG5 IT Target A). Some participants even stress that the very notion of "autonomy" stated in contracts rarely matches reality: *"These contracts that say 'autonomous' need to be revised—no elderly person is really autonomous"* (FG5 IT Target A).

Unforeseen tasks and undefined working conditions. This ambiguity extends to unforeseen tasks that exceed agreed responsibilities, such as overnight stays in hospitals or constant night-time care at home. A worker explained how they were expected to stay overnight in a hospital despite their contract stating that night duties applied only at home: *"Night duties are only supposed to be at home, not at the hospital"* (FG5 ES Target A). In other cases, workers described staying awake at night without proper rest for weeks: *"In the morning, after not sleeping or sleeping just a few hours, I'd feel dazed all day"* (FG5 ES Target A).

Lack of clear information on patient conditions and expectations. The lack of clear information on patients' conditions and care expectations often leaves workers feeling exposed when facing complex situations — especially with new patients or emergencies. As some participants noted: *"We don't always have the necessary information on the patients' pathologies or precise expectations"* (FG6 FR Target A); *"It's about not finding yourself alone with complex problems"* (FG6 FR Target A). Others highlighted how unclear or insufficient guidance increases daily difficulties: "*The information we are given is not always clear or sufficient, which complicates our work even more"* (FG2 FR Target A).

Role stretching and unacknowledged responsibilities. Functional ambiguity pushes workers to take on tasks beyond their role out of a sense of duty or pressure, without formal recognition or compensation. Whether it's assuming clinical responsibilities, covering night shifts, or handling tasks unrelated to care, this flexibility is imposed rather than negotiated. As a participant explained, *"I had a lady with depression and psychosis who refused any medications—it was mental torture… and the problem was also the lack of contact with the family"* (FG2 DE Target A). Over time, this dynamic of adapting individually to undefined expectations erodes both working conditions and professional standards in the sector.

Role ambiguity undermines both the clarity and safety of home care work. When expectations are undefined or shift informally, workers face increased pressure, unacknowledged responsibilities, and reduced capacity to set limits. Over time, this contributes to unstable working conditions and a progressive erosion of professional standards.

Emotional Demands. To address emotional demands, three distinct aspects are highlighted: [19] display, sensitivity, and sympathy. Display refers to the need to express certain

[19] Wieck, C., Kunzmann, U., & Scheibe, S. (2021). Empathy at work: The role of age and emotional job demands. *Psychology and Aging*, *36*(1), 36.

emotions at work (such as kindness or calm) while suppressing others that might be considered inappropriate (like frustration or sadness). Sensitivity involves being attentive and perceiving how care receivers feel, even when they don't express it verbally. Sympathy describes the emotional response to another person's suffering or emotions, without becoming personally involved. Additionally, the subcategory involvement has been added to capture situations in which care workers develop a deep emotional bond with the people they care for, making it difficult to maintain emotional distance.

Display. Regarding emotional display demands, a care worker describes the constant effort to remain calm in front of the person she looks after, especially when dealing with emotionally challenging situations such as dementia. Even when she feels unwell or irritated, she tries not to show it: *"all I try to do is to remain, first of all, stoically calm with my charges and not show, for example, my irritation, even when I'm sick or feeling bad."* (FG1 DE Target A). She acknowledges that this emotional restraint sometimes occurs unconsciously. What allows her to cope is having three days off per week, which gives her time to rest and "mentally reset" before returning to work.

Sensitivity. In relation to emotional sensitivity demands, home care workers describe how they must emotionally adapt to the vulnerable psychological states of those they support. They often act as confidants, absorbing the emotional burdens accumulated by care receivers: *"you end up taking all the crap they've been bottling up..."*. (FG1 ES Target A). At the same time, they acknowledge the rewarding aspect of this emotional connection —*"what would I do without you?"* (FG1 ES Target A). — but emphasize the patience and empathy required to match the slower pace, frustrations, and emotional needs of older adults. One caregiver explains how she offers reassurance when care receivers feel abandoned by their families, while another notes that emotional support often means *"acting as a psychologist"* (FG3 ES Target A). This sensitivity involves not only listening and comforting, but emotionally adjusting to the tempo and fragility of the care receivers' lives.

Sympathy. When it comes to demands of sympathy, some workers describe the emotional difficulties they face when trying to build trust and connection in complex situations, especially with people with dementia. In the absence of proper follow-up care, some caregivers resort to uncomfortable adaptive strategies, such as pretending to be a colleague to avoid rejection or aggressive reactions: *"I prefer to tell them that I am X"* (FG7 FR Target A and C). Although they acknowledge these are not ideal solutions — *"It's no good, but at least I can do my job"* (FG7 FR Target A and C) — they feel it is the only viable way to provide support in certain situations. This reflects the emotional pressure involved in sustaining an empathic bond, even when personal limits are being

pushed.

Involvement. On the other hand, involvement is strongly present in the context of home care, where many workers describe an intense and sustained emotional dedication to the people they support. This involvement goes beyond professional duty and creates a strong emotional bond, as one caregiver illustrates: *"I haven't been able to detach from her, because I give myself so fully to her."* (FG5 ES Target A). The connection with those they care for is sometimes experienced as if they were part of the family, which can lead to emotional distress when these individuals are treated unfairly or face difficult situations: *"I care for them, I love them, I don't want anything bad to happen to them. So when he treats you badly, you think: look at all I've done, and still he treats me this way?"* (FG3 ES Target A). This deep involvement also makes it hard to switch off after the workday ends, as another participant explains: *"You're always left with that uneasiness about what you'll find the next day."* (FG1 ES Target A). While this closeness is seen as a source of satisfaction and meaning, it also entails significant emotional risks, especially when there are no adequate spaces to process the impact of loss, suffering, or conflicts with families.

Emotional demands are an integral part of home care, shaping daily interactions and requiring continuous adjustment from workers. Although emotional connection can bring a sense of fulfilment, the sustained effort to regulate emotions, respond to vulnerability, and remain involved without support increases the risk of emotional overload and makes it harder to maintain personal balance over time.

Exposure to Suffering and Death. Home care workers are constantly exposed to situations of suffering, decline, and death, often without access to psychological or institutional support. As they care for individuals over months or even years, strong emotional bonds are formed, making it difficult to remain detached when the person's health deteriorates: *"You can't forget... the person you've bathed, accompanied, and known in good health is dying. It's not possible to separate"* (FG1 ES Target A).

Emotional impact of end-of-life situations and patient suffering. This emotional closeness makes it especially hard to face end-of-life situations or extreme expressions of suffering, such as when patients express a desire to die: *"It's hard when someone tells you again and again that they're tired of living... and you have to keep encouraging them"* (FG5 ES Target A).

Exposure to traumatic events and unsafe situations. Workers also encounter traumatic events, including suicide attempts or domestic violence, often having to intervene alone in unsafe environments. One caregiver recounted: *"I saw him hanging from the*

window… He jumped. He'd been crying out for help" (FG3 ES Target A). Another described witnessing domestic abuse during a shift and having to intervene physically to protect the victim: *"I stepped in and told him, 'You may not love her, but that doesn't give you the right to hit her'"* (FG3 ES Target A).

Emotional toll and lack of support mechanisms. These cumulative experiences lead to deep sadness, helplessness, and emotional exhaustion: *"Some situations are harder to forget than others… There are times I've come home and couldn't hold back the tears"* (FG8 FR Target C). While some workers rely on personal coping strategies or seek therapy—"*What I often do is create little routines to relax. I do yoga in the morning before I start my day, which helps me to stay zen. But sometimes I realise that it's not enough. It's when there are really difficult situations, like patient deaths, that it becomes complicated. At times like this, I call on the services of a therapist to help me through these periods."* (FG7 FR Target A and C).

Prolonged exposure to suffering, death, and traumatic events places a heavy emotional burden on home care workers, particularly in the absence of structured support. The strong bonds developed with care receivers, combined with the lack of institutional mechanisms to process grief or crisis, leave workers to manage these experiences on their own—often at the cost of their emotional well-being.

Exposure to Violence. Home care workers in Italy, Germany, and Spain report having experienced multiple forms of violence from care receivers: physical aggression (hitting, spitting, pulling hair), verbal abuse (insults, shouting, humiliation), and symbolic violence (false accusations, demeaning treatment). In most cases, these episodes are linked to neurodegenerative conditions—such as dementia—that affect the behaviour of those being cared for. These situations are exacerbated by the isolation of the private home environment, the lack of institutional oversight, and limited training to manage such conditions. In some cases, workers were forced to leave their jobs abruptly to protect themselves. One participant in Spain described the situation as follows: "*Then the grandmother would chase me, she would chase me to hit me, she told me 'get out of here, I'm going to call the police'… I would hide and lock myself in the room, scared, because it was my first time, I hadn't worked with people with dementia before."* (FG9 ES Target A).

Although some receive support from family members or colleagues, many face these episodes alone, relying on emotional self-control or physically hiding to cope. The daily occurrence of violence and the impunity with which it happens reinforce a sense of helplessness.

Exposure to Abuse. Home care workers report experiences of sexual, physical, and verbal abuse by care receivers, occurring in private settings without supervision. Some participants described situations where agencies or employers were aware of the abuse but allowed the employment relationship to continue: *"It was still with sexual overtones...It's really awful. But this company knew it... This company knew everything... but acted as if it wasn't happening"* (FG2 DE Target A). In other cases, when the caregiver was hired directly by the family, there was no structural support to intervene or mediate repeated harassment. One home care worker recalled: *"He took his clothes off and said: 'Come touch me'... I told him I'd call his children. 'No, no, I won't do it again,' he said"* (FG9 ES Target A).

In these situations, workers are left to manage the abuse on their own, facing professional isolation, power imbalance, and economic dependency. As one participant put it, *"I take a deep breath and say, 'I'm leaving, I'll pick up my things and go,' and then he says, 'no, no, don't go, I'll die'"* (FG9 ES Target A). The normalisation of such behaviours—often justified by the age or health condition of the care receiver—reinforces their invisibility and perpetuation.

Exposure to Discrimination. Some migrant home care workers report experiences of discrimination and racism linked to their foreign origin, often expressed by care receivers or their families. These situations include derogatory remarks and rejection, which directly affect the emotional well-being of the workers and reinforce feelings of exclusion. As one participant explained, *"There are Italians who don't accept you... even racists... and also certainly good families who accept you and value the work we do"* (FG5 IT Target A). Another mentioned, *"Then the fact that you are a foreigner... a bit of racism... a bit of a lot of things"* (FG5 IT Target A).

This discrimination takes place in private homes, with no witnesses or oversight, making it difficult to report and contributing to its normalisation. Although some workers also recount positive experiences with families who appreciate their role, the lack of institutional support and the isolation typical of home care amplify the emotional impact of discriminatory treatment.

Perceived Exploitation. The perception of exploitation among domestic care workers spans labour, legal, and emotional dimensions, revealing normalised abuses that undermine their health and dignity. Many report extremely long working days—from 08:00 to 21:30—combined with multiple household tasks, without rest or holiday pay: *"I had to iron every day. Five people. For 900€. I went out every fifteen days, they didn't pay me holidays or rest days"* (FG9 ES Target A). While some families are kind, this does not compensate for the workload or the absence of boundaries.

> Abusive recruitment and informal intermediaries. The recruitment of migrant workers through informal intermediaries deepens the precariousness: *"He charged 1600€, gave*

us 600€, and didn't pay social security. He told us we were registered" (FG9 ES Target A). On top of this are abusive conditions in which the supposed rest time is not respected. Live-in workers, who already carry out tasks during the day, are also required at night: *"They didn't respect me, they would come at 11 p.m. asking me to iron pyjamas. […] Even if it's your room, it's not respected"* (FG9 ES Target A).

Overwork and insufficient resources for quality care. Work demands far exceed the resources available. High-quality care is expected even in complex situations, yet without the necessary staff or time to deliver it: *"Even if you are a very good worker, you cannot provide quality care under those conditions"* (FG9 ES Target A). This contradiction generates both professional and emotional frustration.

Lack of respect for rest time. The right to rest is systematically violated. A caregiver in Germany was ridiculed for requesting a day off: *"A day off? None of them ever asked for that"* (FG2 DE Target A). Even though she was aware of her rights, she was only offered "free" hours under supervision: *"Basically I couldn't go out. Families pretend. They treat us like modern slaves. […] It's written '24-hour help' in the documents"* (FG2 DE Target A).

Legal vulnerability and impunity for abuse. Exploitation also extends to the legal sphere. A Polish worker had to go to court to recover one month's unpaid wages: *"The company disappeared. The case went to court and then to a bailiff"* (FG2 DE Target A). She denounced legislation that allows the creation of agencies with minimal capital, facilitating impunity for fraud: *"This is human trafficking—hard work without pay"* (FG2 DE Target A).

Taken together, these accounts reveal a system that makes rights invisible, normalises abuse, and devalues care work as a profession. Exploitation goes beyond physical exhaustion: it involves legal vulnerability, degrading treatment, and sustained psychological strain.

Cognitive Demands. Home care work entails a significant cognitive load, marked by constant reflection, self-monitoring, and autonomous decision-making. Workers describe living under continuous self-questioning, wondering whether they have handled situations correctly or fulfilled their responsibilities as expected. As one participant put it: *"We ask ourselves questions: Has the situation been well managed? Did we take our responsibilities properly? Sometimes we'd like a doctor to reassure us, but that's not always possible"* (FG8 FR Target C).

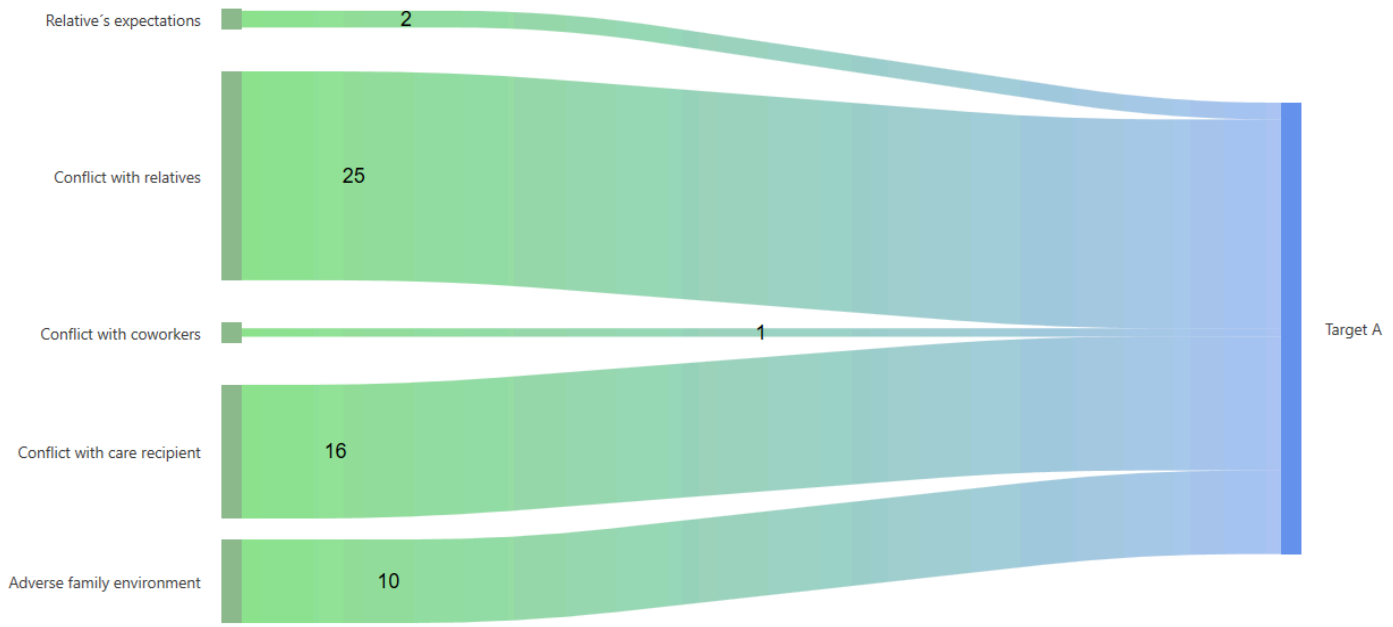
This persistent mental load often carries over beyond working hours, affecting workers during their free time, commutes, or even at night: *"We always think after we've seen a care receiver… I sometimes even think about it at night or during the journey"* (FG4 FR Target A). Some participants also highlight the strain caused by the solitary nature of home care, where

responsibilities are less shared than in institutional settings: *"At home, responsibilities are less shared than in hospital... this mental burden is sometimes heavy"* (FG8 FR Target C).

These cognitive demands—arising from decisional solitude, high self-expectation, and limited institutional support—emerge as a source of strain that extends the psychological impact of work into personal life, as reflected in participants' accounts of constant worry and mental overload.

Relational Risk Factors and Conflicts

Figure 99. *Relational risk factors and conflicts at home care workers group*



Conflicts with Coworkers. In home care, conflicts with coworkers are also reported, for example when a home care worker takes on tasks that do not correspond to her role, as illustrated by this quote: *"A substitute arrives and does tasks that don't belong to her [...] and then there's trouble. She's doing tasks that I don't do"* (FG3 ES Target A). By taking on tasks outside the defined role, expectations are created that later fall on the regular worker, causing discomfort and sometimes prompting questions from families about why some workers perform certain tasks and others do not.

Conflicts with Care Receivers. Conflicts between home care workers and care receivers take three main forms: role conflict, task-related, and emotional. These situations affect not only the organisation of work but also emotional well-being and the perception of fairness in the workplace.

Role conflicts. Many workers report contradictory demands from care receivers: *"if I did it, it was bad, and if I didn't do it, it was also bad,"* (FG5 ES Target A) which creates constant insecurity. Some care receivers demand tasks outside the scheduled work plan: *"she says to me: 'here, take the bucket with the cloth…'"* (FG4 ES Target A), and tensions arise when workers refuse to carry out inappropriate tasks: *"don't come to my house tomorrow, because if you're not going to bleach that, what do I need you for?"* (FG2 ES Target A) Comparisons with other workers also trigger conflict: *"the other one did it for me, this one doesn't want to,"* (FG3 ES Target A) causing discomfort with the care receiver and their family.

Task-related conflicts arise mainly due to a lack of clear information about service rules and operating protocols. Many workers discover over time that there are conditions nobody informed them about, leading to misunderstandings with care receivers and their families. One caregiver explained that after a year working with a couple, she found out: *"if the husband is not home, I'm not supposed to do anything,"* (FG3 ES Target A) and when she tried to explain this, she was insulted over the phone. These situations show how institutional silence leaves workers exposed to conflicts that could be avoided with better communication. Tensions are also common when family members misinterpret the worker's role or schedule, blaming them for unplanned visits: *"I was stuck in the middle."* (FG3 ES Target A). Another source of conflict emerges when care receivers refuse to follow professional advice and force workers to take physical risks, such as lifting them without assistance: *"you're the one who has to lift me."* (FG3 ES Target A). This dismissal of professional judgment reinforces an unequal work relationship, resulting in overload, insecurity, and emotional strain.

Emotional conflicts. Workers describe dynamics of manipulation or emotional control, where care receivers use relatives or others around them to pressure the caregiver: *"she tells him, and he passes it on… tell that to the caregiver,"* (FG3 ES Target A) creating an atmosphere of tension and surveillance. Some workers face unjustified reproaches or hostile silence *"how can I react like this? If you're saying all of that to me"* (FG3 ES Target A), while others become involved in emotionally charged situations, such as one care receiver who left a note explaining why he didn't want to continue a prescribed treatment. In many cases, workers feel trapped between the desire to help and the inability to set boundaries without consequences: *"he needed to talk… but it wasn't possible, because she didn't want it."* (FG3 ES Target A).

Overall, these conflicts reflect the fragility of labor relations in home care, where workers are often exposed to both structural and emotional pressures without institutional support. The combination of contradictory demands, unclear rules, and unacknowledged emotional

expectations poses a significant risk to their mental health and job stability.

Conflicts with Relatives of Care Receivers. Conflicts with relatives of the care receiver are a frequent source of strain for home care workers. These tensions arise when families fail to respect professional boundaries, question workers' decisions, or project their own frustrations onto the caregiver. Three main subtypes can be identified: role conflicts, task-related conflicts, and emotional conflicts.

Role conflicts. A common form of role conflict emerges when family members make disproportionate demands that go beyond the caregiver's professional role. Some workers report being unfairly blamed for the emotional well-being of the care receiver, such as when *"the family members don't understand that all the mother needs is a daily phone call... and they make you feel responsible if she cries."* (FG5 ES Target A). Others describe having to give up their rest periods or adjust their schedules to meet the relatives' expectations: *"I can't leave at the time I'm supposed to, but I have to be back at the exact time he says."* (FG5 ES Target A). These demands undermine their labor rights and often include the delegation of domestic tasks that fall outside their responsibilities: *"they want me to clean the entire kitchen so they don't have to."* (FG2 ES Target A).

Task-related conflicts. Another recurring issue involves task-related conflicts, where relatives attempt to assign chores or responsibilities that exceed the agreed-upon care plan. Some caregivers have been confronted or even forced out of the home for refusing to clean up after family members or care for additional people: *"I clean the grandfather's room... what's yours, you do yourself."* (FG1 ES Target A). They also describe pressure to perform tasks in ways they consider inappropriate or unsafe, or to replicate the routines of other caregivers: *"the regular one does it every day, and now I show up and everyone is protesting."* (FG4 ES Target A). This pressure to take on extra duties creates friction, particularly when families expect the caregiver to manage the entire household.

Emotional conflicts often stem from distrust, emotional detachment, or power dynamics between the caregiver and the relatives. Many workers say the relationship with the family is more difficult than with the care receiver: *"the family watches everything you do, you've got cameras pointed at you... it stops being a job and becomes something unbearably difficult."* (FG9 ES Target A). Some face constant suspicion or verbal attacks, especially when family members choose to believe accusations without question: *"if the mother says the caregiver steals, who do they believe? The mother."* (FG9 ES Target A). In contrast to the emotional bond often formed with the care receiver, workers feel rejected or undervalued by the family: *"my care receivers are like family to*

me, but the relatives are not." (FG3 ES Target A). In some cases, these tensions push caregivers to speak up after long periods of silence: *"If the family doesn't like me or treats me badly, I respond! [...] Because it's been many years that I've been silent."* (FG3 IT Target A). This emotional climate of control, disregard, and lack of trust significantly impacts caregivers' well-being.

These conflicts reveal a persistent imbalance in the relationship between home care workers and the families of care receivers. When professional limits are disregarded and trust is lacking, workers are exposed to unfair demands, emotional pressure, and even hostility. The absence of institutional backing further intensifies this vulnerability, making family relationships a critical source of stress in home-based care.

Expectations from Relatives. Some care workers identify the need to manage unclear or disproportionate expectations from families as a source of difficulty. These expectations are not always explicitly communicated and can create tensions or frustration for both families and workers. As one participant stated, *"The main challenges I face relate to organisation and the sometimes unclear expectations of care"* (FG7 FR Target A and C).

Another caregiver highlighted that managing families' expectations can become an additional task in itself: *"The challenges I face even include having to manage the expectations of patients and families, which is very complicated at times"* (FG7 FR Target A and C). Managing these excessive expectations from families represents an added challenge that goes beyond the caregiving role, and it often falls solely on the workers.

Dysfunctional or Adverse Family Environments. Some home care workers describe how the family situations of the people they care for pose a significant obstacle to their work. These conditions not only affect the well-being of the care receiver but also create physical and emotional difficulties for the professionals. A common situation is family disorganisation, where caregivers must navigate chaotic and unstable environments. One participant recounts: *"It was a very large family [...] the care receiver was the mother, and the poor mother was kind of pushed aside [...]. You went there to care for her, but you had to fight your way through to reach her."* (FG1 ES Target A).

Unsafe environments linked to substance abuse and aggression. Environments marked by substance abuse and aggressive behaviour are also described. Some professionals mention households where individuals with active addiction are present, creating risky situations that hinder or make it impossible to provide proper care. *"The son was an alcoholic. The grandson smoked joints in front of me while I wore a mask in the middle of the pandemic,"* (FG1 ES Target A) a worker explains. In some cases, the danger of the environment has been such that police intervention was required.

Family neglect and emotional impact on care workers. Another dimension of the adverse environment is the emotional neglect or absence of family members. Many workers express the emotional toll caused by abandonment, especially by the children, which affects both the care receiver and themselves. A participant explained: *"That feeling, that absence of the son who doesn't call [...] we are the ones who have to face that situation"* (FG5 ES Target A). In these cases, caregivers are treated as family substitutes, without any emotional recognition: *"they just say: look, there's your caregiver, she'll take care of you, we'll handle the payment and that's it."* (FG5 ES Target A).

These experiences show how certain family configurations represent a structural source of adversity that directly impacts the workers, forcing them to take on responsibilities that clearly go beyond their professional role.

Personal Risk Factors

Figure 100. *Personal risk factors at home care workers group*

Overcommitment. Many workers display a high level of overcommitment that goes beyond their contractual obligations. This is expressed as constant dedication, motivated by the desire to do a good job and provide quality care, but also by structural and ethical pressures that make it difficult to separate professional responsibilities from personal life. This overcommitment manifests itself in different ways—ranging from being permanently available to assuming a strong sense of responsibility at work.

Be available. One of the most common expressions of overcommitment is the expectation of permanent availability in the face of unexpected changes. Some workers express frustration when they are forced to cancel personal plans due to last-minute interventions: *"We have a life, and when they change the schedule without warning, it's frustrating."* (FG2 FR Target A). Although in theory they could refuse, many feel morally obliged to accept for the sake of the care receiver: *"I know I could say no, but if I don't accept, they don't have anyone else and I'm thinking mainly of the care receivers, so I*

accept." (FG2 FR Target A). This availability is not always a free choice, but rather a form of implicit pressure that turns flexibility into a constant requirement.

Sense of responsibility at work. Overcommitment also manifests as a strong sense of professional responsibility. Even when caregivers acknowledge that perfection is unattainable, they strive to do their best: *"We always try to do our best, even if we know that perfection is not always possible. We have a lot of resources at our disposal, but it's important to know how to use them effectively and to remain open to exchanges with other professionals"* (FG8 FR Target C). This attitude reflects a deeply internalised ethics of care, based on commitment and cooperation with other professionals.

Ultimately, overcommitment may be perceived as a professional strength, but when it is not supported by clear boundaries or institutional backing, it can lead to cumulative strain. The risk is that this constant availability and sense of duty become normalised, sustaining a care model that relies on the self-sacrifice of workers rather than on fair conditions and shared responsibility.

Foreign Language. The language barrier is a significant challenge for many migrant care workers, especially at the beginning of their employment. As one participant recalled, *"For me it was when I arrived that I didn't know a single word of Italian. This was a door in the face for me"* (FG5 IT Target A). The difficulty of not knowing the language extends beyond communication, as it can also prevent workers from understanding their rights and legal obligations. One caregiver noted, *"I have this impression that if we don't know German well, we don't know German law well and we won't demand something… that's why you have to fight for your rights"* (FG2 DE Target A).

In this context, language limitations may expose workers to unclear or unfavorable employment conditions, especially when information about duties or contracts is not fully transparent. As one participant explained, the absence of translators or language support meant having to learn care work, language, and job expectations simultaneously: *"There were no translators… I didn't know the language when I started this job, so I had to learn care, learn the language, and work 16 hours a day"* (FG1 DE Target A).

Moreover, care work itself is a highly communicative profession that relies on clear interaction with care receivers, families, and agencies. As expressed by a participant, *"Communication must be absolute… You have to know the language"* (FG2 DE Target A). Without sufficient language skills, workers face greater emotional strain and increased risk of misunderstandings in daily care tasks.

Non-Work Risk Factors

Figure 101. *Non-work risk factors at home care workers group*

Family Care Responsibilities and Work-Life Conflict. The personal and family lives of home care workers deeply intersect with their professional obligations, often generating chronic stress, emotional fatigue, and significant sacrifices in their private sphere. This intersection is shaped by various structural, organisational and personal factors that hinder a healthy balance between caregiving and personal life.

Family care responsibilities and emotional burden. The personal and family circumstances of home care workers have a decisive impact on their emotional wellbeing and their ability to sustain their work. Many live with young children, elderly relatives or family members with disabilities, which seriously limits their room for manoeuvre. The difficulty of balancing work and personal life is a recurring issue: *"I have a signed reduction in my working hours because I'm responsible for my young daughters [...]. There are so many of us in the same situation"* (FG1 ES Target A). Non-school periods make the situation worse: *"You're being pulled in every direction just to be able to breathe [...] there aren't enough hours in the day"* (FG1 ES Target A).

Domestic responsibilities and emotional stress pile up on top of the demands of paid work, generating constant mental fatigue. As one participant put it: *"Sometimes work really wears you out [...] between the problems you have at home and the problems the care receivers bring you — they want to take everything from you"* (FG1 ES Target A). Other workers speak openly about going through personal crises, pointing out that *"the family overload is just awful"* (FG1 ES Target A). This accumulation of responsibilities with no time for rest also takes a toll on mental health: *"I come home to another 92-year-old, how am I supposed to disconnect from this job?"* (FG1 ES Target A); *"When I arrive at the care receiver's home, I leave everything behind. But when I come back home, it catches up with me [...] I'm arriving, even today, I'm arriving and I'm very tired mentally"* (FG4 FR Target A).

Life circumstances of vulnerable women. The situation is especially hard for women who are separated, widowed or migrants, many of whom lack both family and financial

support. A home care worker explains: *"I've been alone for 14 years"* (FG3 IT Target A); another entered the care sector after a medical operation forced her to leave the hospitality industry: *"I couldn't stand for 12 hours anymore, so my kitchen work came to an end"* (FG5 IT Target A). In the most extreme cases, fatigue becomes chronic: a Polish worker, widowed for twenty years, says she hasn't taken a holiday in eight years and is on the brink of burnout: *"I have stress at home, I go to work, I have stress [...] I can't remember the last time I had a moment to rest"* (FG1 DE Target A).

Unpredictable schedules and constant availability. Balancing work and personal life is a constant challenge for many care workers. Testimonies reveal that, beyond physical exhaustion, work organisation and the constant demand for availability directly affect their private and family lives. Participants describe how changing schedules and the inability to plan personal activities make it difficult to manage daily life: *"You can't plan ahead because you don't know when you'll be on call [...] So you cancel your plans and cover the shift"* (FG4 ES Target A). This lack of control over their time leads to frustration and a sense of personal sacrifice: *"That's how it is, and on weekends, when you're supposed to have time off, you end up doing everything you couldn't do during the week"* (FG4 ES Target A).

Some participants describe pressure from companies to cover shifts outside of their contractual hours, even during holiday periods: *"They asked me if I would cover for holidays. I said no. Then they started pressuring me [...] but my contract is for 30 hours, they can't ask me for more"* (FG4 ES Target A). This kind of forced availability, when imposed without taking into account workers' personal situations, exacerbates distress: *"I had a free morning to go to the pool with my kids and they called me right at that moment"* (FG4 ES Target A).

Moreover, several testimonies mention the emotional strain of being constantly available or having to cancel personal plans at short notice: *"They change our schedule without warning. You feel obliged to accept it, and it's burdensome. Sometimes I have my weekend planned with my family and then I have to cancel everything because they need me"* (FG2 FR Target A). Some participants manage to set boundaries, but many express the difficulty of doing so, especially when the nature of the job fosters a sense of personal responsibility for those they care for.

Emotional spillover and missed family time. This constant overlap between work and personal life extends beyond time management. Many participants highlight how care responsibilities intrude emotionally, making it difficult to fully disengage during free time. Some speak of the mental load they carry home, which affects family relationships or prevents them from enjoying moments of rest: *"The accumulated*

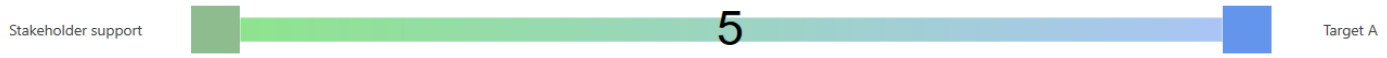
fatigue can really affect us. When we get home, there's a certain amount of tension that can affect our family relationships" (FG6 FR Target A). Others refer to missed family events or milestones due to unpredictable work demands: *"There are days when I start super early and finish late, and that hardly leaves me any time for my family. Like the time I missed my child's birthday because I was stuck at work... That's hard to swallow"* (FG7 FR Target A and C).

The testimonies reveal how care work is carried out under highly demanding conditions and constantly intersects with personal responsibilities, particularly for women with family care duties. The resulting overload—exacerbated by unpredictable schedules, forced availability, and emotional spillover—leads to chronic strain and the erosion of rest, family life, and personal well-being. In the absence of institutional safeguards, balancing both spheres becomes a daily effort sustained by individual resilience rather than systemic support.

7.1.2. Protective Factors

Context Protective Factors

Figure 102. *Context factors at home care workers group*



Stakeholders Support. Trade unions and migrant associations were identified in some cases as potential sources of support for home care workers, offering spaces for guidance, representation, or integration. However, references to these stakeholders were limited and context-specific, suggesting that access to external support structures remains uneven across the sector.

Trade unions as limited support channels. Trade unions were mentioned as potential channels for raising concerns and seeking solutions to labour conflicts, though their effectiveness was perceived as limited. Some participants valued union membership as a way to address irregularities and demand improvements in working conditions: *"If you have a problem, you call the union and if it can be solved, it is solved. Some things can be solved, and others can't"* (FG2 ES Target A). Others mentioned that union affiliation allowed them to voice concerns about working conditions they considered unfair or even unlawful: *"I'm a member of the trade union and soI told my colleague, look, we have to do something about our conditions, because there are many things that are totally illegal"* (FG4 ES Target A).

Migrant support associations as key resources. Migrant support associations were described as key spaces for welcome, guidance, and empowerment. One participant explained how a colleague—who already attended a support foundation—encouraged her to go and even accompanied her the first time, teaching her how to get there by bus: *"She was the one who told me about the foundation... I had never taken a bus here... it was the first time"* (FG9 ES Target A). These associations provided social support, information about rights, and training opportunities. Participants expressed appreciation for these spaces, emphasizing their value for personal growth, emotional support, and community integration: *"They welcome us in a way that makes us feel good, like a family... they support us, and we know they are always there for us when we need something"* (FG9 ES Target A).

Migrant support associations were mentioned only in the home care sector in Spain, and not in other countries, suggesting a lack of visibility or accessibility of such resources in other European contexts. While these organisations were described as valuable sources of guidance, emotional support, and community integration, their limited presence across countries points to a structural gap in the sector. Promoting and recognising these forms of support—alongside trade unions—as part of broader strategies to protect workers' rights and well-being could help reduce vulnerabilities and strengthen care workers' capacity for collective empowerment.

Organisational Protective Factors

Figure 103. *Organisational protective factors at home care workers group*

Respect for Legal Regulations. Respect for labour and contractual regulations plays a central role in shaping the experiences of home care workers. While some testimonies highlight the protective value of legal formalisation, others expose widespread breaches, irregularities, and gaps in enforcement that limit the effectiveness of legal provisions in practice.

Formal contracts as protection. In some cases, having a formal contract has led to tangible improvements in working conditions and relationships with families, including clearer boundaries around schedules and responsibilities. As one migrant care worker explained: *"Once the contract changed, the whole story changed. The content of the contract was different—they respected my schedule more, and the contract stated that they had to provide food. [...] Before, they wanted to give you stale bread or leftovers, as if you should eat whatever they didn't want. I've lived through that. But once I had formalised everything and had a contract, the story changed. [...] You really notice the difference—how hard things can be when you're not regularised or formally employed by a family."* (FG5 ES Target A). This testimony illustrates how formalisation can provide a sense of security and fairness in contexts where informal arrangements often involve mistreatment or neglect. Nevertheless, even though formal regulation is a protective factor in many cases, the testimonies also reveal that legal provisions are not always respected or

enforced in practice.

Breaches of contractual agreements and labor rights. Many testimonies describe situations where, despite having signed contracts, the agreed conditions are not respected. Workers report working longer hours than established: *"My contract says I work twenty-four hours but I work more"* (FG3 IT Target A), or denounce the failure of cooperatives and agencies to comply with basic rights: *"With a miserable salary not to pay… I am still in trial with them, with this cooperative"* (FG3 IT Target A). The lack of days off over extended periods is also mentioned: *"For four years I've been in different parts of Germany… and this was the first place where I had a day off"* (FG2 DE Target A).

Irregular practices and legal fraud. Other testimonies refer to unclear or directly irregular contractual practices, such as companies changing names to avoid paying social security: *"The companies change the name to avoid paying social security"* (FG1 DE Target A), or the use of civil contracts that offer no guarantees: *"There is no such thing as German terms… just some Polish civil law contract"* (FG2 DE Target A). Some participants also mention that German families themselves engage in irregular practices: *"German families also cheat in contracts"* (FG2 DE Target A).

Overall, the testimonies show that while formal contracts can offer important protections, breaches of agreements, irregular practices, and lack of enforcement remain widespread. Respect for legal regulations is uneven and often insufficient to guarantee fair working conditions in the home care sector.

Organisational Support. Organisational support emerges as a critical but inconsistently available resource in home-based care. Workers describe significant variations in how agencies respond to emotional needs, conflict resolution, and daily work-related challenges. Some employees report positive experiences with agencies that are accessible and emotionally responsive: *"I usually always call the agency who are always available who always try to reassure me, they always find a way to reassure you"* (FG5 IT Target A). Others, describe the absence of formal support mechanisms, particularly for stress management: *"There's also often a lack of more formal support, a kind of resource for stress management"* (FG7 FR Target A and C), or express disappointment in how their needs are disregarded: *"I'm not happy about this. Given my seniority in the company, they could take my wishes into account"* (FG7 FR Target A and C).

Psychological care and institutional protection. Psychological safety is perceived as a valuable organisational provision when available: *"Having access to psychological support sessions is an important resource that helps me cope with difficulties"* (FG7 FR Target A and C). However, such support is not always in place. One participant notes: *"Companies are*

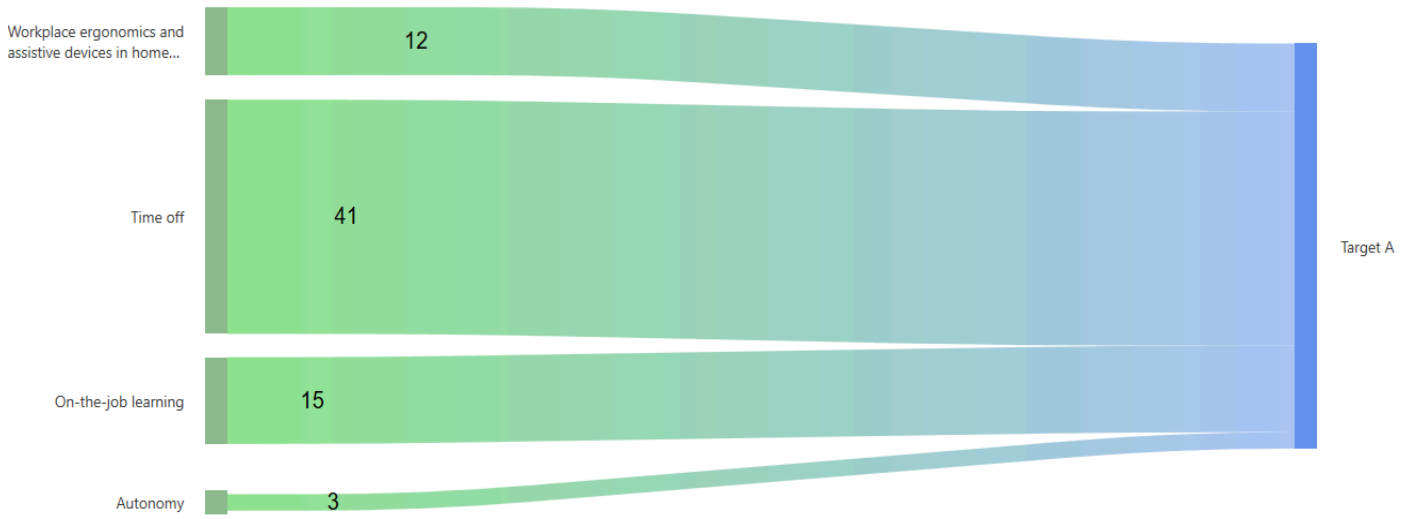
not always supportive either. I can't say about mine, but I hear from colleagues who work in this industry that the company does not help" (FG1 DE Target A). In more precarious scenarios, some workers report being left entirely unprotected in cases of conflict with families: *"If the German family fails me, I'm out in the cold, because when I call the company they threaten them with fines only and I don't know what else"* (FG1 DE Target A). Employees significantly value psychological safety—a context where caregivers can make decisions, express opinions or take risks without fear of retaliation.

Material support and resource provision. Other aspects of support, such as the provision of basic materials, are also perceived as neglected. One worker recalls how the distribution of uniforms was delayed deliberately to cut costs: *"We are going to try to take as long as possible to give it, because if I have this year's uniform with next year's, then I can save two uniforms for the whole team"* (FG1 ES Target A). While seemingly minor, this example reflects broader patterns of disregard and resource scarcity.

Taken together, these accounts reveal that organisational support in home care is not only uneven, but often unreliable—especially in more vulnerable situations such as live-in arrangements or when conflicts with families arise. While some workers benefit from responsive agencies, access to psychological care, or ongoing training, many others report feeling unprotected, ignored, or even threatened. This lack of consistent institutional backing undermines their ability to manage stress and cope with difficult situations, reinforcing a deeper sense of abandonment and structural insecurity in their professional lives.

Job-related Protective Factors

Figure 104. *Job-related protective factors at home care workers group*



Workplace Ergonomics and Assistive Devices. Ergonomy in home care work represents a key resource for preventing physical injuries and ensuring job sustainability. This category includes three main dimensions: the availability of lifting equipment (such as hoists or adjustable beds), the presence of other supportive materials that help adapt the physical environment to the needs of both staff and care receivers, and the physical and functional design of the job itself.

Availability and use of hoists and lifting devices. The availability of hoists and other lifting devices varies significantly across households. Some workers have access to these tools for physically demanding tasks: *"thank God, in heavy work we use the hoist"* (FG5 ES Target A). However, many others are forced to lift care receivers without any technical assistance, bearing the full physical burden alone: *"that person weighed 95 kg, of course, my back was cracking"* (FG3 ES Target A). This strain is often worsened by the lack of understanding from family members, who minimize the effort required or refuse to arrange for a hoist: *"he says that since she doesn't weigh much, a hoist isn't necessary [...], but a man's strength isn't the same as a woman's"* (FG3 ES Target A).

Lack of other ergonomic devices and supportive materials. In addition to hoists, professionals also emphasize the importance of other ergonomic devices. They report a lack of adapted wheelchairs, accessible bathrooms, safety rails, or suitable furnishings. These shortcomings increase the risk of injury and highlight the lack of appropriate equipment in many homes: *"she doesn't have a proper wheelchair [...] I'm really afraid that she might fall when I take her out"* (FG5 ES Target A). The absence of adequate devices often leads to makeshift or precarious solutions, especially when family support is lacking.

Physical strain linked to repetitive tasks and job design. Finally, some participants point out that the functional design of the job itself is closely linked to accumulated physical strain. Repetitive tasks and awkward postures lead to injuries that directly affect workers' health: *"one has a dropped shoulder, another has a bulging disc, another a herniated disc [...] this comes from repetitive work: mop, mop, mop"* (FG3 ES Target A). These common ailments among care workers reveal how job design in the home care setting often fails to consider the physical demands of the profession.

Overall, the testimonies highlight how poor workplace ergonomics and the lack of assistive devices in home care not only increase the risk of physical injury, but also undermine the long-term sustainability of the job. Inadequate equipment, insufficient adaptation of the home environment, and the physical design of care tasks expose workers to cumulative strain, especially in the absence of institutional or family support. Addressing these shortcomings is essential to protect caregivers' health and ensure safe, dignified conditions

for both workers and care receivers.

Respect for Time Off. The effective respect for rest time and days off is an essential resource for preserving the physical and emotional health of home care workers. A Polish worker reports having *"three days a week off, so I can afford to really take a breather, reset myself mentally... I can sleep all day. Nobody bothers me here, I can invite friends"* (FG1 DE Target A). In other cases, workers are allowed to take time for themselves due to special circumstances or flexible routines: *"Yesterday was my birthday, so I went out all day"* (FG5 IT Target A); *"Tomorrow is Saturday, they'll give me half a day on Monday... for me there's no problem either Saturday or Monday"* (FG3 IT Target A). When this kind of respect and flexibility is present, rest becomes a true protective factor against emotional and physical exhaustion. However, this resource is often limited or directly undermined—either due to the way work is organised, the constant-availability logic that characterizes the sector, or the difficulty some families and agencies have in respecting caregivers' personal time.

Unstable and interrupted rest periods. The rest periods are not effectively respected. Breaks during the workday and scheduled days off are often compromised by work organisation and family demands that delay or interrupt their time off. Even when there is a formal schedule, tasks must be completed beforehand, forcing them to extend their working hours without compensation: *"I can't leave at the time I'm supposed to... I have to leave her completely ready—showered, with lunch prepared, everything"* (FG5 ES Target A). Last-minute requests or waiting for a family member to arrive are also common, as one worker explains: *"I've never left at 12 on a Saturday, it's always been two hours later or just a little more, or the daughter is on her way..."* (FG5 ES Target A). This dynamic creates a sense of control over the worker's time, turns rest into an uncertain and unstable period, and effectively cancels its restorative function: *"They don't respect the time of rest, neither the time of the day, nor the time to sleep, nor anything else."* (FG5 ES Target A).

Cumulative impact of disrupted rest and lack of recovery. The lack of rest has cumulative effects on health. Some workers report how interrupted sleep at night due to the needs of the person they care for leads to persistent exhaustion: *"At night I stay awake... and in the morning, without sleep or with just a few hours, I feel like dumb all day"* (FG5 ES Target A). In more prolonged cases, this lack of recovery can last for weeks or even months: *"That has lasted a week or two, sometimes two or three months"* (FG5 ES Target A). These conditions pose clear risks to cognitive and emotional well-being, and erode the sustainability of care over time.

Barriers to accessing holidays and personal days. Access to vacations or extended days off is also uneven. Some workers explain that they went years without a vacation,

or that they were only granted one after securing a stable contract: *"I went two years without a vacation, until they saw I wasn't changing my contract"* (FG2 ES Target A). Others mention difficulties in requesting personal days due to technological barriers: *"They make us submit a written request, go into the employee portal, and do more computer stuff, and some of us don't know how. Some of us are totally lost with those things"* (FG3 ES Target A). This unaccompanied digitalisation creates exclusion in access to basic rights.

Systematic noncompliance with legal rest. In certain contexts, noncompliance with legal weekly rest is systematic. In Italy, some workers report that they are only given Sundays off, falling short of the 36-hour legal minimum: *"They only give Sundays off, and Sundays are no good!"* (FG3 IT Target A). In addition, workers may be pressured to self-manage replacements during their holidays: *"When it concerns holidays... you have to talk at least two weeks in advance with family members as well as with the agency... and if a family member doesn't want to talk to the agency, that's their problem, not the home caregiver's"* (FG3 IT Target A). In this sector, it seems to be common that the responsibility for managing tasks and handling incidents resides with the worker and not with the company, and that the argument used is an emotional one, the pity for the person being cared for. This situation generates helplessness in the caregivers and reinforces their precarious position.

Disempowerment through agency discourse. In some cases, the denial of rest is accompanied by justifications from agencies that infantilize or disempower the workers. One participant recalls: *"I didn't know I could object... the agency never took my side. They even told me: 'And what will you do on your break? If you go into town, to Berlin, you'll get lost'"* (FG1 DE Target A). These narratives reveal how some caregivers, particularly migrants, are discouraged from asserting their rights.

In summary, days off and rest are an essential resource for the sustainability of home care work. Their respect depends on the work arrangement, type of contract, families' attitudes, agency support, and the worker's awareness of their rights. When this resource is undermined, the consequences for health are serious and cumulative; when protected, rest enables the recovery of energy, the maintenance of psychosocial balance, and the ability to carry out caregiving duties with dignity.

On-the-Job Learning. On-the-job learning is a key resource for home care workers, enabling them to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.

The need for ongoing and practical training to face real care challenges. Related to formal training, workers often stress the importance of structured training that prepares them for the realities of care work. Some highlight the necessity of specialised guidance when dealing with complex cases: *"Even though we have training, we still have difficulties with certain groups of people. How do you deal with people who have Alzheimer's or Parkinson's at a very advanced stage?"* (FG7 FR Target A). Training is also seen as particularly relevant for new employees, helping them to adapt and perform their role more effectively: *"It's important for new employees. You have to train them"* (FG6 FR Target A).

Limits of formal training and the search for alternative knowledge. Some participants argue that formal training does not always meet the real needs of day-to-day care. Theoretical knowledge is sometimes insufficient when facing complex or aggressive behaviours. In response, many caregivers turn to other sources: online forums, support groups, personal research, or peer discussions. As one Polish caregiver described: *"I gained so much information... about the rights of caregivers, what we can, what we can't... sometimes the coordinator is helpful, but often I learn from forums or my own search on the internet"* (FG2 DE Target A). Others recall how past training helped them prepare: *"At school I learned how to deal with such patients... how to be assertive in this profession... First my needs, then the care receiver's"* (FG2 DE Target A). Still, several note that quality training is often self-initiated and not always accessible or tailored to actual caregiving challenges.

Learning by doing is described as the most immediate and meaningful way to gain caregiving skills. As one participant put it: *"You go to a care receiver's home and learn something new from every person you see"* (FG4 ES Target A). Experience is considered the primary learning method: *"In the end, our training comes from experience"* (FG4 ES Target A). Some workers also draw on personal histories to guide their practice: *"I cared for my mother with dementia for eight years... I know how to treat someone with Alzheimer's"* (FG2 ES Target A). At the same time, others emphasise that experience should be complemented with continuous learning: *"Training and support between colleagues are essential to deal with difficult situations. Even with experience, it's important to continue training and to ask for help"* (FG6 FR Target A).

This experiential learning is also described as personally enriching and emotionally meaningful. Some caregivers express that *"you learn something new every day"* (FG4 FR Target A), and that close relationships with those they care for can offer powerful insights: *"Some patients share slices of life that put our own existence into perspective"* (FG8 FR Target C). These experiences help caregivers grow not only in skills, but also in

empathy and resilience.

Overall, the testimonies highlight that on-the-job learning is a central pillar of professional development in home care. While formal training is often limited or poorly adapted to real-life challenges, experience, peer support, and self-directed learning emerge as more effective and accessible resources. These informal learning pathways not only help workers build practical skills, but also foster personal growth, emotional resilience, and a deeper understanding of care. Ensuring access to relevant, ongoing, and experience-based training remains essential to strengthen this core dimension of the caregiving profession.

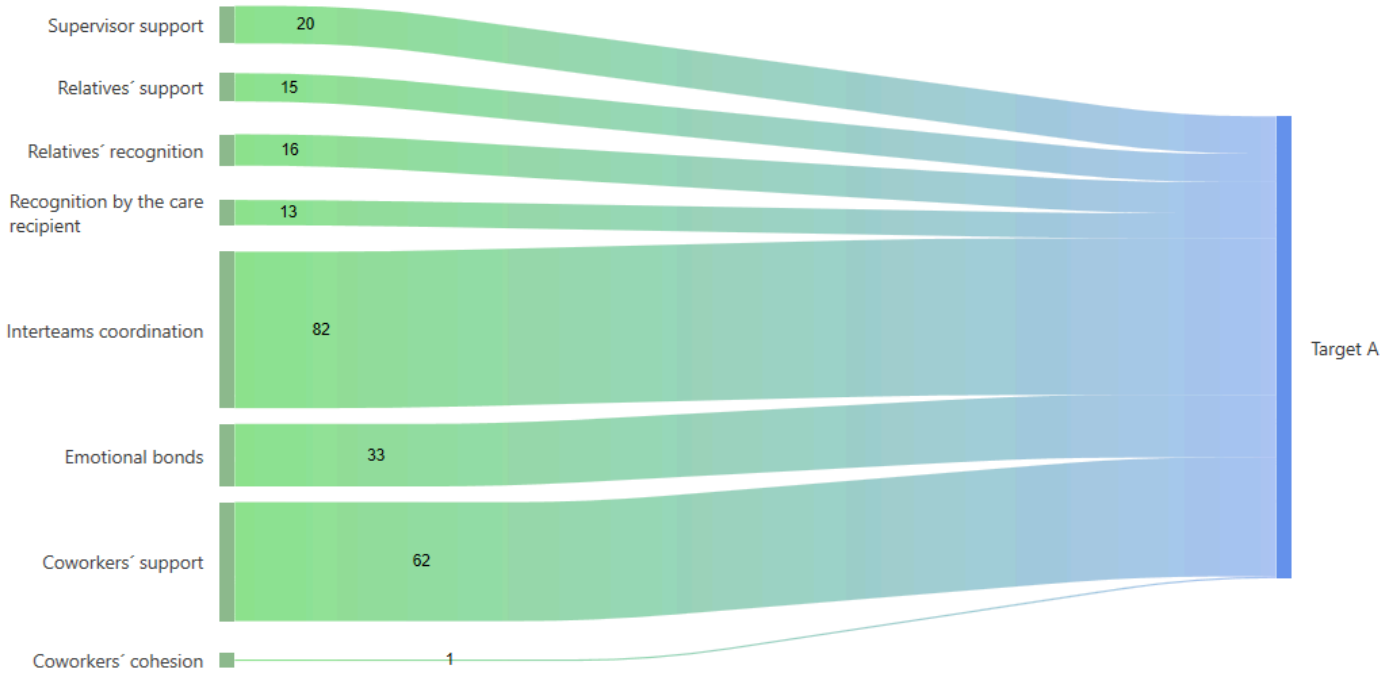
Autonomy. Autonomy emerges as a valuable resource in home care, particularly in contrast to more hierarchical or rigid institutional settings. Several workers describe appreciating the freedom to make decisions and organise their work: "*The positive side that I like is the autonomy you have when you're working at home. You can make decisions and put things in place*" (FG7 FR Target A and C). This sense of control over the daily routine allows for greater flexibility and personal initiative, which contributes to job satisfaction.

Autonomy is also associated with the absence of constant supervision or team pressure. One caregiver states: *"I like this autonomy, the fact that I don't have to work in a team like in a hospital or elsewhere with everyone around"* (FG7 FR Target A and C). While home care is usually performed alone, workers underline that this does not make them feel emotionally isolated: *"I don't feel alone, even though you're on your own at home"* (FG7 FR Target A and C). Another adds: *"For me, autonomy is essential, but it shouldn't mean isolation"* (FG7 FR Target A and C), suggesting that maintaining some form of connection or support remains important.

Finally, autonomy enables a degree of creativity and variation in care delivery: *"We always do the same things for certain care receivers, but we still have a small margin of creativity... Today we're going to do it like this, for a change, and that's what I like"* (FG4 FR Target A). Even within the routines of care, workers value the ability to adapt approaches and personalize interactions, which helps sustain motivation and engagement.

Relational Protective Factors

Figure 105. *Relational protective factors at home care workers group*



Coworkers' Support. Coworkers' support is a fundamental resource in the home care sector, where working alone and the lack of formal support structures mean that peer networks are often the only real source of help, guidance, and emotional relief. In the participants' testimonies, both strong solidarity and situations of disconnection, mistrust, and lack of communication among workers emerge, highlighting the importance—and at the same time, the fragility—of this resource.

Self-management strategies and mutual aid in crisis situations. During the COVID-19 pandemic, self-management strategies became crucial in the face of institutional abandonment. Workers described how they coordinated shifts, obtained supplies, and protected one another: *"It was us, the committee, who organised the work schedules for our coworkers [...] We were the ones who went looking for masks, gowns, asking around... Knocking on the doors of all the companies. Basically, the company just stepped aside."* (FG1 ES Target A). This practical solidarity also included the informal distribution of improvised materials: *"I worked wearing black garbage bags. My husband made me aprons, and I bought a roll at the supermarket and, whenever I ran into coworkers, anyone really, I'd say: 'here, take a bag, take a sack.'"* (FG1 ES Target A).

Emotional support and coworker solidarity. Coworker support also plays a vital role as an emotional outlet in a job with heavy psychological demands. One participant noted:

"It's a real psychological support to have someone who understands exactly what you're going through and with whom you can share these difficult moments." (FG8 FR Target C). Across different settings, this mutual release after difficult shifts is consistently valued: *"Just talking to a colleague when things aren't going well helps enormously"* (FG8 FR Target C); *"The debriefing sessions with my colleagues are really nice."* (FG6 FR Target A).

Communication, teamwork, and care continuity. Collaboration among coworkers also ensures continuity of care, especially when active coordination is present: *"I always call, I always call and ask what they do here. What needs to be done? I always, always call."* (FG3 ES Target A). Yet others report the opposite: *"She sends you a PDF and tells you to figure it out yourself. But figuring it out on your own doesn't make sense—especially not for the care receiver."* (FG4 ES Target A). The absence of communication directly affects the people being cared for, creating risks and inconsistencies in service.

Coworker tensions and mistrust. Tensions and informal hierarchies also surface, weakening mutual support and eroding trust. Some participants describe competitive attitudes: *"That has a name: lack of camaraderie"; "Let's see if I can take your position and stay on, or get more hours for myself."* (FG2 ES Target A). These dynamics compromise collective work and create a climate of individualism. In contrast, teams with stable and trusting relationships offer mutual protection: *"It's true that we have a very close-knit team. We've known each other for quite a long time [...] It's our main resource. [...] it's this solidarity that makes the job more bearable, especially when the days are tough."* (FG8 FR Target C).

In summary, coworker support functions as a vital yet fragile resource—one that can make the difference between isolation and solidarity, burnout and resilience. When present, it strengthens the work, improves the quality of care, and emotionally sustains the workers. When absent, it leaves a void that institutional structures do not fill. Creating opportunities for connection, encouraging inter-shift communication, and formally recognizing the value of peer support are necessary steps to reinforce this essential source of care, which currently relies heavily on individual initiative.

Coworkers' Cohesion. A participant highlights team cohesion as an important element for coping with work-related challenges. Although they were advised in meetings to go through management in complex situations, she explains that they still rely mainly on peer solidarity: *"I think that team cohesion is the key to overcoming difficulties. [...] When we come across a problem with a care receiver, we usually call each other to find solutions"* (FG6 FR Target A). This testimony suggests that, in some cases, support from colleagues is perceived as more effective than institutional assistance.

Inter-Teams Coordination. Inter-teams coordination is an important aspect of home care work. To examine how it is structured in this sector, the analysis follows a framework[20] that distinguishes four key mechanisms: mutual adjustment, direct supervision, standardisation, and higher-order mutual adjustment. The testimonies provide insights into how these mechanisms are applied in practice, revealing different degrees of effectiveness depending on the situation.

Mutual adjustment. In many cases, mutual adjustment between home care workers is weak or unreliable. Some participants explain that when there is no direct communication between colleagues, tasks are left unfinished or passed on without proper handover: *"If we don't coordinate among ourselves..."* (FG2 ES Target A); *"They say: 'I've been waiting for you to put her on the toilet.'"* (FG3 ES Target A). Others mention that some regular staff avoid helping or giving explanations, expecting others to manage on their own: *"They don't want to waste time explaining things and they tell you to figure it out on your own"* (FG4 ES Target A). In some situations, workers who also have coordination roles try to help when problems arise: *"Some colleagues have contacted me privately and I've solved it"* (FG2 ES Target A).

Direct supervision is often seen as insufficient or poorly managed. Several participants report that when they inform their coordinators about problems — such as conflicts with care receivers or difficult situations — they do not receive real support. Instead, coordinators tend to shift the responsibility back to the workers or make arbitrary decisions: *"When you report this to your coordinator, they say: 'Tomorrow I'll take the care receiver away... but then you'll owe me hours'"* (FG1 ES Target A). Others describe a lack of direct involvement or field presence by coordinators: *"We have a ghost service... The coordinators don't come, they don't visit"* (FG1 ES Target A). Poor communication with the office and last-minute schedule changes are also mentioned: *"They change our timetable in the evening for the following day"* (FG6 FR Target A). These situations often leave workers to solve problems on their own.

Standardisation, through formal rules or administrative procedures, does not always work as intended. Some participants explain that requesting leave or managing schedules now requires using a digital app, which they find confusing or unreliable: *"Now we have to go through an app... but sometimes it doesn't work, and some people don't even know how to use it"* (FG3 ES Target A); *"Sometimes you're misinformed with the application, that's just what needs to be reviewed"* (FG4 FR Target A). Others add that formal procedures are often disconnected from the realities of care work, creating

[20] Wagner III, J. A. (2024). Inter-team coordination in multiteam systems: Mechanisms, transitions, and precipitants. *Organizational Psychology Review*, *14*(3), 425-448.

confusion or frustration: *"They should at least give us a meeting and explain it, because I don't understand it"* (FG3 ES Target A). Rather than making things easier, these systems often create confusion and frustration.

Higher-order mutual adjustment, which would involve coordination with other professional teams, appears weak or practically absent. Several participants mention persistent difficulties when trying to collaborate with doctors or other health professionals, especially in critical situations: *"Coordination with doctors is often problematic"* (FG8 FR Target C). Others point out the lack of structured meetings or effective communication channels with external professionals, which complicates teamwork and care continuity: *"We have meetings between care assistants, but not with other professionals"* (FG6 FR Target A). This limited interaction reduces the chances of solving complex cases together and often leaves care workers handling situations without the necessary support.

Overall, the testimonies highlight that inter-teams coordination in home care often depends on individual initiative, informal solutions, or temporary fixes rather than structured mechanisms. Although some coordination processes work in certain situations, participants frequently describe gaps, lack of support, or disorganisation across different levels of coordination. This fragile system may increase the risk of miscommunication and add extra pressure on care workers.

Emotional Bonds. The nature of home care work, which involves sustained closeness and exposure to care receivers' intimate lives, often fosters deep emotional connections. Caregivers are not merely witnesses to the daily realities of those they support—they become confidants, emotional anchors, and sometimes even surrogate family members. *"How do you not get attached to someone who tells you everything because they can't say it to their relatives?"* asked one worker (FG1 ES Target A).

Long-term care relationships and emotional bonds. Long-term care relationships often intensify these bonds. *"After seven or eight years,"* one caregiver shared, *"they become like family."* (FG1 ES Target A). The anticipated loss of a declining care receiver can trigger pre-emptive grief: *"He's dying. I already feel that pain."* (FG1 ES Target A). Others described being called "one of the daughters" or treated as part of the household: *"Every time I walked in, he'd say, 'Here comes one of my daughters.'"* (FG1 ES Target A).

Reciprocal bonds with care receivers and families. This emotional closeness is not always initiated by the caregiver. Care receivers and families often reciprocate or reinforce the bond. One home care worker recalled becoming deeply attached after just a few months: *"I can't let go of her. I give myself completely."* (FG5 ES Target A).

Respect, appreciation, and mutual support. The emotional involvement can also create vulnerability when dealing with families who are disrespectful or intrusive. Others, however, report that respectful families become a source of mutual support and appreciation, especially when they recognize the caregiver's value. This sense of being appreciated—by the older person or the family—often anchors the caregiver's sense of purpose and belonging: *"The family respects me. If I have a problem, they're flexible. We sit at the table and talk."* (FG3 IT Target A).

Emotional burden and personal coping strategies. Still, caregivers remain aware of the emotional cost: *"There are pros and cons. You feel like part of the family, but you also carry their burdens with you."* (FG3 IT Target A). Some try to protect themselves through emotional regulation or activities like gardening, music, or socializing, as one explained: *"I cry, then it gets better."* (FG4 FR Target A).

These accounts show that emotional bonds are an intrinsic part of home care work, shaped by time, trust, and mutual recognition. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries. Sustaining this balance requires not only individual coping strategies but also greater institutional awareness of the emotional dimension of care, which remains largely unsupported despite its central role in workers' well-being and continuity in the profession.

Recognition by Care Receiver. Recognition from care receivers emerges as an emotional resource for home care workers. While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking. One caregiver recalled: *"There are care receivers who can't even speak, but when they see your face, they're saying it all."* (FG1 ES Target A). Recognition can be especially powerful when it comes from care receivers with cognitive impairments or those who initially responded with hostility: *"From trying to hit me to asking for a kiss before I leave—that's something else,"* one worker shared (FG1 ES Target A). These experiences not only validate the workers' efforts but also help buffer the emotional strain of the job, providing a sense of purpose, motivation, and human connection that counterbalances the more demanding aspects of care.

Recognition by Care Receiver's Relatives. Recognition from the relatives of care receivers emerges as a significant emotional factor in the experience of home care workers. While not a formal part of the employment relationship, this recognition—or lack of it—can strongly influence workers' emotional well-being, motivation, and sense of fairness in their

daily tasks.

Feeling unappreciated and undervalued by care receiver's relatives. Recognition from the relatives of care receivers is perceived as a valued—though often inconsistent—source of emotional validation. Many caregivers describe feeling unappreciated, perceived by families as "just another number" despite the time, care, and personal dedication they invest. The absence of even a simple expression of gratitude can feel deeply unjust: *"I've given everything, more than I should've… and they didn't even say thank you. I'm not asking for inheritance, just a 'thanks'."* (FG1 ES Target A). Others highlight how families often ignore their contractual hours or show little regard for their emotional and physical wellbeing, reinforcing a sense of invisibility and devaluation.

The emotional value of gratitude and recognition. At the same time, some caregivers do receive genuine appreciation from relatives, which can ease the emotional burden of their work. Gestures such as verbal thanks, respectful treatment, and acknowledgment of the care provided are experienced as motivating and affirming. One caregiver shared, *"When we receive sincere thanks from care receivers or their families, that offsets the negative aspects."* (FG6 FR Target A). Others emphasised the importance of being treated not just as workers, but as professionals and members of the extended care network: *"We must be respected as other people are respected in any workplace. We respect their relatives, but we also wish to have the same response from them."* (FG3 IT Target A).

These accounts highlight the emotional weight of how relatives perceive and treat caregivers. A sincere "thank you" can carry immense meaning, while disregard or disrespect can wear down caregivers' emotional resilience and undermine their long-term commitment to the work.

Support from Care Receiver's Relatives. The support of care receivers' relatives can have a relevant impact on the work experience of home care workers, both positively and negatively. Some caregivers appreciate the cooperation of family members who are available and understanding. For example, one participant mentions that the care receiver's daughter, who is a doctor, *"She is available 24 hours a day; if I have to call her at 3 a.m., she's ready."* (FG9 ES Target A). In other cases, family members show genuine concern for the caregiver's well-being: *"the daughter came at seven in the morning to see if everything was okay, just to make sure I didn't have any problems."* (FG2 DE Target A).

However, this kind of involvement is not always present. Some workers describe difficulties due to a lack of cooperation, such as having to insist on getting basic supplies: *"you have to*

ask for pampers, for basic things [...] the daughter is very stingy." (FG1 DE Target A). At times, poor communication or indifference from the family adds strain to the daily work.

Overall, the testimonies show that the relationship with family members can either ease or complicate the caregiver's work, depending on the level of availability, recognition, and communication established with them.

Supervisor Support. Supervisor support plays a central role in the organisation of home care, particularly when workers must navigate complex tasks, emotional demands, or conflictive situations. However, testimonies reveal major disparities in how this support is experienced—ranging from accessible coordination and problem-solving teams to a persistent sense of abandonment, inaccessibility, or even punitive oversight.

Feelings of abandonment and inaccessibility of supervisors. Supervisor support is often described by workers as a necessary pillar for managing daily challenges in home care. However, their experiences reveal significant shortcomings in how this support is provided. Many home care workers express a strong sense of abandonment: *"We are very, very, very abandoned, very neglected. We're just a number."* (FG1 ES Target A). This is intensified by the inaccessibility of coordinators: *"You have a problem and you can spend, I don't know, three days calling and maybe they'll pick up one of these years"* (FG1 ES Target A).

Supervisors focus on coverage rather than support. Supervisors are often perceived as prioritizing logistical coverage over employees' well-being: *"I'm going to cover the day-to-day, and I won't bother looking at this colleague's empty slot in the schedule."* (FG1 ES Target A). When workers raise concerns, the response can be vague or even punitive: *"Your coordinator says, 'Tomorrow I'll take her off your schedule (referring to the care receiver).' Okay, so what will you give me from eight in the morning onwards? And then they say, 'Well, I don't know, maybe you'll end up owing hours.' Excuse me?"* (FG1 ES Target A). There is also a sense of structural vulnerability: *"If you refuse to say yes to something, you're already seen as the bad one — they call the organisation, and you get into trouble"* (FG2 ES Target A).

Lack of support in critical situations. Some testimonies describe a lack of support from coordination during critical incidents or particularly complex situations. One participant reflected: *"We don't have the support.... If we had coordination that was in place, I think we would be much better off"* (FG1 ES Target A). Another added that the problem often lies not in the nature of the tasks, but in the absence of institutional backing: *"There are very complicated things, but if you had support from your coordination... For example, in that house, I did it because coordination told me to—and they called me stupid, and I still did it"*

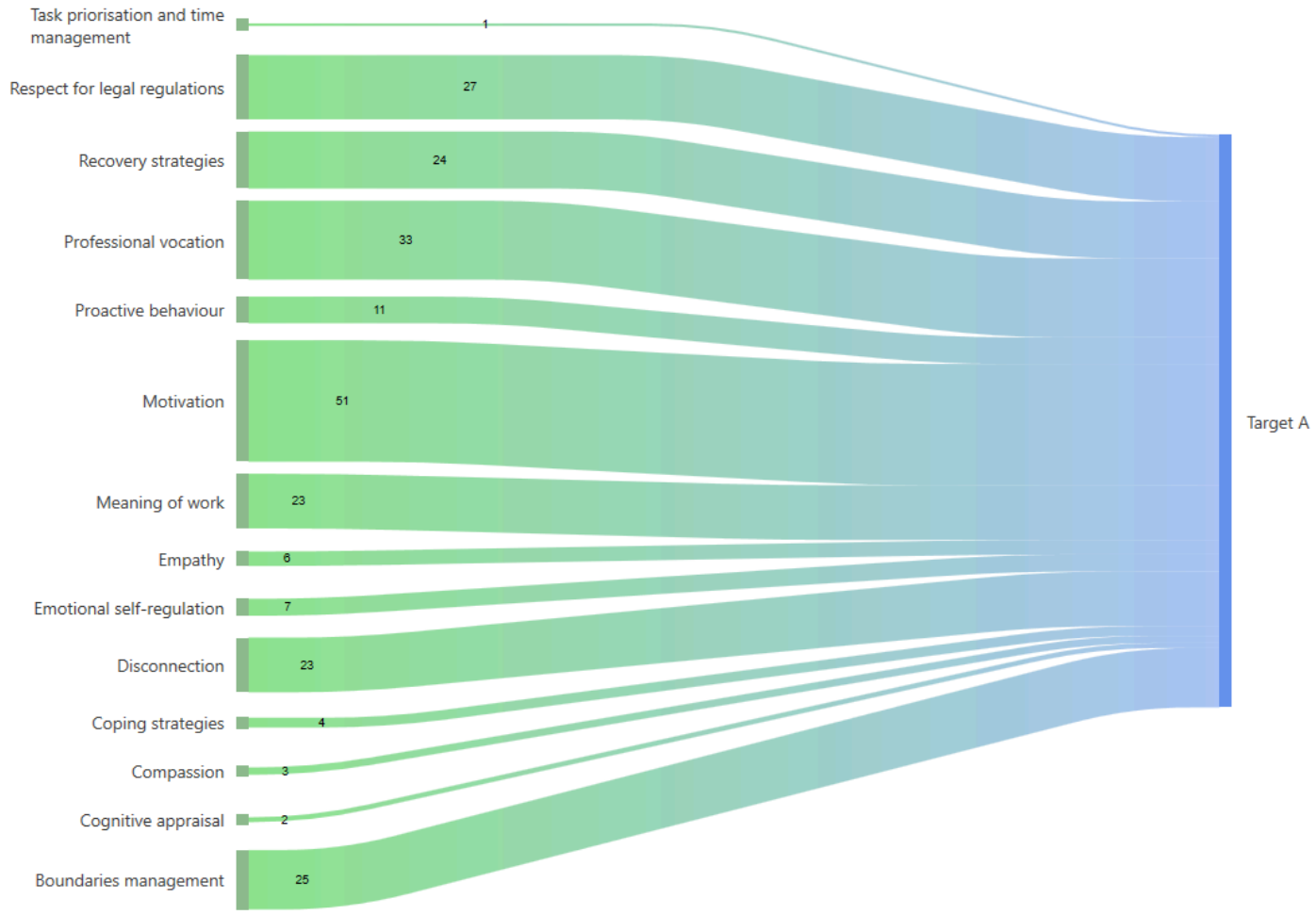
(FG1 ES Target A). This perceived lack of support is also evident in situations where coordinators side with care receivers, even when they are aware of the caregiver's professional boundaries: *"Instead of defending you as a worker, she defends the care receiver, even though she knows she already told you there's a manual outlining what you're supposed to do as a worker"* (FG3 ES Target A).

Positive experiences and the limits of reactive support. Nevertheless, a few participants from better-supported environments note the presence of responsive supervisors and accessible multidisciplinary teams: *"As soon as there's a problem, I call her and we try to find solutions"; "We have occupational therapists, we have a neuropsychologist... all the staff are very well looked after"* (FG4 FR Target A). Still, even in these contexts, the support is often reactive, depending on the caregiver's initiative: *"I don't think we should have to ask for help, it could come from them too"* (FG2 FR Target A).

Despite some positive examples, workers' experiences reveal a deep ambivalence regarding supervisor support. While some benefit from accessible and empathetic coordination, many others feel neglected, unheard, or even undermined in their daily challenges. This uneven support system leaves workers feeling isolated and unprotected, particularly when navigating emotionally or ethically complex situations.

Personal Protective Factors

Figure 106. *Personal protective factors at home care workers group*



Coping Strategies. Coping strategies appear in the testimonies as personal resources that help care workers deal with the emotional and practical demands of their job. Participants mention different ways of coping with stressful situations, ranging from avoidance to emotional expression, distancing, or the use of humour.

Avoidance. Some participants refer to avoidance, simply enduring the situation without confronting it directly: *"Holding on, holding on, holding on"* (FG2 ES Target A). This strategy seems based on holding on and continuing despite difficulties.

Distancing. Others mention distancing, learning over time to step back and take a broader view of challenging situations: *"Over time I've learnt to put things into perspective, to stand back"* (FG2 FR Target A).

Expressing emotions. In some cases, coping involves expressing emotions openly and maintaining honest communication with families and care receivers: *"I try to be clear from the outset and to maintain open communication with the families and with the patient, because it's the patient who matters most to me"* (FG7 FR Target A and C).

Humour. Some participants use humour as a way to ease tensions in difficult situations: *"I use humour as a strategy to lighten difficult situations. [...] This doesn't always solve the problem, but it helps to maintain a calmer, less stressful atmosphere"* (FG6 FR Target A).

Taken together, the testimonies show that care workers rely on a range of individual strategies—from avoidance ("holding on"), distancing and putting things into perspective, to open emotional expression with families/patients and the use of humour—to get through daily difficulties and regulate tension in their work.

Emotional Self-Regulation. Emotional self-regulation is described as an internal resource needed to sustain caregiving, especially in emotionally intense situations such as illness or end-of-life care. Several participants emphasize the importance of being emotionally prepared in order to support others: *"To be able to help someone emotionally, we must first be emotionally prepared ourselves"* (FG5 ES Target A). This maturity is described not only as a professional skill but also as a personal strength required to face grief or prolonged suffering: *"At some point, the older person will be gone—the one you laughed with, ate with, cared for like a father—and we go through that loss too"* (FG5 ES Target A). Other workers stress the need to remain composed even when emotionally affected: *"If she cries, you can't cry too; you have to try to stay strong, even if your heart is breaking"* (FG5 ES Target A). The emotional burden of witnessing suffering is also mentioned, along with personal strategies to manage it: *"There are emotions that can be difficult to manage. When you see a patient in pain or at the end of life, it affects you"* (FG8 FR Target C); *"Personally, the main difficulties lie in managing the emotional burden. To cope with it, I make sure to take time for myself outside of work and do relaxing activities"* (FG7 FR Target A and C). Altogether, these testimonies show how regulating one's own emotions becomes a daily effort that allows workers to keep caring without becoming overwhelmed.

Disconnection from Work. Disconnection from work emerges in the testimonies as a recurrent theme that reflects how care responsibilities extend beyond the formal boundaries of working hours. We have used Sonnetag's theory (2012)[21] to classify this category, which recognizes this variable under the name of psychological detachment from work. Participants

[21] Sonnentag, S. (2012). Psychological Detachment From Work During Leisure Time: The Benefits of Mentally Disengaging From Work. *Current Directions in Psychological Science, 21*(2), 114-118. https://doi.org/10.1177/0963721411434979

describe the tension between the need to mentally and emotionally disconnect and the difficulty of doing so in practice, particularly when their role involves close emotional engagement and constant concern for others' well-being.

The persistent mental burden of care work. Disconnection from work is a recurring concern in the testimonies of home care workers, who describe both the need to disconnect and the difficulty of achieving it. While some participants manage to separate their professional and personal lives, many others admit they struggle to switch off, carrying the emotional weight of their job beyond working hours.

For some, the inability to disconnect leads to constant mental rumination: *"I've seen nights when I couldn't fall asleep because I was thinking about what I had to do for the care receiver the next day"* (FG2 ES Target A); *"The patients' stories run round and round in my head and it keeps me awake at night"* (FG7 FR Target A and C). Even moments meant for rest, like weekends or holidays, are affected: *"You enter a loop and can't get out… I spend the whole Sunday thinking tomorrow is Monday again"* (FG2 ES Target A); *"When I go on holiday, it takes me a few days to really relax"* (FG7 FR Target A and C).

Emotional weight and blurred boundaries. The emotional demands of care work often make it hard to leave work behind. Some participants report feeling haunted by doubts or responsibilities towards vulnerable care receivers: *"My work follows me home and even at night… I ask myself: did I do it right?"* (FG4 FR Target A); *"I used to come home with this burden, it was eating me up inside"* (FG4 FR Target A). Living in small communities intensifies this, as frequent encounters with care receivers or their families outside of work blur the boundaries between personal life and professional duties: *"In a small town, you never really leave the job behind"* (FG2 ES Target A).

Personal strategies for disconnection. However, some participants have found personal strategies to protect themselves. A few speak of having learned, over time, to compartmentalize their work and maintain clear boundaries: *"I go to the care receiver's house, I take care of him 100%, once I leave, there's nothing left"* (FG4 FRTarget A); *"Once I leave work, I don't think about people anymore, but it took a long time to achieve that"* (FG7 FR Target A and C). Others mention deliberate efforts to switch off by spending time with family, relaxing at home, or engaging in leisure activities: *"When I get home, I switch off"* (FG2 ES Target A).

Still, the testimonies suggest that disconnection is far from automatic—it often requires conscious strategies, emotional effort, and other personal resources. The inability to disconnect not only prolongs work-related stress but also intrudes on rest time and personal well-being.

Recovery Strategies. Recovery strategies are described by participants as essential for coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.

Self-care and personal time. Many participants highlight the importance of self-care, understood as dedicating time to oneself, taking breaks, and consciously disconnecting from work. Some mention doing activities like walking, gardening, relaxing, or simply enjoying personal time: *"I take time out for myself. This allows me to recharge my batteries and come back to work with more energy. I think that's essential if you want to last in this profession"* (FG2 FR Target A). Others emphasize the value of small daily routines or treating oneself, such as going shopping, taking care of their appearance, or enjoying personal hobbies: *"I try to stay calm and breathe deeply. When I feel the pressure building, I take a few minutes to myself"* (FG2 FR Target A).

Sport is mentioned as a way to release tension and prevent emotional overload: *"Sport helps me to disconnect from work"* (FG4 ES Target A).

Music also plays a role as a means of emotional release and transition between work and personal life: *"When I get home, I put on loud music to clear my head and relax"* (FG6 FR Target A); *"I play music in the car to relax... it helps me get rid of the stress I've built up"* (FG2 FR Target A).

Social outings and leisure time. Social outings — such as going out for dinner, or spending time with friends— are seen as opportunities to disconnect and recharge: *"And at the weekend, you go out and have a good time"* (FG2 ES Target A).

Taken together, these testimonies show that recovery strategies are a central personal resource for maintaining balance in the face of ongoing emotional and physical demands. Whether through self-care routines, physical activity, music, or social interaction, workers actively seek ways to protect their well-being and sustain their ability to care for others over time.

Motivation. The understanding of motivation is grounded in Self-Determination Theory (Deci, Olafsen & Ryan, 2017), which differentiates types of motivation according to their level of autonomy—from more self-determined forms, such as intrinsic motivation, to external motivations and even the absence of motivation (amotivation).

Intrinsic motivation emerges strongly in numerous testimonies, suggesting that the emotional satisfaction and enjoyment derived from the act of caregiving itself are a

central driving force for many workers. This form of motivation is reflected in repeated expressions such as *"I love it. I enjoy my job very much, and the gratitude it gives me"* (FG1 ES Target A), or *"It's vocational. I love it. I truly love it"* (FG1 ES Target A). The emotional bond with care receivers, the affection received, and the sense of doing something meaningful further reinforce this commitment. As one participant explained: *"At the beginning I used to say I love my job, and I still love it despite all the downsides. I still like it, because otherwise, I don't think we would last here, even if we went hungry"* (FG1 ES Target A). These statements are frequent and expressed with enthusiasm, highlighting the importance of enjoyment and emotional connection in sustaining caregiving. However, intrinsic motivation alone is not always enough to endure over time. One participant shared: *"I hit rock bottom in this job. I started with the most beautiful excitement you can imagine. Right now, I don't feel it. Honestly, I used to love my job, but right now, I don't"* (FG1 ES Target A). This quote reflects how difficult working conditions can gradually erode even the most deeply felt initial commitment.

Integrated regulation refers to motivations that are fully internalised and aligned with personal values, even if the activity is not always pleasurable in itself. In the testimonies, this form of motivation appears linked to a deep emotional commitment and a sense of moral responsibility towards care: *"We keep going because we have a vocation. Otherwise, I don't think we could take it"* (FG1 ES Target A). The job is often described as emotionally demanding and difficult, yet participants persist because they feel it is *"a job that has to be done with love"* (FG5 IT Target A). This highlights how caregiving is experienced not merely as a professional task, but as a personally meaningful choice that resonates with their identity and ethical values.

Identified regulation is evident when the activity is personally important and consciously valued, even if not inherently enjoyable. Some workers describe a clear sense of usefulness and fulfillment: *"Helping people in their personal environment is very rewarding"* (FG7 FR Target A and C). Others mention that the impact of their work gives them a reason to continue: *"It gives me incredible energy when my patient at some point says thank you. For me, it's such a boost"* (FG1 DE Target A). In these cases, satisfaction arises not from the task itself but from the recognition of its social value and the positive outcomes it produces for others.

External regulation appears in a minority of accounts and is mostly linked to economic necessity or lack of alternatives. As one participant states bluntly: *"Forgive me, but we need the job more than we like it"* (FG1 ES Target A). Another explains: *"Unfortunately, I don't have anything else to do... as long as I'm here, I have to do it"* (FG3 IT Target A).

Amotivation (or the lack of motivation) is reflected in narratives where emotional fatigue and loss of purpose become evident. One participant, whose earlier testimony highlighted a sense of disillusionment, illustrates how initial enthusiasm can erode over time. Others convey a more subtle emotional detachment: *"I think I've lost a bit of empathy"* (FG1 ES Target A).

Testimonies reveal the diversity of motivational experiences among home care workers—from strong intrinsic commitment and personal identification with the caregiving role, to motivations based on necessity or signs of emotional detachment. While many express genuine satisfaction and a deep sense of purpose, others reveal how difficult conditions can wear down even the most meaningful engagement, highlighting the fragile balance between internal motivation and the external realities of care work.

Professional Vocation. Professional vocation appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps workers stay committed to their tasks, especially in emotionally and physically demanding situations.

Vocation as a personal inclination and source of meaning. Vocation represents a personal inclination toward care, strengthening the emotional bond many workers develop with their tasks beyond contractual obligations or financial compensation. Several testimonies express a genuine love for the work involved in caring, accompanying, listening, and offering affection—especially to older people. This vocational commitment is described as an internal driving force that gives meaning to everyday work and enables workers to persevere even under difficult conditions: *"At the beginning I used to say that I love my job, and I still love it despite all the downsides we face."* (FG1 ES Target A).

This emotional connection is often described in deeply human terms. As one participant expressed: *"This is a job with a lot of heart."* (FG4 ES Target A). This statement shows that care work is not perceived as a mechanical or technical task, but rather as a human relationship imbued with emotional closeness.

Several workers mentioned that the desire to care was already present before entering the profession, describing it as a prior inclination or a particular sensitivity towards caregiving: *"This is a job that really requires a passion and a love for people above all. I do it with love because I have a predisposition for the elderly, because I grew up with grandparents and I have an overwhelming love for them."* (FG5 IT Target A).

Vocation as a protective factor for endurance and retention. Some participants insist that without vocation, it would be impossible to sustain this type of job, given its

physical and emotional demands: "*Yeah, but I think we also endure because we have a vocation. Without it, I don't think we could hold on.*" (FG1 ES Target A). Vocation thus emerges not only as a key resource to endure the harshness of the job, but also as a condition for staying: without it, many would leave. In this sense, vocation is closely linked to retention and may play a protective role against turnover intention, especially in contexts where working conditions are challenging.

Social perceptions and emotional tensions surrounding vocation. On the other hand, vocation is not always understood by the family environment. Some workers describe how their children question their emotional involvement and criticize them for treating the people they care for as if they were part of the family: *"They say I've taken it all to heart, as if they were my own family. So I suffer... but I do like it."* (FG5 ES Target A). This dedication, which for them is an expression of humanity, may be perceived from the outside as an excessive burden.

Taken together, these accounts show that vocation contributes to workers' perseverance and continuity in the care profession. It is often rooted in personal experiences, emotional connection, and a strong sense of purpose that helps sustain their commitment despite difficult conditions.

Meaning of Work. The meaning of work in the home care sector emerges in the testimonies as a central dimension of workers' experience. Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.

The meaning of care work as human connection. For many care workers, this job is not just a functional or mechanical occupation — it carries a deeper meaning rooted in human connection. Unlike other sectors, here *"we don't work with papers, we work with people,"* as one participant put it, highlighting how this changes everything (FG4 ES Target A). The meaning of the job lies in direct human contact, in the ability to offer well-being, comfort, and presence. One caregiver summed it up by saying: *"we give light, we give families light, we give well-being, we give, a cuddle, a caress, to be listened to — this is what the elderly need."* (FG5 IT Target A).

Social contribution and the relational meaning of care work. This social and human value gives the work a personal dimension that goes beyond financial compensation: *"I feel that I'm doing social good and that makes me feel so good [...] it's a beautiful job."* (FG5 IT Target A). Even in moments of fatigue or overload, many workers find meaning in the impact they have on others' lives, and in what they receive in return. As one of them

said: *"what I love about my job is the exchange with the elderly. They give us as much as we give them."* (FG2 FR Target A).

Professional growth and personal fulfillment. Several participants also noted that this job has helped them find their place, strengthen their self-confidence, and develop a more empathetic understanding of life: *"I have found my dimension [...] I am really doing something good, something good for myself that gives me peace and gives peace to others."* (FG5 IT Target A). Although the daily work can be demanding, that connection to the deeper meaning of care is what allows them to keep going: *"it's a rewarding job, because you go home feeling that you've done something useful."* (FG8 FR Target C).

Overall, the testimonies show that the meaning of this work stems from the human relationships it fosters, the tangible difference it makes in people's lives, and the emotional connection that grows through care. This sense of purpose is not abstract — it's something workers experience daily, and it helps them carry on with their work despite the difficulties.

Empathy. Empathy emerges as a deeply personal resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support. As one male worker explained, *"I'm not his blood, I'm just someone who takes care of him, but he has a son, a brother, and still no one visits him. That weighs on me, it makes me feel pity."* (FG5 ES Target A). Empathy is also described as central to building relationships with care receivers and their families, helping to navigate emotionally charged situations with compassion and tact. One participant noted, *"They live it with all the emotional and sentimental implication... we live it with professionalism, but we must make both the patient and the family feel understood."* (FG5 IT Target A). For many, these emotional connections are not only a source of strain but also of gratification. Workers describe moments of genuine human exchange—*"There are times when you manage to put a smile back on someone's face, and that's really nice"* (FG8 FR Target C) —which reaffirm their sense of purpose. Empathy, then, is not simply a soft skill; it is a double-edged psychological resource that offers meaning and satisfaction while exposing care workers to emotional fatigue.

Compassion. Compassion appears in some testimonies from Latin American migrant care workers as a personal value that shapes their responses to emotionally demanding situations. One participant described the emotional weight of witnessing clients' deterioration or expressions of despair: *"It hurts when someone tells you they're tired of living... I just look at her and say: let's keep going, let's get through this"* (FG5 ES Target A). In this account, compassion becomes both a deeply rooted value and a source of emotional strain.

Cognitive Appraisal. Cognitive appraisal functions as a personal coping mechanism that allows care workers to reinterpret challenging experiences in a more constructive light. By consciously focusing on positive elements of their work, professionals can buffer the emotional toll of difficult days. As one participant expressed: *"I concentrate on the positive aspects of the job. When I finish a difficult day, I take the time to think about the successes, however small..."* (FG7 FR Target A and C). Others reflect on how their way of emotionally engaging with the job shapes their response to loss and suffering. As one caregiver noted: *"I don't compartmentalise... when they die, well, it's like Niagara."* (FG4 FR Target A). This strategy helps to reframe stress and sustain motivation, even in the face of persistent strain.

Task Prioritisation and Time Management. In line with Aeon et al. (2021)[22] classification, task prioritisation and time management as a personal resource is reflected in care workers' efforts to protect time for core responsibilities, even in contexts where external demands compete for attention. One participant emphasised the importance of staying focused on the person receiving care despite interruptions from the family: *"Your priority is the person you care for. Then everything else will come later."* (FG1 ES Target A). This quote illustrates how workers actively set boundaries to safeguard time for essential caregiving tasks, resisting pressures to respond to peripheral requests. Such strategies reflect a conscious attempt to preserve the quality of care amidst complex and sometimes conflicting expectations.

Boundaries Management. Boundaries management emerges as a key dimension in the home care sector, particularly in relation to tasks, emotions, and time.

> Managing task-related boundaries. Regarding task-related boundaries, many home care workers describe the daily challenge of delimiting their responsibilities in households where they are often expected to perform cleaning and domestic chores beyond their professional duties. As one participant firmly stated: *"I clean the grandfather's bedroom, I wash him and do everything I have to do for him, because he's my care receiver. But if you have the sink full of dishes, I will wash one plate, one glass, one spoon—what I need to give him breakfast—and that's it. You do the rest yourself."* (FG1 ES Target A). Others recount more extreme situations in which they were pressured to clean rooms used by live-in carers or perform physically risky tasks: *"They told me to go up on a ladder to clean chandeliers. When I said no, for some it was like the end of the world—'why are you even here?' they said"* (FG1 ES Target A). These testimonies reflect persistent attempts to clarify professional limits in contexts where the boundaries between personal service and care work are often blurred. Such clarity is frequently

[22] Aeon, B., Faber, A., & Panaccio, A. (2021). Does time management work? A meta-analysis. *PloS one*, *16*(1), e0245066. https://doi.org/10.1371/journal.pone.0245066

undermined by inconsistency across workers: *"Then someone comes for a few days as a replacement and cleans the lamps, scrubs the tiles… and then the care receiver tells you: 'why don't you do this? She did.' And you feel bad. You feel guilty."* (FG2 ES Target A).

However, not all care workers are able or willing to maintain such boundaries. Some express discomfort when saying no to extra tasks: "*They ask me to take the flowerpots outside while it's raining… I feel incapable of saying no."* (FG3 ES Target A). Others admit to doing things outside their duties to avoid confrontation or because of emotional pressure: *"You know you shouldn't do it, but you feel bad, especially if they can't do it themselves"* (FG 3 ES Target A). These blurred lines are reinforced by social proximity or local familiarity: "*We are incapable of saying no, because you're my neighbour, or I've known you since you were a child—it's a small town."* (FG3 ES Target A).

Managing emotional boundaries. In relation to emotional boundaries, workers also describe the effort to protect themselves from being overwhelmed by distressing experiences or the disrespect of care receivers and families. While some insist on the need to stand their ground—*"We must not let ourselves be trampled on"* (FG1 ES Target A)—others highlight the emotional toll of the job and their limited ability to disengage: *"This job is beautiful, it gives you satisfaction… but it's also very painful. If you don't truly love it, you can't take it."* (FG1 ES Target A).

Managing personal time. Time boundaries also generate ambivalence. Some participants assert their right to free time: *"If I want to stay in bed and rest, I stay there, I lock myself in my room. If I want to go out, I go out. Freedom costs us too."* (FG3 IT Target A). Others acknowledge the fragility of such boundaries, particularly when personal circumstances or care receiver dependency blur the line between work and private life: *"I love my work and it doesn't spill over into my personal life too much… but maybe if my children were younger it would be more complicated."* (FG7 FR Target A and C).

The testimonies show that managing boundaries in home care work involves constant negotiation. Whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving experiences.

Proactive Behaviour. Proactive behaviour refers to self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. According to the framework proposed[23], this type of behaviour can be classified into three

[23] Chia, H. W., & Sharon, K. P. (2013). Thinking and acting in anticipation: A review of research on proactive behavior. *Advances in Psychological Science, 21*(4), 679.

distinct subtypes: proactive person-environment fit behaviour, which involves efforts to adjust one's actions or mindset to better align with macro-level demands (e.g., feedback seeking, role negotiation); proactive work behaviour, which focuses on improving internal processes or practices within the organisation (e.g., taking charge, innovation); and proactive strategic behaviour, aimed at influencing the broader institutional environment (e.g., strategic scanning, issue selling). While the first two subtypes were clearly present in participants' accounts, proactive strategic behaviour was not reflected in the focus groups discussions.

Proactive person-environment fit behaviour was reflected in participants' accounts of how they adjusted their actions to meet the challenges of care work. One participant illustrated this by stating: *"To overcome the difficulties I encounter in my work, I try to follow a method and adapt to each situation. When something happens, like an accident or something I start by assessing everything based on my experience, taking into account not only the physical aspects but also the psychological ones. If the situation is very complex, I know I can call the people in charge and, in extreme cases, the fire service"* (FG6 FR Target A). This quote highlights a proactive and experience-based approach to problem-solving, showing how workers align their behaviour with the evolving demands of their environment.

Proactive work behaviour also emerged, in participants' narratives as a self-initiated effort to manage risk, regulate emotions, and improve day-to-day practices within the organisation. One home care worker explain: *"I try to maintain my inner calm so as not to aggravate the situation [...] if I can be with a colleague, I don't hesitate to contact her"* (FG6 FR Target A), highlighting the use use of emotional regulation and peer collaboration in conflictual scenarios. Others described flexible planning and anticipation strategies, such as: *"I try to remain flexible and anticipate the unexpected. I plan my days according to priorities..."* (FG7 FR Target A and C). These accounts show how home care workers engage in active problem-solving and process management, often drawing on their own experience, as illustrated by one participant: *"To overcome difficulties [...] I start by assessing everything based on my experience, taking into account not only the physical but also the psychological aspects."* (FG6 FR Target A).

In summary, proactive behaviour in the home care sector took the form of anticipatory and self-directed strategies aimed at managing complex or unpredictable situations. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work. These forms of initiative, although individually driven, contributed to maintaining stability, ensuring the continuity of care, and coping with the emotional and practical demands of the job.

Knowledge of Legal Regulations. Knowledge of legal regulations and labor rights

emerges in the testimonies of migrant care workers as a crucial factor shaping their experiences in the sector. Several participants underline the importance of knowing their rights to demand better conditions or assert limits at work. This theme includes how legal awareness enables workers to set boundaries, act upon violations, and navigate the gap between legal frameworks and their enforcement.

Rights awareness and boundary setting. Some participants highlight that knowledge of legal regulations gave them tools to act, for example, by filing complaints or seeking advice from authorities: *"I send a complaint by email... the next day I already have a reply from the clerk who contacts the family"* (FG2 DE Target A). Others described how knowing specific clauses helped them enforce time boundaries, especially with families: *"If the contract says I leave at nine on Saturday, the family members know they have to be there at nine because I'm leaving"* (FG5 ES Target A). Nonetheless, they also point out that knowing the law is not always enough if agencies or families impose abusive clauses or create psychological pressure, making workers afraid to assert their rights: *"Most people are afraid of the contractual penalties. They are under mental pressure"* (FG1 DE Target A).

Legal knowledge versus actual enforcement. Testimonies also reflect significant gaps in the application of these rights. Workers report situations where, despite legal regulations, they are overburdened with tasks, denied rest periods, or subjected to exploitative conditions: *"The law is not that the home caregiver has to do everything — nurse, cook, driver... But we all do it"* (FG4 IT Target A). Some participants describe how, despite the risks, they actively try to assert their rights — for example, by refusing to accept unfair contract terms: *"I crossed out what I didn't like in the contract... I communicated it to my boss that it was signed, but I crossed out the illegal parts"* (FG1 DE Target A).

Impact of legal status on rights enforcement. Several migrant workers link this issue to their vulnerable legal status and the lack of regular contracts, stating that this pushes them to accept poor conditions and limits their ability to assert their rights: *"Nobody wanted to make me a contract... I was badly paid, with no rights"* (FG9 ES Target A). Others stress that respecting labor rights benefits both the workers and the host countries, as regularisation allows them to contribute formally to the system: *"Giving us a contract is a lesser burden for the country because we pay social security"* (FG9 ES Target A).

Overall, the testimonies show that legal knowledge represents an important resource for home care workers, particularly migrants, as it helps them understand their rights and set limits. However, the gap between legal provisions and their actual enforcement remains a significant barrier. Many workers continue to face irregularities, excessive workloads, or fear of retaliation when trying to assert their rights. Without structural support and effective

enforcement mechanisms, knowledge alone is not always sufficient to guarantee fair and safe working conditions.

Non-Work Protective Factors

Figure 107. *Non-work protective factors at home care workers group*

Social Support. Family and friends' support is perceived in home care as an essential resource to cope with the emotional and practical demands of the job. Many participants highlight how spending time with their loved ones allows them to relax and recharge after work: *"I try to share time with my daughter and my grandson, and play with them for a while"* (FG5 ES Target A). Others appreciate simple moments at home that help them unwind: *"If I stay at home, my husband on the sofa and me in the armchair with my feet up and a bag of popcorn watching a movie... total disconnection"* (FG2 ES Target A).

Some participants also mention friends or acquaintances as a source of support, whether for sharing experiences, seeking advice, or simply spending time together: *"You take a walk in your free hours. You can call a friend or relative, go out to a café and have a coffee"* (FG3 IT Target A). In some cases, they highlight having built close-knit friendship networks, including other care workers, which provide mutual support and companionship: *"We have a really nice group that meets often... they are still there for me today"* (FG1 DE Target A).

Overall, this network of personal and social connections is described as a key resource that helps them cope with work-related stress and maintain emotional well-being.

Psychological Help. Some participants mention seeking psychological help to cope with emotionally demanding situations, especially when personal strategies are not enough. They refer to moments of particular difficulty, such as patient deaths, when the support of a therapist becomes necessary: *"At times like this, I call on the services of a therapist to help me through these periods"* (FG7 FR Target A and C). Others highlight the possibility of accessing psychological support through their organisation, although it often requires a personal request: *"You have to ask for it to have a psychologist you can consult when you're not feeling well"* (FG4 FR Target A).

7.2. Institutional Care

This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree). It is necessary to bear in mind the definition of this professional role in order to achieve an adequate interpretation of codes´ frequency.

3.2.1. Risk Factors

Context Risk Factors

Figure 108. *Context risk factors at basic and professional care workers group*

Social Status of the Profession. The social status of the care profession emerges as a recurring concern across participants' accounts. Workers describe a pervasive perception of low prestige, institutional disregard, and lack of public recognition, which collectively undermine their professional identity and motivation. These concerns are particularly salient in the residential care sector, where comparisons with other healthcare professions intensify the sense of inequality and invisibility.

Perceived devaluation and invisibility. The testimonies reveal a widespread sense of devaluation and institutional neglect toward the care profession, especially in residential settings. Workers see themselves as *"the forgotten ones here"* (FG7 ES Target B and C), feeling invisible and unrecognised. The COVID-19 pandemic heightened this perception: *"Half of them died, and we were the bad ones on top of it... and now it's all being forgotten again"* (FG7 ES Target B and C).

Lack of representation and professional parity. They highlight the lack of representation: *"We feel that we don't speak anywhere at all"* (FG7 ES Target B and C), and criticize the disparity with hospital staff: *"It seems like the nursing assistants are the ones who really work in the hospital... We are nursing assistants too, and they depend on us"* (FG7 ES Target B and C). Their work is described as *"exploited, underpaid, forgotten by*

everything… We are nothing and nobody!" (FG2 IT Target B). They reject being treated as mere cleaning staff: *"The OSS is not the man or the cleaning woman at your command!"* (FG2 IT Target B), and insist on defending their role: *"The profile has to be respected… when they don't respect it, we have to take action"* (FG2 IT Target B).

Emotional strain and lack of systemic recognition. The lack of recognition leads to frustration and emotional strain: *"It can be frustrating. You take it all on yourself, and you don't always feel recognised"* (FG3 FR Target B). After the pandemic, *"things got really complicated, because we didn't get the recognition we should have had"* (FG3 FR Target B). Participants also stress structural injustice: *"You realize how everyone is stumbling, even though this job wasn't particularly well regarded at the beginning"* (FG4 DE Target C). Even managers admit that *"they don't feel valued by the system"* (FG5 PL Target B and C).

Negative public image and barriers to recruitment. The profession's poor image discourages new staff: *"They are closing down training courses because people don't want to come… and yet the pay is still oscillating at the minimum wage"* (FG5 PL Target B and C). Wage gaps with other healthcare jobs are a common complaint: *"There are large disproportions between medical professions and the very similar, or actually identical, work that we do"* (FG5 PL Target B and C).

Need for collective representation and long-term motivation. Finally, they highlight the absence of unified representation: *"We don't have that association… that unification that would make that voice strong"* (FG5 PL Target B and C). Many believe that, in this sector, *"with these low wages, these good hearts play the biggest role"* (FG5 PL Target B and C), which fosters demotivation: *"It makes you so uncomfortable… so demotivated to study in this field or to work here"* (FG5 PL Target B and C).

Overall, the testimonies underscore the urgent need to elevate the social status of the care profession. The perceived devaluation—manifested through unequal treatment, low wages, and lack of visibility—not only affects workers' emotional well-being but also hampers recruitment and long-term retention. Without structural recognition, fair representation, and adequate compensation, the sector risks perpetuating a cycle of demotivation and workforce instability, despite the essential nature of the work performed.

Precarious Employment. In institutional settings, precariousness is mainly reflected in low wages. Although employment contracts tend to be more stable than in home care, some workers report that their salaries are insufficient to live independently. As one participant stated: *"You don't have an adequate salary because I've been a widow for eleven years, I live alone and I'd like to say that I can live on my salary"* (FG2 IT Target B). This highlights the ongoing devaluation of care work, contributing to both financial insecurity and emotional distress

among professionals.

Organisational Risk Factors

Figure 109. *Organisational risk factors at basic and professional care workers group*

Staff Shortage. Lack of staff in the institutional care sector is described as a persistent structural issue, with widespread effects on the quality of care, work organisation, and the well-being of professionals. This situation manifests on multiple levels: from overload during shifts *"we're always short-staffed because we're always doing double duty"* (FG1 FR Target B) to the inability to properly carry out basic care duties *"a quick toilet is not our job... we're there to take our time with the resident"* (FG1 FR Target B). Staff shortages prevent workers from performing with the attention and dedication required, generating a constant state of stress, exhaustion, and frustration.

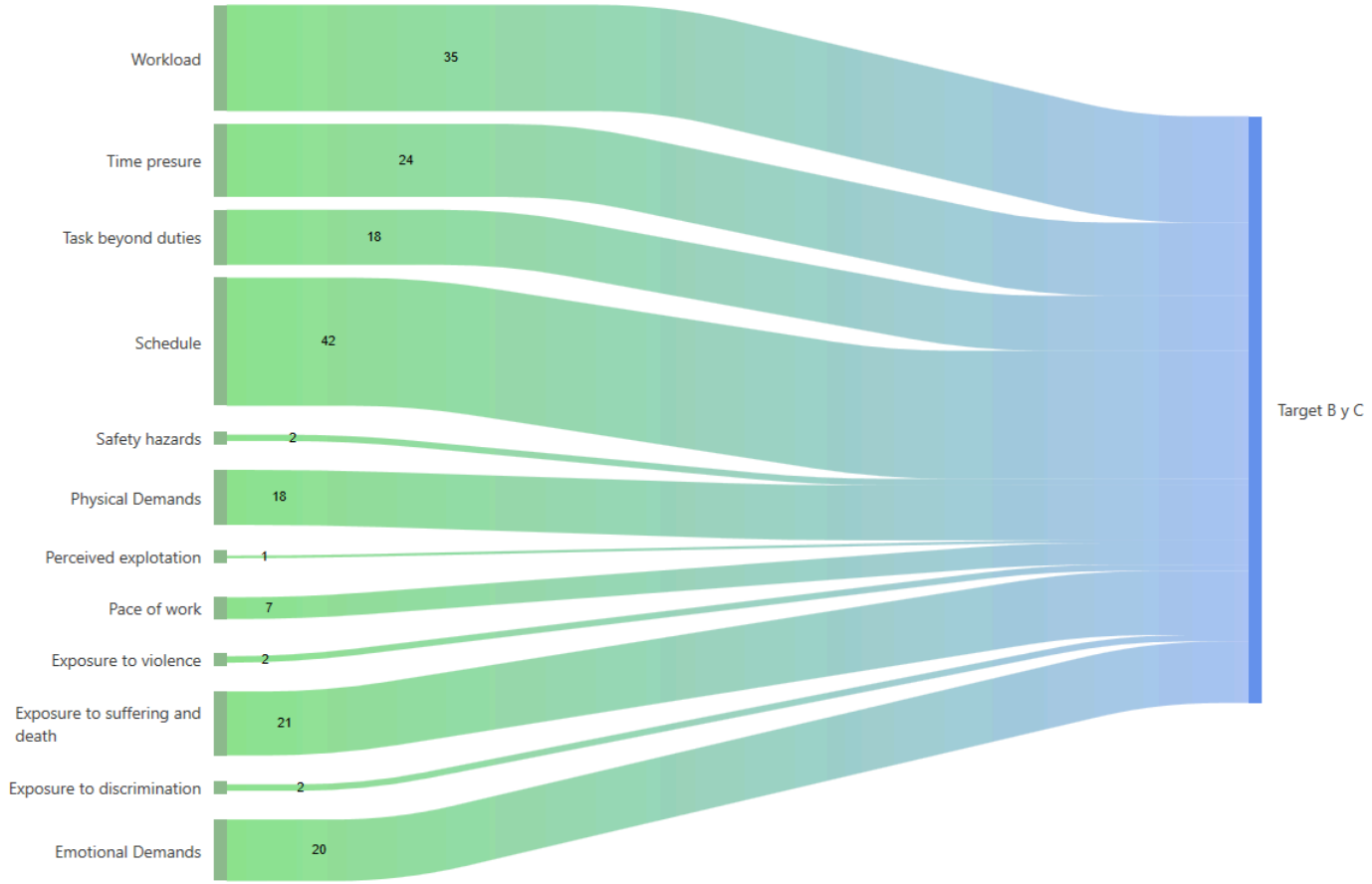
The disorganisation resulting from understaffing also deteriorates teamwork and the stability of professional teams, especially when units are temporarily closed due to insufficient human resources *"after a short time they decided to close it due to lack of staff and so we were shunted to various departments"* (FG6 IT Target C). This imbalance affects both direct care and staff morale, as many feel their efforts are not adequately recognised.

Lack of Funding. In some institutional care settings, professionals report that the shortage of resources directly affects the quality of care. They mention difficulties due to a lack of staff, basic supplies, and technical aids, which increases the care burden. In certain cases, management decisions prioritize budget cuts over clinical needs: *"There is this thing of being a company, of being managers on the part of the nursing coordinators which goes to emphasise giving much more importance to the budget than to the actual care... Because what matters is the budget, we even went as far as to say that she wanted to reduce the quantity of drugs ...We are a haematological department, we are a hospital department, I have to give two 20 mg tablets to the patient who takes the 40 mg tablet?" (*FG6 IT Target C).

This economic focus, perceived as lacking sensitivity and disconnected from the realities of care work, deteriorates the work environment and undermines staff motivation. While tensions among colleagues are not always present, many challenges are attributed to organisational or administrative decisions (such as protocol changes or pressure to cut costs), which complicate day-to-day work and generate a sense of powerlessness.

Job-related Risk Factors

Figure 110. *Job-related risk factors at basic and professional care workers group*



Physical Demands. Physical demands are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. The testimonies reflect how structural conditions—such as staff shortages, time constraints, and increasing patient dependency—amplify the physical toll of care work, leading to a high prevalence of pain, injury, and long-term health problems.

Risk of musculoskeletal injuries and chronic pain. Care work in institutional settings entails chronic physical overload, mainly due to the repeated mobilisation of dependent individuals, bed transfers, and assistance with physically demanding tasks. Even though technical aids like hoists or changing equipment are available, their effective use is often limited by staff shortages, time pressure, or the lack of colleagues to assist—forcing workers to perform risky maneuvers alone. As one participant explained, *"If you have to use a lift by rule you should be in two, but sometimes you can't... so it's at your risk"* (FG4 IT Target B).

The risk of musculoskeletal injuries—particularly in the back and neck—is recurrent. Workers frequently report chronic pain, use of painkillers, medical treatments, and repeated sick leaves. *"We have many sick leaves because of bone issues... cervical problems, lifting weight"* (FG8 ES Target B and C). Some acknowledge how repeated strain accumulates over time: *"I've been carrying them on my back for 28 years"* (FG7 ES Target B and C). Even nursing staff, who are not primarily tasked with heavy handling, recognize the physical toll: *"It's a very physical job... even nurses bend down to do a dressing"* (FG7 ES Target B and C).

Staff shortages, time pressure, and unsafe practices. Moreover, the time pressure often leads workers to take unnecessary risks, as highlighted by one participant: *"Sometimes you're in a hurry and lift someone alone... and then you carry it in your back"* (FG7 ES Target B and C). This happens even though some patients require assistance from two people or technical aids. The repeated exposure to such situations makes back pain a normalised part of the job: *"Back pain in intensive care is normal... I would describe all that as negative, it's physically, emotionally, and psychologically stressful"* (FG5 DE Target C).

Ineffectiveness of prevention measures and undervaluation of physical effort. Despite existing training in prevention, workers perceive that it's ineffective when structural conditions—like adequate staffing and realistic work rhythms—are not in place. Many feel that their physical effort is undervalued or taken for granted. *"This is the hardest job... the one that hurts my back the most"* (FG7 ES Target B and C). They also highlight that patients' increasing dependency worsens the strain: *"Now the patients are heavier... and even though we have the machinery, it's not the same if you're alone"* (FG4 IT Target B).

In sum, the institutional sector reproduces some of the same patterns identified in home care: a high level of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.

Safety Hazards. Care workers are regularly exposed to biological risks, especially in contexts of viral outbreaks or health crises. They feel that the danger inherent to their profession is not recognised by institutions or society. As one worker stated: *"We are exposed to health hazards that no one even realizes; no one sees how dangerous this profession is. We were the ones facing the new virus, we were there, keeping things going."* (FG7 ES Target B y C).

In addition, many feel that the compensation they receive does not reflect the physical effort and risks involved, either in terms of salary or institutional recognition. In the words of another worker: *"I can care for patients every day or risk my life... but in the end, there's almost nothing left. I work the whole month just to be able to pay the rent, electricity, insurance..."* (FG3 DE Target B).

These accounts highlight how the biological risks faced by care workers remain largely invisible and insufficiently recognised, both in terms of prevention and compensation.

Workload Pressures. Work overload intensifies due to the structural lack of personnel, the constant emergence of unforeseen incidents—such as falls or health deteriorations—and the pressure arising from unrealistic family expectations. As one participant stated, *"There are moments when you need more staff because you just can't meet all their needs"* (FG6 ES Target B and C). The absence of even a single worker can disrupt the entire workflow: *"The main problem is when a colleague is missing... then the tasks can't be done as they should, and you have to reorganise everything"* (FG8 ES Target B and C).

This dynamic forces staff to take on additional responsibilities, often beyond their capacity, creating a reactive and exhausting environment. The interdependence within care teams means that each absence delays the entire operation: *"If nursing assistants are missing, everything gets delayed—activities, nursing work, everything"* (FG7 ES Target B and C). To this objective overload, unpredictable incidents are added: *"It's the unexpected—a fall, someone getting sick, family demands... those are the worst days"* (FG6 ES Target B and C).

Beyond the workload itself, subjective pressures reinforce this overload. Workers often hesitate to refuse tasks, endure peer judgment, or feel responsible for covering unfulfilled duties of others: *"You find yourself having to compensate for what a colleague or two have not done"* (FG1 IT Target B). In some cases, boundaries become so blurred that staff normalise postponing tasks or completing them outside of working hours: *"If I can't do it today, I'll do it tomorrow-or even at home, it's not a big deal"* (FG8 ES Target B and C).

Although similar dynamics appear in home care—such as task accumulation, emotional strain, and difficulty setting boundaries—the collective impact in institutions is more pronounced. The structural imbalance forces teams to compensate for organisational

shortcomings daily: *"We come in the morning with very few people and have 50 patients… by the end of the shift you're exploding"* (FG6 IT Target C). Rather than lightening the load, shared effort amplifies it, normalizing a system of chronic exhaustion.

Work Pace. The pace of work varies depending on the care setting. In hospital emergency departments, everything happens very quickly: *"So there the workload is different because it's all faster, much faster…"* (FG1 IT Target B). This speed imposes constant pressure, limits room for maneuver, and can increase physical and emotional strain.

In EHPADs (Residential establishment for dependent elderly people in France), the pace of work is tightly structured by schedules and job descriptions, creating pressure to stay on time and avoid delays that could affect other teams. In protected units, care can be somewhat more flexible and adapted to residents' own rhythms, with activities designed to support autonomy in a setting that feels more like home. Even so, staff constantly balance institutional demands with their ethical commitment. As one worker said: *"We stay as long as we have to, and if I have to stay more than a quarter of an hour, I'll stay more than a quarter of an hour, and I don't want to be told anything because there are people who need more, and maybe that's reassuring for them."* (FG1 FR Target B). This kind of personal dedication, while valuable for care receivers, results in sustained physical and emotional overload for workers, who take on extra tasks without recognition or compensation—leading to moral strain and professional fatigue.

Time Pressure. Time pressure is one of the main structural demands in residential care work. Staff shortages, task overload, and accelerated work rhythms lead to exhausting shifts and hinder the ability to provide personalised care. Work organisation, based on official staffing ratios perceived as unrealistic, forces constant prioritisation, affecting both the quality of care and the physical and emotional health of the workforce. As one participant remarked, *"Politically there's a ratio, but it's not made by people who know what a nursing home is like… they say you have 13 minutes per resident. Sorry? Can you bathe someone with reduced mobility in 13 minutes? That's impossible"* (FG7 ES Target B and C).

In this context, workers are often compelled to take risks—such as transferring residents alone—or to give up essential aspects of care, like listening or providing emotional support. As one professional put it, *"We don't have enough staff and we end up working like a factory. Because we have to move fast, we don't take the time. A quick toilet is not our job. We're there to take our time with the resident"* (FG1 FR Target B). Another participant added, *"We'd like to be able to spend time with each resident… but unfortunately, this isn't always possible"* (FG3 FR Target B).

While coworkers' support acts as a protective resource, many professionals experience ongoing strain from being unable to deliver the kind of care they consider dignified and humane. As one caregiver reflected, *"The main difficulty for me is the lack of time. You're always running out of time... It puts a strain on us"* (FG3 FR Target B).

Schedule Demands. In institutional care work, schedule organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models—such as 12-hour shifts with extended rest periods or the option to condense the weekly schedule—are perceived positively, offering more days off and better recovery. As one worker noted: *"On the positive side, I work days now, whereas I used to work nights, which has improved my social life. I work three days and have four days off, so it's a good balance."* (FG5 FR Target C). Another added, *"I work four days a week, which allows me to take my children to school... This flexibility is a company policy"* (FG5 FR Target C).

However, many professionals face constant shift rotations, extended workdays, weekend duties, and unpredictable scheduling. The alternation between morning, evening, and night shifts—sometimes all in the same week—makes it hard to maintain a healthy personal rhythm. As one worker explained, "*Sometimes I have early shift today, late shift tomorrow, then again late, then a night shift... it's exhausting"* (FG3 DE Target B). Others highlighted the impact of long consecutive shifts: *"Working six days a week with changing shifts... by the end, you're exhausted"* (FG3 DE Target B).

Although some flexible arrangements are appreciated, overall, institutional scheduling often relies on staff over-availability and fails to guarantee predictable patterns. As a participant critically noted, *"I'm supposed to have my shift, but in reality I never do"* (FG1 IT Target B). This system imposes a constant adjustment to operational needs, eroding workers' ability to recover and contributing to long-term strain.

Tasks Beyond Duties. Workers frequently report being asked to perform tasks that do not correspond to their professional role. These include clinical tasks—such as administering enemas, removing catheters, or placing IV drips—despite lacking the required qualifications. As one worker stated: *"It's my business! Because it's not written in my competence that I have to go and put in the drip! And how arrogantly do you expect me to go and put in the drip! (...) They're playing with fire"* (FG2 IT Target B).

Other participants described situations where they regularly carried out duties not belonging to their role, either due to team pressure or work organisation: *"We are often asked to do much more than what we are responsible for"* (FG6 IT Target C), or *"Unfortunately there are things I shouldn't do... but if you have a nurse for fifty patients, you end up giving a hand"* (FG2 IT Target B). Non-clinical tasks were also mentioned, such as cleaning beds or handling maintenance

duties previously assigned to other personnel: *"Everything is now done on the ward... in addition to the actual work, and it's really exhausting"* (FG 4 DE Target C). Sometimes, these additional tasks extend beyond working hours, without recognition or compensation.

These testimonies reflect how staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence of specific personnel, leading to a steady extension of their duties.

Emotional Demands. As mentioned above, emotional demands are divided following Wieck, Kunzmann and Scheibe's (2021) proposal into three subcategories: display, sensitivity and sympathy, and in addition the subcategory of involvement has been added.

Display. Regarding emotional display demands, several care workers report the need to maintain an appearance of calm and strength in front of the people they care for, even in situations of loss, aggression, or personal distress. Although they experience emotional pain, they must "put on a brave face" and continue *"with a smile, while we suffer."* (FG7 ES Target B and C). This emotional restraint is upheld even when there are more patients to attend to: *"You have to keep your game face on and keep going. So, it's not always easy."* (FG5 DE Target C). Some acknowledge that, despite their efforts to hide it, care receivers still perceive their emotional state: *"They're like sponges. When you have personal worries, even if you try to hide them behind a smile, they see it."* (FG3 FR Target B). This constant requirement of emotional self-regulation constitutes an invisible yet deeply exhausting burden.

Sensitivity. In relation to emotional sensitivity demands, several care workers emphasize the need to perceive and respond appropriately to the emotional states of those they care for, using "the right words" to calm, accompany, or avoid causing further distress. One caregiver explains: *"the difficulty is to understand the patient's state of mind, to say the right word and to calm him down."* (FG1 IT Target B). Others describe different strategies to cope with this emotional requirement: some choose to engage and take the time to listen —*"I'd rather leave knowing that everyone is fine"* (FG3 FR Target B)— while others adopt emotional distancing as a form of self-protection, avoiding certain conversations for fear of making mistakes or feeling overwhelmed: *"I create a sort of wall for fear of saying the wrong things and I cut it short."* (FG6 IT Target C). This range of responses reflects the challenges posed by emotional sensitivity as a daily component of care work.

Sympathy. In addition, sympathy-related demands are reflected in the account of a worker who highlights the psychological burden of caring for patients with serious illnesses, with whom emotional bonds inevitably develop: *"you necessarily establish a*

relationship of empathy, sympathy or antipathy, whether you like it or not." (FG6 IT Target C). This emotional closeness, although sometimes unavoidable, can intensify the psychological strain of care work.

Involvement. On the other hand, involvement is reflected in multiple testimonies that reveal both a high level of emotional and practical engagement in the job, as well as difficulties in setting boundaries. Some care workers describe how the bond with seriously ill or terminal patients deeply affects their well-being: *"I still do not know if he will be able to, it is difficult to create this barrier that then leads you to think about your life [...] because if not, we really could not do it for as many years"* (FG6 IT Target C). This involvement also appears as a strong professional commitment, even beyond what is required: *"when I'm involved somewhere, it's not to become a reference point [...] I think it's important, whether or not there's a shortage of staff, to get involved, not less but more"* (FG1 FR Target B). However, other accounts show how this dedication can have an emotional cost that sometimes carries over into personal life, as one worker notes: *"The facts are that depending on the degree of emotional involvement with the resident more difficult. And that sometimes this work is brought home"* (FG2 PL Target B and C).

The accounts analysed underscore the complexity of relational care work, where professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These invisible demands—from emotional display to sustained engagement—are rarely acknowledged or supported at an institutional level, despite their significant impact on mental health and professional endurance. In the absence of formal recognition or adequate support mechanisms, emotional labour remains a silent yet critical risk embedded in everyday care practice.

Exposure to Suffering and Death. Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds. This emotional involvement generates pain that is not always acknowledged or adequately managed. As one participant expressed, *"We care for them... we love them... and when they die, or we face aggression, we have to smile and carry on, but we suffer too"* (FG7 ES Target B and C).

Many report that it is impossible to fully disconnect after their shift and that they carry this emotional burden home: *"There are complicated days... deaths... and I used to come home and cry. I couldn't sleep at night"* (FG1 FR Target B). The feeling of powerlessness—especially when a resident deteriorates or dies despite all efforts—adds a lasting emotional toll*: "This stays with us, even on our days off, and it's emotionally hard to bear"* (FG5 FR Target C).

Although the institutional setting allows for some coworkers' support, this strain accumulates, particularly in cases of successive deaths, advanced dementia, or aggression. Workers emphasised that even when they try to shield themselves, the emotional toll remains: *"We deal with human lives… you can't shield yourself completely. Even if you try, it stays with you"* (FG6 FR Target C). Many acknowledged relying on colleagues to cope with these situations, highlighting the value of mutual support. However, they also stressed the absence of structured psychological assistance: *"We should actually see a psychologist every day. But that's not how it works"* (FG5 DE Target C). As one participant put it, *"I also rely a lot on my colleagues… but difficult days still make for complicated evenings"* (FG7 FR Target B).

Exposure to Violence. In hospitals and residential facilities, care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. Although such incidents are not always labeled as violence—due to their clinical origin—they are experienced as highly stressful and emotionally draining. As one participant explained, *"After the operation, many patients are also aggressive because of the medication… This is not normal and extremely, extremely stressful"* (FG5 DE Target C).

Frontline staff bear the brunt of these interactions, spending long hours directly exposed to challenging behaviours without sufficient coping resources: *"It's us who spend eight hours at the bedside… We have to talk to the patients and repeat everything several times. And then we are confronted with these patients, which makes it difficult and has a negative impact"* (FG5 DE Target C).

In some cases, these behaviours tend to be normalised or dismissed as inevitable consequences of illness: "*Our employees are exposed to all sorts of behaviour… even violence… but it is difficult to call it violence, because these are often uncontrollable behaviours resulting from disease entities… Our employees are a little bit too little protected"* (FG5 PL Target B and C).

These accounts suggest a structural issue: behaviours linked to illness are often not recognised as an occupational risk, which may contribute to their invisibility and to the emotional strain experienced by care workers.

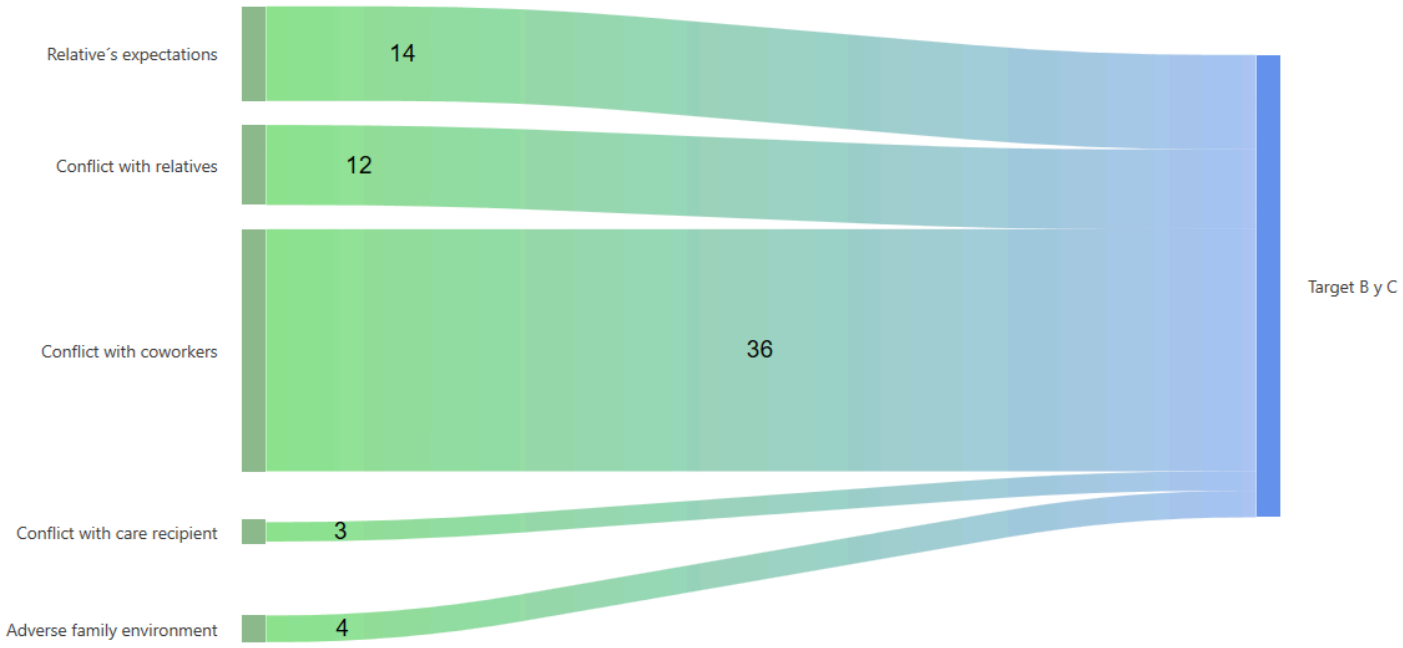
Exposure to Discrimination. In the institutional care sector in Italy, some care workers report dynamics of discrimination and workplace harassment within teams, characterised by mobbing, professional disparagement, and constant mockery. Particularly serious practices are described, such as the unauthorised access to colleagues' medical test results in order to ridicule them, which violates their privacy and reflects a complete lack of ethics in the work environment. One participant summarised her experience by saying: "*I've seen all kinds of mockery… but I responded politely."* (FG2 IT Target B).

These situations reveal a hostile and unregulated work climate, where discrimination is normalised and no effective control or protection mechanisms are in place. Professional inequalities—often linked to migrant backgrounds—undermine workers' self-esteem and generate deep emotional strain.

Perceived Exploitation. In the institutional care sector, the perception of exploitation does not always stem from extreme working conditions, but rather from the loss of ethical meaning in caregiving. One worker put it clearly: *"For me, it's important to be useful without feeling exploited. It's sometimes hard to see how the elderly are treated, and I don't want to be part of that."* (FG3 FR Target B). When caregiving loses its dignity, the work becomes morally unsustainable. Unlike the home care sector, where exploitation is more visible in material and legal terms, here it is expressed as an inner conflict triggered by practices that contradict the core values of care.

Relational Risk Factors

Figure 111. *Relational risk factors at basic and professional care workers group*



Conflicts with Coworkers. Although many testimonies acknowledge the existence of support and cooperation among colleagues, it is also pointed out that such relationships are not always present: *"You don't have that on all wards. It really depends on which colleague is working."* (FG5 DE Target C). These differences set the tone in many teams, where a lack of collaboration, distrust, and disorganisation generates significant distress.

The most frequent conflicts are related to the unequal distribution of shifts, rest periods, or holidays, which results in certain workers—especially those with part-time contracts—bearing a greater share of responsibility: *"I am always the one who has to cover the shift."* (FG1 IT Target B). There are also reports of unfulfilled tasks, inappropriate delegation, or neglect of duties, which burden the following shift. Frustration increases when these situations become normalised and are not addressed collectively: *"When the shift does not turn and there is little communication or continuous spite... that's the problem."* (FG4 IT Target B).

Another major source of tension is the constant rotation of staff and the resulting difficulty in establishing stable and trusting relationships: *"Every week you don't know who you're working with... you know everyone, but basically you don't know anyone."* (FG6 IT Target C). This uncertainty affects both the organisation and the emotional climate of the team.

Communication problems are also described, such as destructive criticism, lack of listening, and constant finger-pointing without a willingness to improve. In some cases, this leads to dynamics of moral harassment, authoritarianism, or disregard for differing opinions: *"If you try to point something out, they say: 'You want to command, who do you think you are?'"* (FG4 IT Target B).

These tensions not only damage relationships among coworkers but also have a direct impact on the quality of care. The accumulation of discomfort can affect how residents are treated: *"You've consumed your patience with them, and then it is the care receiver who pays the consequences."* (FG4 IT Target B).

Overall, the coexistence of experiences of effective cooperation and everyday conflict highlights the urgent need to foster a professional culture based on respect, communication, and shared responsibility—for the well-being of the staff as well as for the quality of care.

Conflicts with Care Receivers. Unlike in the home care sector, where task-related, procedural, and relational conflicts were identified, in the institutional sector, conflicts with care receivers were found exclusively in the relational dimension. These tensions are expressed through dynamics of misunderstanding, excessive emotional demands, and difficulties in establishing empathetic and balanced communication.

Professionals report that some patients constantly expect to be understood without showing willingness to acknowledge the actual working conditions of the staff: *"they want to be understood, but not understand our working situation."* (FG 1 IT Target B). This emotional imbalance generates frustration and strain, especially when demands are expressed in a demanding or disrespectful tone: *"the tone... has become very demanding... and there is a lot of incomprehension."* (FG4 DE Target C).

There are also situations where care receivers insist on accessing services that are unavailable or not covered, refusing to accept explanations or institutional limits: *"they don't want to understand, even when they are referred to other centers."* (FG4 DE Target C). These tense and repetitive interactions disrupt the normal workflow and lead to significant emotional fatigue: *"these are things that take you out of your day-to-day work."* (FG4 DE Target C).

Overall, these relational conflicts reflect a silent yet persistent emotional burden that is often invisible and unaddressed by institutional structures. The need to maintain a professional attitude in the face of tense interactions—without specific support or emotional coping tools—contributes to psychological exhaustion and a sense of relational vulnerability in the caregivers' daily work.

Conflicts with Relatives of Care Receivers. Conflicts with relatives take various forms, which can be grouped into excessive demands, procedural misunderstandings, and relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional management of family interactions.

Excessive demands. One of the most common sources of conflict arises when relatives make demands that exceed the actual capacities of the service. Workers report that these expectations often lead to frustration, as they are impossible to fulfill: *"they demand more than what can be provided at that moment."* (FG6 ES Target B and C). Frequently, the requests focus on specific routines that the care facility cannot realistically accommodate, such as serving *"kiwi at 8 a.m."* (FG6 ES Target B and C). This personalised logic disregards the collective nature of institutional care. Contradictions are also evident between the lack of family involvement and their high expectations: *"we're inviting them... and then they ask why their father wasn't taken out,"* (FG6 ES Target B and C) which highlights the imbalance between demand and participation. In many cases, family disorganisation—characterised by poor communication, lack of coordination, and unclear responsibilities—directly interferes with the team's work and complicates decision-making.

Procedural misunderstandings emerge when institutional rules clash with family habits or preferences. For example, the requirement to wash clothing at high temperatures for hygiene reasons causes complaints: *"everything here is washed at very high temperature."* (FG6 ES Target B and C). Conflicts also arise when different family members give contradictory instructions, leaving staff caught in the middle: *"one relative tells you he wants the pillow placed a certain way, and another comes later asking who changed it."* (FG6 ES Target B and C). These situations highlight the need for stable

communication channels and a designated point of contact within each family.

Relational level. Workers report that some families tend to project their personal frustrations onto the care team, maintaining a critical and distrustful stance toward their work. It is often perceived that any problem arising in daily care is immediately blamed on the staff: *"if something bad happens, the blame is placed on us."* (FG5 PL Target B and C). Additionally, there is frequent confusion between the role of the facility as a care space and expectations of immediate, personalised attention, which puts constant pressure on workers to respond instantly to every request: *"they want everything... in an hour, they won't wait a day."* (FG4 PL Target B and C).

Taken together, these conflicts reflect the complexity of family relationships in institutional care settings. Care workers face not only demanding physical tasks but also the emotional burden of managing interactions with relatives who may not understand the service's limitations or the reality of the working conditions. This dual exposure has a significant emotional impact and underscores the need for organisational structures that support and protect those who care.

Expectations from Relatives. Another key challenge reported by workers in institutional care settings concerns the expectations held by the families of the residents. These expectations are not always clearly communicated and are often unrealistic or difficult to meet within the context of collective care.

One of the most common expectations is that of individualised and continuous attention—something nearly impossible to maintain in facilities with many residents and limited staff. *"Some families believe that their mother or grandfather can have someone by their side 24 hours a day, and that's just impossible,"* (FG7 ES Target B and C) noted one care assistant. Such demands lead to frustration and force staff to constantly justify their work, even when they strive to provide high-quality care.

These expectations also impact the adaptation process to the centre. Several participants mentioned that it is often more difficult for the family to adjust than for the resident themselves, which adds another layer of emotional complexity to the staff's work. Unrealistic beliefs about the potential for improvement also appear: *"There are expectations that are just not real,"* said one worker (FG6 ES Target B and C), especially when families hope for full recoveries in cases of advanced illness or dementia. These misunderstandings can lead to direct complaints or even accusations, as one participant illustrated: *"They come and say: my father is worse than before. What's going on here?"* (FG6 ES Target B and C). A social worker expressed this dynamic with notable clarity: *"We are a bit of a punching bag for a lot of people and situations, and that is indeed one of the most thankless parts of this job."* (FG6 ES Target B

and C).

Tensions also arise when families do not understand the limitations of the institutional environment. Some question falls or behavioural changes without considering the difference between the home and the residence: *"My father doesn't do anything,"* they say, forgetting that *"he's been locked at home watching TV for years."* (FG6 ES Target B and C). While many families appreciate the care provided, those with disproportionate expectations add an emotional burden that falls directly on the staff.

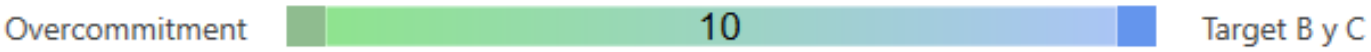
Dysfunctional or Adverse Family Environment. Participants emphasize how strained or disorganised family relationships directly affect both residents and staff. When the children of a resident are estranged or do not communicate, caregivers are often caught in the middle: *"The siblings don't speak to each other... each one has different ideas... and who's in the middle? Us. And the grandfather."* (FG6 ES Target B and C). Everyday matters, like clothing, can also create tension with relatives who show little understanding of how the center operates: *"Some families understand... others say: 'This jacket isn't my mother's.' And I tell them: please, understand we are human and can make mistakes"* (FG6 ES Target B and C).

On the other hand, abandonment or little family involvement has a visible impact on residents. Workers observe that: *"When they don't come to visit, they lose their appetite, stay in bed, stop attending sessions... They simulate symptoms or health decline to get their family to visit."* (FG6 ES Target B and C). Some residents get anxious when family members are absent for a few days: *"They think something has happened... and they make themselves sick. They get nervous, and then they make us nervous."* (FG6 ES Target B and C). Even though caregivers stress that the facility is open to families, they often have to explain that admission does not mean abandonment: *"This isn't abandonment... this is their home, and the doors are open 24 hours a day... this is not family abandonment."* (FG6 ES Target B and C).

Finally, participants remark that even when care is good, family disengagement or conflict remains a source of problems for both residents and staff: *"She was perfectly fine here... but the family completely abandoned her... The family was the one causing the problems."* (FG6 ES Target B and C).

Personal Risk Factors

Figure 112. *Personal risk factors at basic and professional care workers group*



Overcommitment. Overcommitment in the institutional care sector manifests as an involvement that goes beyond what is stipulated in employment contracts, driven by both ethical convictions and structural pressures. This excessive commitment stems not only from a desire to provide quality care but also from a strong sense of inescapable responsibility in the face of staff shortages and team dependency. Workers internalize these demands, often sacrificing their own well-being to avoid letting down colleagues or care receivers.

Be available. One of the most visible expressions of this overcommitment is total availability. Faced with a lack of substitutes or support, many feel they cannot refuse to show up when needed, even if it means giving up their free time or cancelling personal plans. As one participant put it: *"I don't have a knife at my throat, but in conscience, how can I not go?"* (FG1 IT Target B). Over time, some learn to set boundaries and acknowledge that *"being too available is not good"* (FG1 IT Target B).

Perseverance at work. Overcommitment also takes the form of unconditional perseverance. Workers describe how they are expected to appear strong even under extreme physical and emotional exhaustion. The pressure not to let the team down prevents self-care and reinforces a professional culture that makes it difficult to stop or acknowledge one's limits: *"You learn to ignore the pain and fatigue, but it can really catch up with you. Even if you're exhausted, you tell yourself you still have to keep going"* (FG3 FR Target B).

Sense of responsibility at work. This strong sense of responsibility is also evident in daily decisions, such as spending more time than scheduled with a person in need, even if it means working overtime without pay. Some workers assert this ethic of duty with conviction, while still recognizing its toll: *"Today I see this sense of duty as an essential part of our professional commitment [...] even though it can lead to burnout"* (FG3 FR Target B). This deeply rooted mentality is seen as essential for sustaining care work in contexts of high demand and limited support.

Taken as a whole, these testimonies show how overcommitment becomes embedded in the daily routines and professional identity of many institutional care workers. While this dedication sustains essential care delivery amid chronic understaffing and systemic gaps, it

also blurs the line between commitment and self-sacrifice. Without organisational safeguards and recognition, this form of overinvestment places workers at heightened risk of exhaustion, emotional distress, and long-term disengagement.

Non-Work Risk Factors

Figure 113. *Non-work risk factors at basic and professional care workers group*

Family Care Responsibilities and Work-Life Conflict. The personal and family circumstances of institutional care workers profoundly affect their emotional balance and their ability to sustain care work. As in the home care sector, many professionals face a double burden: meeting the demands of their job while also dealing with domestic, economic, or emotional tensions. Work–life balance remains a constant challenge, shaped by structural conditions, emotional demands, and difficulties in fully disconnecting from the job.

Emotional overlap between personal and professional life. In institutional settings, the overlap between work and personal spheres becomes especially evident when workers try to maintain a separation that, in practice, is difficult to achieve. *"It is true that you have to try to get on with your life"* (FG6 ES Target B and C), says one participant, revealing the effort involved in holding both dimensions together without adequate support. This mutual interference increases the risk of emotional exhaustion, particularly in the absence of institutional resources to help manage it.

Some participants recognise the emotional spillover of the job into their private life: *"It's a job that eats you up inside... if you've had a bad day, you feel it at home too"* (FG3 FR Target B); *"These events don't just stop when you leave work... they keep weighing on you, even at home"* (FG5 FR Target C). The accumulated impact of stress, fatigue, and organisational difficulties affects both personal well-being and family relationships, representing a shared concern among institutional care workers.

Impact on family and personal relationships. The lack of time and energy caused by work demands has a direct effect on family life. Many participants acknowledge how

relationships suffer as a result: *"Our husbands are a bit fed up with us"* (FG7 ES Target B and C); *"Sometimes I don't even see my husband all day"* (FG7 ES Target B and C). Having children to care for while working in emotionally and physically taxing conditions results in a continuous care workload with no real space for rest.

In some cases, the workplace becomes a more bearable environment than the home itself. One participant describes work as an emotional refuge from personal stress, reversing the usual pattern that associates home with rest: *"After all, I'd rather be at work than at home, so I'm better off here than at home. [...] I'm too stressed, too angry, too anxious, my children feel it so when I'm at work I'm calm. The work is therapeutic, and after that we're lucky to have good solidarity in the team."* (FG1 FR Target B). This kind of peer support acts as a buffer against emotional strain.

Strategies to preserve boundaries and personal space. Although emotional commitment is part of their professional identity, many caregivers stress the importance of managing personal boundaries. Several professionals describe strategies to separate the two spheres and preserve their own space: *"As soon as I go out the door, I have my family—so, outside of here, nothing"* (FG4 IT Target B); *"There are times when I manage it better and times when I manage it worse. When I realize it, I try to do something relaxing before going home"* (FG2 IT Target B); *"I also need my space, because otherwise, it's not good enough"* (FG1 IT Target B).

Other participants express the importance of consciously avoiding emotional spillover, not only to protect themselves but also for the well-being of others: *"Because if you bring problems at home or home problems at work, it is a big problem [...] it's also dangerous for your well-being and then for colleagues and care receivers, especially for care receivers."* (FG4 IT Target B). Recognising these situations as "alarm bells," one participant explains her strategy to protect herself and others: *"I leave here and the job is finished here; I don't take anything home, I leave my personal life."* (FG4 IT Target B). While this form of emotional self-regulation is seen as essential for the quality of care, it relies heavily on personal effort and maturity: *"maybe even for the years it's a bit more difficult but you have to work on it"* (FG4 IT Target B).

Some workers describe critical moments in which this balance was tested: *"I went back to work three months after my pregnancy, and it was mentally difficult. I had a mini-depression and took three months off, which really helped me to regain my balance."* (FG3 FR Target B). Her testimony highlights the psychological toll of early return to work after childbirth, and the crucial role that adequate rest and recovery time play in preserving emotional well-being.

Scheduling constraints and limited leisure. Long shifts, rotating schedules, and the obligation to work weekends or holidays make personal and family organisation difficult: *"The three shifts and working weekends and public holidays are negative. Which also puts quite a strain on a private life."* (FG4 DE Target C); *"I went down from 40 to 32 hours because I just couldn't do it anymore"* (FG4 DE Target C). For some workers, flexible arrangements—when available—have brought some relief: *"I was able to spread my 32 hours over four days thanks to a very considerate director"* (FG5 FR Target C).

Finally, the ability to live independently on a care worker's salary also plays a key role in emotional and material balance. Widowed, separated, or unsupported women describe increased economic vulnerability. *"I wish I could live on my salary,"* (FG2 IT Target B) states a participant who has lived alone for eleven years, revealing the dual pressure of needing to be self-sufficient within a structurally precarious context.

Taken together, these accounts portray a scenario of overload, insufficient institutional support, and highly demanding living conditions. Yet they also offer specific nuances: for some, work can provide temporary emotional stability, and for others, the team becomes a key source of solidarity. Caregiving is not only a professional task but a practice that coexists with equally intense personal demands—within a precarious balance that must be sustained day by day.

7.2.2. Protective Factors

Context Protective Factors

Figure 114. *Context protective factors at basic and professional care workers group*

Stakeholders Support. Workers' views on trade union support reflect a general sense of limited impact and weak collective representation. Some participants described trade unions as useful in specific situations, mainly for legal advice, acknowledging that *"sometimes even only for legal support... the contact with the unions... works quite well, at least in the hospital"* (FG1 IT Target B). However, they made no reference to collective action or organised mobilisation.

Limited impact of trade unions. Others stressed the absence of professional cohesion and the fragmented nature of the sector, referring to institutions as *"a bit of a closed island"* with little connection between them. This perceived lack of unity is reinforced by the feeling that *"we don't have that association... we don't have some kind of unification that would make that voice strong"* (FG5 PL Target B and C).

Absence of collective voice and visibility. Workers also compared their situation to other professions seen as better organised and more publicly visible. They noted that *"in our case, we don't have the kind of support like teachers, for example, who can go out and strike. In our case, we don't have the kind of support like the nurses who pitched tents outside the Diet"* (FG3 Target B and C).

Disconnection and passivity among professionals. The absence of networking among professionals contributes to this isolation. When asked if they had contact or meetings with colleagues from other institutions, the answer was clear: *"For good measure, no"*. This disconnection often leads to resignation and passivity, as summed up by the statement: *"We accept everything that is imposed on us... we don't even know some kind of fight... we don't even know where"* (FG3 PL Target B and C). Participants also recalled previous experiences with ineffective or merely symbolic unions, describing them as having *"no sort of efficiency at all in social welfare... zero efficiency... I used to be in a labor union... and zero efficiency"* (FG3 PL Target B and C).

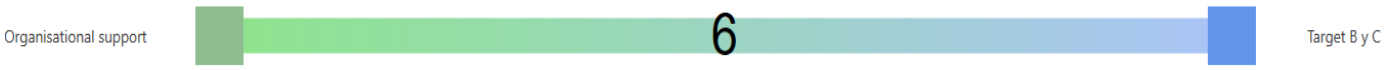
Sector invisibility and lack of advocacy. Some linked this weakness to the low social visibility of the sector itself, remarking that *"teachers, for example, are more in the media... and about social welfare they don't say good things... maybe that's the explanation*

for the lack of unions" (FG3 PL Target B and C). Although trade unions are present, their capacity to represent workers and improve working conditions is perceived as minimal, feeding a broader sense of neglect and lack of protection.

Altogether, the testimonies point to a limited but potentially valuable role of stakeholder support in the institutional care sector. While trade unions are present, their visibility and perceived impact remain low, and collective action appears weak or absent in many contexts. The lack of coordinated advocacy contributes to a sense of isolation among professionals and reinforces the sector's low public profile. Enhancing support structures and fostering stronger professional networks could help improve representation and strengthen the voice of care workers over time.

Organisational Protective Factors

Figure 115. *Organisational protective factors at basic and professional care workers group*



Organisational Support. Organisational support in the institutional care sector is perceived as insufficient and poorly structured. Several workers express that management does not provide adequate support in dealing with day-to-day challenges, often prioritising the needs of families over the wellbeing of staff: *"Sometimes we get the impression that the management doesn't support us enough and favours the families. And yet we too need to be listened to"* (FG3 FR Target B). This lack of recognition and responsiveness creates discontent among staff and weakens trust in the organisation's involvement.

Lack of managerial responsiveness. In some contexts, there are occasional psychological support initiatives, such as the presence of an in-house psychologist with whom workers can share their concerns: *"We have a lady psychologist. After all, we also talk to her and discuss the problems of residents."* (FG2 PL Target B and C). However, this resource is not always continuously available or clearly structured, as one participant notes: *"I think it's a very cool thing. I for one regret that it's so rare."* (FG3 PL Target B and C). Psychological care is therefore viewed as valuable, but offered irregularly and often dependent on specific projects: *"Now we have a project. [...] You come, this is a psychologist, because such a task that this is to give us support."* (FG3 PL Target B and C).

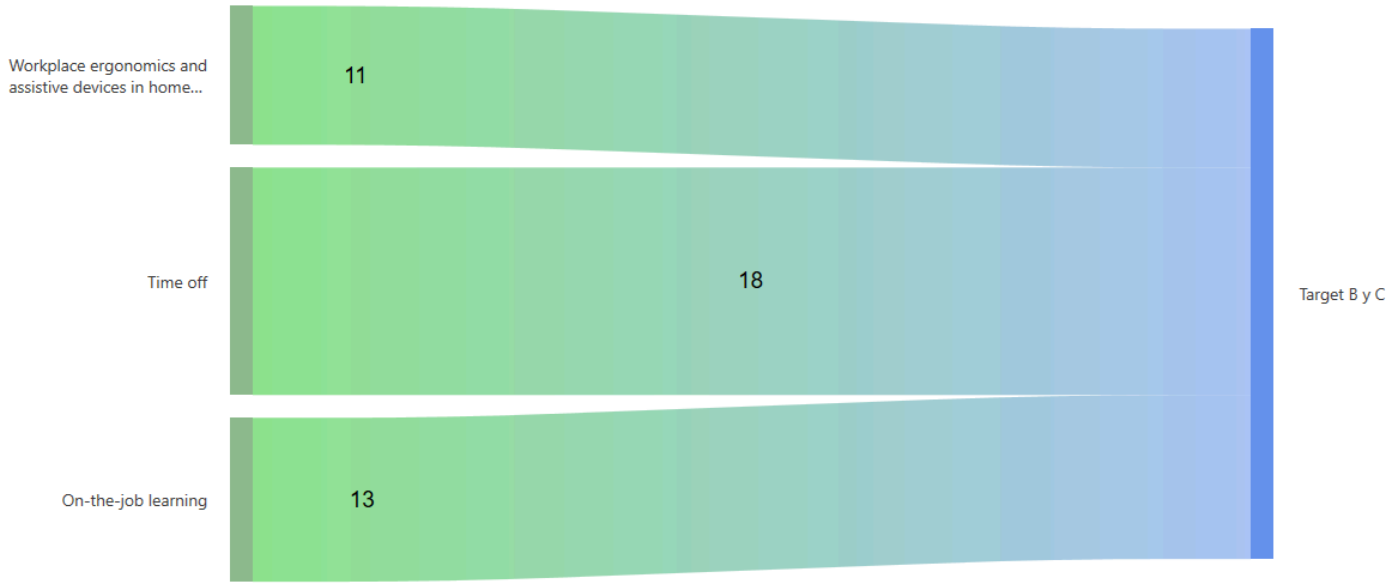
Sporadic well-being measures. Additional measures are also mentioned, such as allocating extra hours to an in-house physiotherapist so that staff can receive

treatment. This initiative is appreciated by some workers: *"They gave one of our team physiotherapists an extra hour to attend to staff members who want to make an appointment. [...] I think it's a good initiative."* (FG7 ES Target B and C). Still, these isolated efforts do not replace the need for a consistent and structured support system.

Overall, organisational support is perceived as limited and fragmented. While there are examples of good practices, workers highlight the absence of a proactive institutional policy that systematically addresses their physical and emotional wellbeing.

Job-related Protective Factors

Figure 116. *Job related protective factors at basic and professionaL care workers group*



Workplace Ergonomics and Assistive Devices. Ergonomic aspects of institutional care work are a key resource for both health and job sustainability. This category includes three main dimensions: the availability of lifting and transfer equipment (such as hoists or adjustable beds), other supportive materials that help adapt the physical environment to the needs of both staff and care receivers, and job design.

Lifting and transfer equipment. The availability of equipment for mobilizing dependent individuals is a central component. In several facilities, participants reported having hoists, adjustable beds, height-regulable stretchers, and other devices that facilitate physically demanding tasks and reduce the risk of injury: *"we have good beds, we can move them properly"* (FG8 ES Target B and C). Some professionals view these developments positively, noting that current conditions have improved compared to

earlier times when *"care receivers were lifted with our arms"* (FG4 IT Target B). However, this is not a universal reality: in other settings, the lack of adequate equipment forces staff to move patients without technical support, putting them at risk of physical injury. Even when devices are available, using them often requires two people, which is not always feasible: *"if you have to use a lift, by rule you should be in pairs, but if you're alone, it's at your own risk"* (FG 4 IT Target B).

Other ergonomic resources. In addition to lifting devices, workers also stress the importance of other ergonomic materials. These include the need for wheelchairs suitable for people with obesity, accessible toilets, side rails on stretchers, and proper lifts. A lack or deterioration of such resources compromises both safety and quality of care, especially in settings already affected by understaffing. Some professionals link these shortcomings to the gradual deterioration of material conditions due to budget cuts and lack of maintenance: *"with fewer staff, fewer grants, and less equipment"* (FG3 FR Target B).

Job design and physical demands. Several participants emphasize that job design must be adapted to the specific nature of institutional care, which involves high physical demands and ongoing strain. It cannot be organised as a conventional office workday. As one worker explains: *"It seems they are beginning to understand that this is not an eight-hour-a-day job, because it's very physical, very repetitive, and very exhausting"* (FG7 ES Target B and C). In some settings, this specificity is starting to be acknowledged, representing a necessary step toward aligning working conditions with the real demands of intensive care.

Together, these testimonies underline the importance of workplace ergonomics and appropriate equipment as fundamental resources for protecting workers' health and ensuring the sustainability of institutional care. While some facilities are making progress in adapting material conditions to the physical demands of care work, others still lack essential devices or the staffing needed to use them safely. Addressing these structural gaps is key to reducing physical strain and aligning job design with the realities of caregiving.

Respect for Time Off. Respect for time off emerges in the testimonies as a key dimension of work organisation in institutional care settings. While rest periods are formally established, their practical implementation is uneven. Many care workers report difficulties in disconnecting due to overlapping responsibilities, blurred professional boundaries, or cultural expectations of constant availability, even during designated rest days.

Benefits of time off. Rest days are widely recognised by institutional care workers as a key resource for physical and mental recovery. Many participants affirm that *"when you come back from a rest day, you feel like new"* (FG7 ES Target B and C), and that even though *"they are few... they're worth it"* (FG7 ES Target B and C), the impact is positive. In facilities with 12-hour shifts and rotational weekends, workers report beneficial effects: *"We're lucky enough to work 12 hours and that means we only have to work one weekend a month. That gives us one week's rest a month... it's all positive"* (FG1 FR Target B). Similarly, having *"three days off on the weekend is really good"* (FG1 FR Target B), allowing time to rest and reconnect with family.

Barriers to disconnection. However, not all experiences are positive. A recurrent issue is the difficulty in mentally disconnecting from work, even during rest: *"It's very difficult to disconnect. I'd say impossible"* (FG7 ES Target B and C). Several workers who also hold coordination responsibilities describe being contacted by colleagues while off-duty: *"You're at home resting, and the night shift calls, the afternoon shift writes... it's impossible to rest"* (FG7 ES Target B and C). This dual role intensifies the difficulty of mentally disconnecting, even during designated rest days. This sense of being always needed or indispensable undermines the restorative function of rest and contributes to emotional fatigue: *"Then we need our days off, to really rest [...] It's impossible because mentally, for us it's not physical it's mental, when you come out of it you're drained and when I say drained it's drained of tears, drained of brain. It's drained everywhere."* (FG1 FR Target B).

Some participants point to a cultural pressure to remain available and supportive, even at the expense of their own wellbeing: *"We feel that our presence is indispensable... we always want to be there, even if it means putting our own well-being on hold"* (FG3 FR Target B).

Limits to recovery. Others describe structural barriers, such as long consecutive shifts or unstable schedules, that compromise the effectiveness of rest: *"You work six days a week, one day off, then shifts again... I'm exhausted"* (FG3 DE Target B). Some participants highlight that having several consecutive rest days after a block of shifts makes a real difference in their recovery: *"One solution was shortening working hours. That's an important point: that you don't work 100%, but 80% and that you don't have so many shifts in a row. Because you immediately notice when you have seven shifts or five and then four days or three or two off."* (FG5 DE Target C).

While some workers successfully disconnect—*"During the vacations? No, that's two weeks to yourself"* (FG3 PL Target B and C)—others still experience physical or emotional strain during time off: *"I was supposed to be resting today... I woke up with an unbearable backache... morally, it's exhausting"* (FG3 FR Target B). The cumulative nature of stress

and fatigue means that even rest periods may not be enough to fully recover when the work rhythm is too intense.

Overall, the testimonies show that time off is valued as essential for recovery, but its effectiveness is often limited by unstable schedules, emotional fatigue, and constant interruptions. When rest periods are not respected or are mentally disrupted, their restorative function is diminished, contributing to cumulative exhaustion over time.

On-the-Job Learning. On-the-job learning is a key resource, taking place through both structured training programs and daily professional experience. However, the effectiveness and relevance of these two learning modalities vary, as reflected in workers' accounts.

Limits of formal training. In terms of formal training, many workers recognize the importance of continuing education but question the utility and accessibility of the courses offered. One participant explained: *"We are so much obliged to do continuing education and training… but I think it is totally ineffective. I've learned much more from practice than from these courses… and if you really want to take a meaningful refresher course, it's very expensive and totally at your own expense"* (FG6 IT Target C). Even when training is available or funded by employers, its content does not always align with the practical needs of caregivers: *"We must have a course that can give us all the same skills, in line with the work we do, because otherwise it becomes very difficult to collaborate on an organisational level"* (FG6 IT Target C). While some report support from their institutions, others note that available courses are sometimes driven by institutional shortages or formal requirements rather than staff learning needs: *"This training course was created to make up for the shortage of care assistant staff"* (FG1 FR Target B).

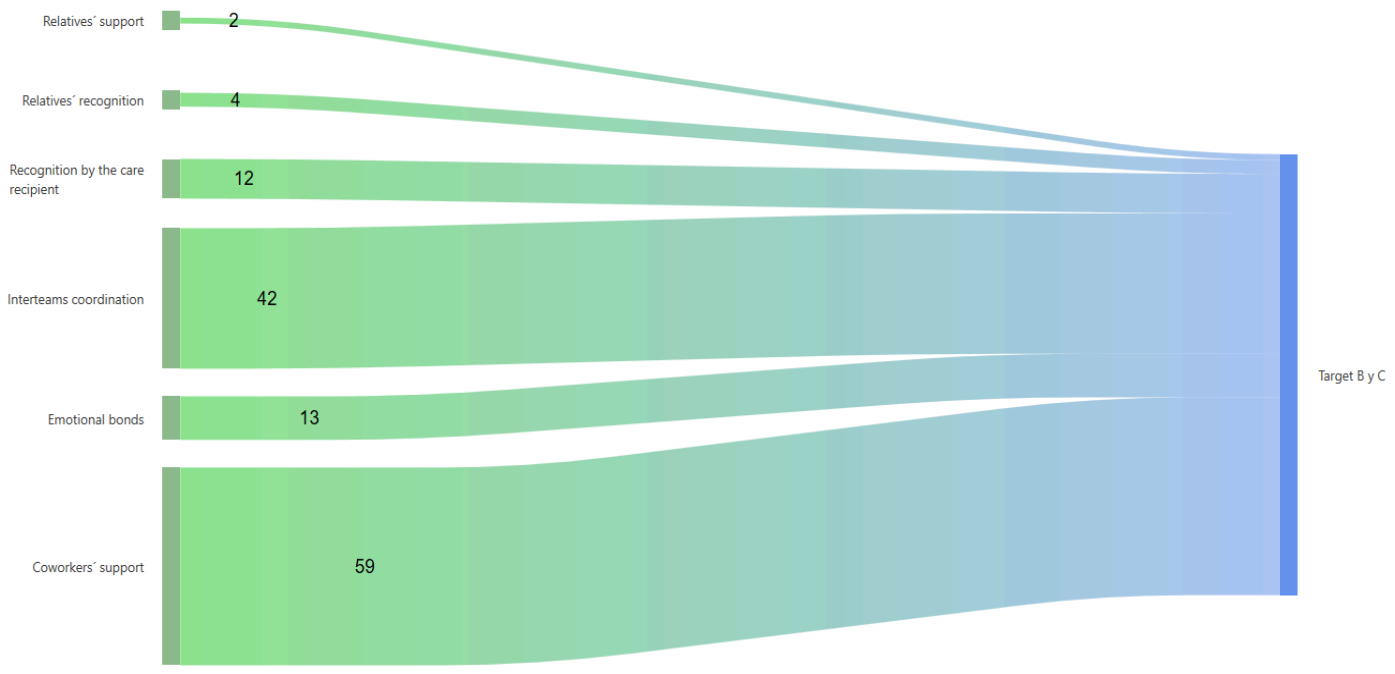
Learning through experience. By contrast, learning by doing is perceived as the most meaningful and transformative form of learning. Workers describe how experience, common sense, and exposure to complex cases shape their professional development: *"That comes from experience. It's the day-to-day. It's not teaching—it's practice, the person, and common sense"* (FG6 ES Target B and C). They emphasize that emotional resilience, communication strategies, and behavioural management are refined through direct contact with residents—especially those with mental health issues, addictions, or severe cognitive decline. *"Today, I discover new aspects of my role as a care assistant every day"* (FG3 FR Target B). Others explain how they've learned to deal with emotionally demanding situations like death, trauma, or aggression by developing coping mechanisms over time: *"I guess the brain finds a way to deal with it on its own… over time, we learn how to deal with it and move on"* (FG2 PL Target B and C).

Learning from coworkers and interdisciplinary collaboration. Workers also highlight the value of peer learning, drawing knowledge not only from residents but also from colleagues and interdisciplinary collaboration: *"I learn every day, not only from my work but from my colleagues, from the physiotherapist, from everyone"* (FG8 ES Target B and C). This informal, experiential learning is perceived as more directly connected to real-life caregiving challenges and better suited to building the nuanced skills required in this emotionally and physically demanding field.

Taken together, the accounts highlight that on-the-job learning is essential for care workers, with experiential and peer-based learning perceived as more relevant and impactful than formal training. While structured courses are often limited in content and accessibility, daily practice and collaboration provide the practical knowledge and emotional tools needed to navigate complex care situations.

Relational Protective Factors

Figure 117. *Relational protective factors at basic and professional care workers group*



Coworkers' Support. Support among coworkers plays a crucial role in the emotional balance and daily functioning of care work. Participants highlight the importance of sharing experiences, decompressing, and relying on one another to manage the job's psychological intensity. As one worker put it: *"We vent to each other, that's how I see it"* (FG7 ES Target B and

C).

Emotional release and trust among coworkers. This support often emerges informally—during hallway encounters, coffee breaks, or after work: *"Informally, informally. For example, you run into her in the hallway and we start venting to each other, because there's no other way, no other way"* (FG7 ES Target B and C); *"When we can, we go out for beers"* (FG7 ES Target B and C).

This emotional openness helps manage stress: *"Many times we yell at each other, but we're not really yelling—we just need to let off steam"* (FG7 ES Target B and C). The presence of emotionally available colleagues brings comfort: *"If I cry, it will be with my partner with whom I want to cry. That's how I see it. I couldn't have done this job with someone I didn't get on with"* (FG1 FR Target B). In intense environments, this bond is even more vital: *"There are complicated days, there have already been deaths, so I used to come home and cry. And I couldn't sleep at night [...] so it's good to have a good group of people around you"* (FG1 FR Target B).

Operational support and teamwork. Colleagues are often referred to as "resources" who contribute directly to care continuity and safety: *"Colleagues are always the resources"* (FG1 FR Target B). Their guidance during shift changes or crises is highly valued: *"If we have a good atmosphere, colleagues like them who are tolerant, who listen, who are there to teach us the right things to do, who are there to tell us what to do, then that's a plus in my book"* (FG1 FR Target B). In workplaces where *"we all collaborate"* and *"we have amazing camaraderie"* (FG7 ES Target B and C), operations are smoother and emotional burdens lighter.

Barriers to mutual support. Yet this support is not universal. Some workers express frustration with colleagues who abuse the system: *"Some colleagues believe they have the more right than others to take time off at home and if they are denied for some reason [...] they simply call in sick [...] and being the only person who does part time I am always the one who has to cover the shift"* (FG1 IT Target B). Others note a generational divide: *"The new generation of nurses are quite like: I do mine and the OSS does his. The old generation of nurses, on the other hand, give you a hand no matter what, even if you don't need it"* (FG1 IT Target B). Institutions sometimes contradict their own discourse on teamwork: *"They've given us such a head for precisely working in teams, for the importance of teamwork, for building relationships with colleagues, and then it's not valued at all"* (FG6 IT Target C).

Impact of instability and rotation. Frequent transfers make it hard to build trust: *"You see that it works, it becomes difficult for you to get used to it again, but this happens all the*

time [...] there's not enough staff, and then the department is closed, you are sent to another" (FG6 IT Target C). For some, rotation brings growth: *"Learn different things, new things, to change a point of view"* (FG6 IT Target C). But others feel exposed: *"If I don't know well the colleague next to me I can't create that relationship of trust [...] you're basically alone"* (FG6 IT Target C).

Professionalism and everyday collaboration. Mutual support doesn't require friendship, but it does require professionalism and empathy: *"We are first of all colleagues, if we get on well with each other, fine [...] we work even better, if we don't get along well [...] we work together but that's the end of it"* (FG4 IT Target B). The effectiveness of collaboration varies: *"It depends who is on duty, if we are not those people who communicate well you don't do it, everyone has to rely on himself"* (FG4 IT Target B). Still, many affirm that *"between ourselves we support each other"* (FG5 PL Target B and C), and that even brief exchanges help them *"digest certain things [...] if we are able to talk it through with each other somehow"* (FG2 PL Target B and C).

Informal support structures. Within many teams, "informal support groups" have formed to deal with both routine and complex challenges: *"The support group behind you creates such a community [...] the best panacea for all these problems and difficulties that you face every day"* (FG2 PL Target B and C). Even small gestures like *"a conversation or joke"* (FG3 FR Target B) are seen as vital to maintaining morale.

In sum, coworker connection and collaboration help care professionals endure emotional strain, maintain equilibrium, and uphold the quality of care. But this dynamic depends on stability, attitude, and institutional recognition. When it exists, it buffers stress and isolation. When absent, workers are left to face the challenges alone.

Inter-Teams Coordination. Effective inter-teams coordination is essential for maintaining the continuity, quality, and safety of care in complex service settings. Drawing on Wagner's (2023) classification, four key mechanisms can be distinguished: mutual adjustment through direct interaction; direct supervision by line managers; standardisation via predefined protocols; and higher-order mutual adjustment, which aims to align different coordination mechanisms already in use. Testimonies from participants in different European countries highlight how these forms of inter-teams coordination unfold in everyday practice, exposing both enablers and obstacles.

Mutual adjustment, based on continuous communication between interdependent workers, emerges as a widespread informal practice across care institutions. Participants describe how they routinely share crucial information about residents' needs and daily events: *"Every day we read the notifications and the incident reports [...]*

That's the first thing we have to do. You come in the morning and read the notifications from the night and afternoon shifts." (FG6 ES Target B and C). This ongoing information exchange allows teams to adapt dynamically to each situation, reinforcing shared responsibility. As one worker noted: *"Communication is almost always constant."* (FG6 ES Target B and C). Coordination is not only verbal but also embedded in routines and digital tools: *"We have a tablet where we enter the resident's progress [...] like, this resident has a fever today, so be careful or consult the nurses."* (FG 6 ES Target B and C). Mutual knowledge among coworkers also facilitates flexible responses: *"As we get to know each other, that's it."* (i.e., it works out naturally) (FG6 ES Target B and C). Even in the face of staff shortages, this adaptive coordination remains key: *"We have to rethink it and get help [...] from whoever is more available in another unit."* (FG8 ES Target B and C). This form of face-to-face coordination, grounded in trust and shared experience, proves essential for managing complex care environments.

Direct supervision. Where mutual adjustment is not sufficient or possible, direct supervision emerges as a necessary coordination mechanism. Some participants describe how they consult with their supervisors when reorganisation is needed: *"We ask her, 'Look, could it be done this way?' and she tells us: 'Yes, no, or maybe better this other way' [...] Between what we propose and what she organises, it gets done."* (FG8 ES Target B and C). This form of coordination reflects a dynamic where the supervisor provides approval or guidance in response to suggestions from staff.

However, the absence of consistent supervisory presence is also reported: *"There is a lack of that person who is responsible and who will help us and tell us."* (FG4 PL Target B and C). This lack of guidance can lead to confusion or improvisation, especially when clear decisions are needed to redistribute tasks or resolve unforeseen problems.

Standardisation contributes to inter-teams coordination by structuring routines and responsibilities in advance. In some facilities, participants describe predefined mechanisms for planning and distributing tasks: *"We have a treatment team and then all the problems of the residents are discussed. Conclusions are drawn along with the program that comes up, and we try together."* (FG3 PL Target B and C). These formal meetings enable joint decisions and systematic responses to emerging issues.

Other testimonies point to predefined shift structures and flexible task division embedded in daily routines: *"We work in a team that is quite good, how we divide the tasks and take care of the patients 24 hours with different hands. Each shift has to do the task very well so that the other shift can work as well."* (FG5 DE Target C). Such distribution of tasks across shifts reflects a planned form of coordination that goes beyond spontaneous adjustments.

Higher-order mutual adjustment. Certain testimonies reflect a higher-order mutual adjustment: professionals not only coordinate with other teams, but actively seek to reinforce or amend coordination mechanisms when these prove insufficient. One nurse described the complexity of aligning various working groups around the needs of each patient: *"There are different working groups that have to work with the patient at the same time [...] And we also have to coordinate this number and organise this time: when is what done and when does everything fit? [...] But in the end, I have to say that in my experience and from my ward, this is what works very well [...] Everyone is open and everyone is willing to adapt."* (FG5 DE Target C). This testimony illustrates a context in which team members consciously engage in meta-coordination to ensure that established inter-teams mechanisms function effectively, intervening when needed to preserve care continuity.

The testimonies underscore that inter-teams coordination depends on a dynamic balance between informal interaction, supervisory input, and structured routines. While mutual adjustment remains a core mechanism sustained by communication and trust, its effectiveness is shaped by team stability and shared experience. Gaps in supervision and inconsistent application of protocols can hinder coordination, particularly in resource-constrained environments. Where coordination works best, different mechanisms are combined and actively maintained by the teams themselves. This integrated approach is critical not only for ensuring continuity and quality of care, but also for fostering a collaborative and resilient institutional culture.

Emotional Bonds. Emotional bonds are a central, ambivalent component of care relationships in institutional settings. The daily routines—assisting with personal care, sharing conversations, and witnessing suffering or joy—gradually nurture a deep emotional connection. In long-term or end-of-life care, this bond intensifies: *"It's really hard for me to say goodbye,"* (FG3 DE Target B) admitted one worker, explaining how terminal patients often remain on the ward to spend their final days surrounded by familiar staff. These experiences reflect how difficult it can be to preserve emotional distance over time, especially when dealing with vulnerable individuals facing critical moments in their lives.

Caregivers often described the relationship with residents as reciprocal and familial: *"They treat us like family,"* said one, while another added, *"It's basically our family."* (FG4 PL Target B and C). These connections bring meaning and joy to the job—*"you can see this joy of theirs, it's so joyful"* (FG4 PL Target B and C)—but they also blur professional boundaries and contribute to emotional exhaustion.

Despite the emotional strain, many professionals find deep meaning in the relational aspects of care. Sharing daily life with residents fosters a sense of connection that can be both

fulfilling and taxing. Some describe how their own emotional state influences their response to residents' needs: *"Sometimes you arrive in a bad mood and leave in a bad mood... we're human, and it depends on how the day hits you."* (FG8 ES Target B and C). Even lighthearted moments—chatting, dancing, joking—can shape the emotional tone of the day. These testimonies underscore that emotional involvement is not just a risk of the job, but a fundamental part of what it means to care.

Recognition by Care Receiver. Recognition from care receivers acts as an emotional resource that helps ease the burden of daily work. Simple gestures like a smile, a hug, or a kind word can have a restorative effect: *"They give you a hug, say a word of affection and you have already forgotten everything you carry inside"* (FG7 ES Target B and C). These moments of connection reinforce the meaning of the job and bring a sense of personal satisfaction: *"to see a grandfather with a smile on his face [...] oh daughter, oh how good you are, these are great satisfactions that you take with you"* (FG6 ES Target B and C).

For many workers, this recognition is also a professional motivator. A small gesture can become a source of encouragement: *"I got a little smile from a gentleman from the protected unit just now [...] that's my resource."* (FG1 FR Target B). Others describe it as a boost that helps them keep going: *"seeing a smile or receiving a word of recognition from them can really make a difference."* (FG3 FR Target B).

In addition, the gratitude and trust that develop over time strengthen the bond with care receivers: *"you hear such a sincere thank you and that the patients trust me above all [...] you can see how the patients trust us day after day."* (FG3 DE Target B). This daily recognition is, for many, what gives them the strength to keep going: *"I am glad that the patients give me this feeling, that they are grateful to me. And that's the best thing."* (FG3 DE Target B).

Recognition by Care Receiver's Relatives. Recognition from families toward care workers is perceived as highly variable, and its presence or absence has a direct impact on the work experience. Some caregivers mention families who understand the difficulty of the job and express their gratitude: *"they understand the decline, they appreciate it. They say: I don't know how you can do this work, and we're so grateful."* (FG6 ES Target B and C). This kind of recognition provides emotional relief and reinforces the meaning of their work.

Other experiences, however, reflect a clear lack of appreciation. Some families tend to downplay the complexity of care or display overly demanding attitudes: *"they underestimate this work of ours and expect too much."* (FG3 PL Target B and C). This lack of recognition can be frustrating and demoralizing for staff, especially when their daily efforts go unnoticed or unacknowledged.

Overall, the testimonies show that recognition from families is not always present, but when it is, it can make a meaningful difference in how care work is experienced.

Support from Care Receiver's Relatives. Relationships with the families of care receivers range from complete absence to active collaboration. Some families are understanding and supportive of the staff: *"there are some families who are fun to work with, who understand us and support us in this somewhat difficult work of ours."* (FG3 PL Target B and C). The institution tries to maintain this contact from the moment of admission, although it is not always successful: *"we are very much nurturing this from the moment we are admitted, to maintain these relationships."* (FG5 PL Target B and C). However, not all experiences are positive, and when difficulties arise, the team often fears that the responsibility will fall entirely on them: *"if something bad were to happen, it would probably often be the fault that would somehow be ceded to us."* (FG5 PL Target B and C).

Supervisor Support. Supervisor and management support plays an important role in shaping the daily experiences of institutional care workers. Testimonies reveal contrasting realities: while some participants report accessible and supportive supervisors, the prevailing narrative reflects frustration with passive leadership, insufficient intervention, and a lack of recognition. These perceptions directly affect the emotional well-being of staff and their ability to cope with the demands of care work.

> Feelings of abandonment and inaccessibility of supervisors. Although a minority of participants speak positively of their supervisors — *"I can count on the management or our superiors. [...] We're lucky to have a director who listens"* (FG1 FR Target B) — most testimonies describe a different experience: one in which listening appears merely formal, without meaningful follow-up or practical response. As one worker explains, *"The coordinator listens to you, but then his response is 'yes, we'll have a meeting'. In the meeting, he brings in management who replies 'these are the funds'. Don't give me the satisfaction of saying you held a meeting to listen to us if in fact you didn't listen to us at all"* (FG6 IT Target C). This lack of tangible outcomes contributes to the feeling that workers' voices are not truly heard, discouraging them from reporting further issues and reinforcing a sense of disconnection from management.
>
> Lack of support in critical situations. A recurrent concern is the failure of supervisors to step in when workers face conflicts or challenges beyond their control. Participants emphasize that certain problems require higher-level involvement, yet this support is often absent: *"There are cases in which the superior should intervene because you can't always solve the situation with your abilities [...] if you have a wall in front of you [...] if there was an intervention from them... also because they are figures that are predisposed for this... otherwise there would be anarchy"* (FG4 IT Target B). The lack of proactive

intervention not only exacerbates difficult situations but also generates a sense of abandonment and institutional disengagement.

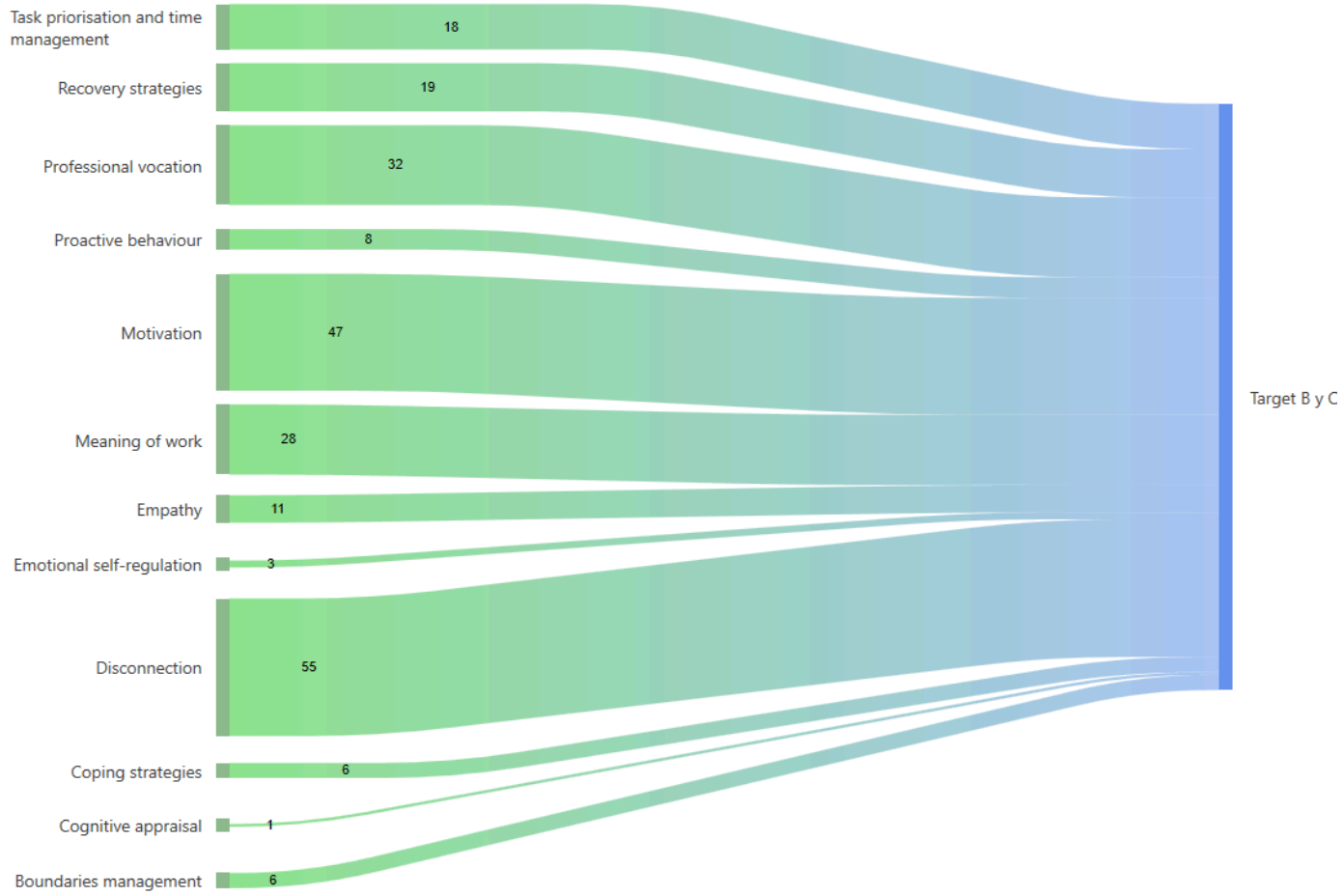
In some cases, this absence of support leads to emotional strain and spillover into personal life. One participant describes how the cumulative stress from insufficient backing causes emotional outbursts at home: *"You arrive at the end of the morning exploding, maybe you even answer badly and you arrive at home starting to get angry with the person in front of you because you want to vent because you can no longer manage the situation"* (FG6 IT Target C). Other testimonies highlight how management's failure to acknowledge the extra effort and responsibility assumed by workers contributes to workplace tension: *"Managers don't always give us enough recognition for our work. We do a lot, sometimes even outside the scope of our duties, such as handing out medication when that's not our role. This lack of support creates tension between the carers and management"* (FG3 FR Target B).

Positive experiences and the limits of reactive support. Even when participants acknowledge that support might exist in theory, it is rarely presented as structured or accessible. Rather than being an embedded part of the organisational culture, it appears conditional and dependent on exceptional circumstances: *"Not yet. There hasn't been such a need. If there was, I'm sure the director would help us with that, because we also have to say that we have great support"* (FG4 PL Target B and C). This conditional availability limits its actual usefulness and contributes to a climate of uncertainty, where workers are unsure of when or how to seek help, or whether their concerns will be taken seriously.

In sum, while some isolated examples of supervisor support are present, the dominant experience reported by institutional care workers is one of institutional passivity, delayed or absent intervention, and emotional disaffection. This gap between expectations and reality not only weakens trust in leadership but also amplifies stress and emotional burden in a highly demanding sector. Ensuring that support mechanisms are visible, consistent, and responsive is essential to foster healthier work environments and reinforce workers' capacity to sustain their care roles.

Personal Protective Factors

Figure 118. *Personal protective factors at basic and professional care workers group*



Coping Strategies. Coping strategies are mentioned in the testimonies as personal tools that help workers manage the emotional demands of institutional care. Participants describe different ways of dealing with difficult situations, including distancing, expressing emotions, and the use of humour.

Distancing. Some participants refer to distancing, highlighting the need to protect themselves emotionally by maintaining a certain separation from the situations they face. One participant explains that creating a "shield" is necessary to continue working, even if it is sometimes difficult to maintain: *"At a certain point you create a shield... otherwise you can't live"* (FG6 IT Target C). Others mention practical ways of distancing themselves, such as using the commute home to reflect and disconnect: *"I think about my day during the journey... and when I get home I can finally let go"* (FG3 FR Target B). Some also speak of stepping back emotionally during intense patient interactions to preserve their professionalism: *"You have to know how to protect yourself while remaining*

professional" (FG5 FR Target C). In high-pressure moments, this emotional regulation becomes instrumental in continuing care delivery: *"You have to act quickly... you had your other ten patients you had to care for as well. You have to keep your game face on and keep going"* (FG5 DE Target C).

Expressing emotions. Some participants mention the importance of speaking openly about conflicts or personal feelings instead of keeping them inside. They emphasize that addressing issues directly, both at work and in other settings, helps to avoid tension: *"If there's a problem with someone, tell them... because if you keep it inside, you don't know how to manage it anymore"* (FG4 IT Target B).

Humour is sometimes used as a coping strategy to handle emotionally difficult situations. One participant shares that joking with colleagues about certain situations serves as a kind of defense mechanism: *"We sometimes find ourselves ironising about situations... probably also as a defence mechanism"* (FG6 IT Target C).

Overall, the testimonies highlight that coping strategies are essential personal resources for navigating the emotional demands of institutional care work. Through emotional distancing, open expression, or the use of humour, workers develop ways to preserve their mental balance and maintain professionalism in high-stress environments. While these strategies vary among individuals, they reflect a shared need to regulate emotional impact and sustain long-term engagement in a demanding sector.

Emotional Self-Regulation. Emotional self-regulation is also regarded as a necessary capacity in institutional care settings, where professionals face demanding situations that require them to remain calm and act with confidence. Some participants highlight the importance of not losing control in such moments: *"You really have to be sure, don't panic, know what you have to do, because then it's a person's life at stake"* (FG4 IT Target B). This need for composure is reflected in statements such as *"you have to have nerves of steel"* (FG1 FR Target B), which emphasize the demand to stay firm even when feeling emotionally affected.

The experience of witnessing the death of residents, sometimes directly, leads many workers to develop internal strategies that allow them to cope with these situations and continue with their work: *"We hold his hand as he just passes to the other side. [...] I guess I get the impression sometimes that the brain is designed in such a way that it just finds some kind of alternative and way to deal with it on its own"* (FG2 PL Target B and C). What might seem like emotional detachment is, in reality, a way of protecting themselves to be able to carry on. One participant put it this way: *"The facts are that depending on the degree of emotional involvement with the resident, it's more difficult. And that sometimes this work is brought home. But also we have to delineate and we know that we have our own lives and we live our lives"* (FG2 PL Target B

and C).

As a whole, the testimonies show that emotional self-regulation in institutional care does not imply a lack of sensitivity, but rather the capacity — acquired through experience — to remain engaged without becoming overwhelmed, especially when working in close contact with fragility, suffering, or loss.

Disconnection from Work. Disconnection from work is often perceived both as a personal resource and as an ongoing challenge for care workers. While taking mental distance from professional responsibilities could help preserve emotional well-being, many participants highlight how difficult —or even impossible— it is to achieve in practice. *"It's very difficult to disconnect. I would say impossible"* (FG7 ES Target B and C). The constant flow of calls, messages, and pending tasks blurs the boundary between work and personal life, especially for those with coordination roles: *"I often arrive home and before I even open the door, my phone is already ringing"* ; *"The night shift calls you, the afternoon shift calls you... it's impossible to rest"* (FG7 ES Target B and C).

Beyond logistical demands, emotionally intense situations or unresolved problems often linger after the working day, making it hard to mentally disengage: *"You always take something from work home, whether you want to or not*" (FG1 IT Target B). Some participants admit that, despite trying to disconnect, certain situations remain present and affect their personal life: *"Some situations are harder to forget than others"* (FG5 FR Target C).

Despite this, some care workers try to set boundaries and adopt strategies to reduce the emotional burden, such as prioritizing urgent matters, refusing to be available at all times, or seeking moments of personal rest: *"I try to disconnect, I don't want to know... I try not to be 24/7"* (FG8 ES Target B and C). These efforts, however, do not always succeed in preventing the impact of work-related stress.

In sum, disconnection is seen as a valuable yet difficult-to-achieve resource—an aspiration that requires continuous effort and that, when not possible, adds an emotional burden. As one participant put it: *"It's not always easy to wipe the slate clean from the previous day, depending on what happened. And that really has an impact on our psychological well-being"* (FG3 FR Target B).

Recovery Strategies. Recovery strategies are mentioned by participants as ways of restoring balance after demanding work situations. These personal resources include practices focused on self-care, physical activity, and leisure, helping care workers to regain energy and maintain emotional well-being.

Selfcare. Some participants emphasize the importance of self-care, which involves setting personal boundaries, taking time for oneself, and finding moments to relax or disconnect. They mention strategies such as reflecting during the commute home, taking walks before going back to family responsibilities, or simply saying no when needed: *"When I have my things, I say no to the head nurse without worrying, because I can't save everything myself"* (FG1 IT Target B); *"I also need time for myself, not just for others, I'm there too"* (FG4 IT Target B). Others highlight the need to consciously separate work from personal life and to find activities that help them relax: *"I try to implement some strategy that leads me to relax and then start again"* (FG2 IT Target B).

Sport is another strategy that several participants mention as a way to release tension and recharge: *"Sport frees me up"* (FG1 FR Target B); *"Sport helps me a bit, sport helps me de-stress"* (FG7 ES Target B and C). For some, practicing sport becomes essential to prevent emotional overload.

Leisure activities. Some participants refer to reading as a simple yet effective way to disconnect: *"For me, it's reading"* (FG 7 ES Target B and C).

Taken together, the testimonies reveal that recovery strategies—ranging from self-care and physical activity to leisure activities like reading—are crucial for sustaining well-being in institutional care settings. These personal resources help workers manage accumulated stress, regain emotional balance, and maintain their capacity to care, especially in contexts marked by high demands and limited structural support.

Motivation. Motivation spans a broad spectrum, from intrinsic motivation to amotivation, following the classification proposed by Ryan and Deci (2017). The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.

Intrinsic motivation emerges strongly in numerous testimonies, reflecting the pleasure and satisfaction derived from the very act of caregiving. Several participants highlight how rewarding this work is, both because of the relationship with the residents and the sense of purpose they find in their daily tasks. They express it with statements such as: *"Working here is worth it for me because this job gives me a lot of satisfaction. I like it. And in the end, it's really worth it."* (FG7 ES Target B and C) or *"The good thing is that I've always loved this job, so it's a real pleasure"* (FG1 FR Target B). In other cases, the emotional connection to the work is emphasised: *"I love my job, the human contact, it's a powerful thing"* (FG3 FR Target B). These statements, expressed with conviction, reflect a strong and enduring motivation that, according to some testimonies, has remained even after

many years in the profession: *"I frankly towards my job even if I have been doing it for many years I am not tired of it [...] I work with the same passion"* (FG4 IT Target B). However, even in this sector, personal satisfaction is not always enough to compensate for accumulated difficulties, suggesting that intrinsic motivation alone may not be sufficient to sustain engagement over time.

Integrated regulation is expressed by those workers who perceive caregiving as part of their identity and personal values. This type of motivation goes beyond immediate enjoyment and is linked to a fully embraced choice. One participant summed it up: *"In any case, it is a job that I have chosen, that I love to do"* (FG6 IT Target C). Others emphasize that this commitment is part of their character and not merely a result of training: *"It's something you carry inside, it's about who you are — your temperament, your mindset"* (FG6 ES Target B and C). These testimonies show how a sense of belonging and personal identification with the job helps sustain long-term commitment.

Identified regulation is observed when workers acknowledge the value of their work, even if they do not always experience it as fully rewarding. In these cases, caregiving is seen as a socially useful and meaningful activity, which helps sustain engagement even in the face of difficulties. As some participants express it: *"Positively, we feel useful, we help and support people, and it feels good to feel that we are supporting them"* (FG5 FR Target C); or *"For me, the job is rewarding when you manage to make a difference to patients. We're happy with what we do and we know that it's good for them"* (FG5 FR Target C). They also value the opportunities for learning and interacting with different people: *"The positive thing about the job is that you get to know lots of people, lots of characters [...] There are also grateful patients"* (FG4 DE Target C). These testimonies show how perceiving the work as inherently valuable can strengthen commitment, even when working conditions are less than ideal.

External regulation appears in some accounts where motivation is linked to job security or the comfort of the position, rather than a genuine interest in the task itself. One participant expressed this candidly: *"However, on the negative side, I'm bored with some of the work and I don't get the full benefit of it. I'd like to be closer to the people I work with, but I have a comfortable working environment that I may not find elsewhere"* (FG5 FR Target C). Although this type of motivation is not predominant, its presence shows that, for some workers, keeping the job may weigh more than personal satisfaction — especially when working conditions are acceptable.

Amotivation is reflected in accounts where disillusionment, fatigue, or the feeling of having lost a sense of purpose emerge. Some workers openly express this lack of enthusiasm: *"I mean, for God's sake, I chose this job. I chose it with full knowledge of the*

facts, but today if they were to ask me about young people, I would tell them 'don't do it'" (FG2 IT Target B). Others show signs of disinterest and disengagement: *"I'm bored with some of the work and I don't get the full benefit of it"* (FG5 FR Target C). The mismatch between the importance of the work and its low social recognition is also mentioned: *"I think this disparity between how important the work is and [...] the fact that the prestige of the social work profession is virtually none"* (FG5 PL Target B and C). Although these voices are less frequent, they reveal the impact that lack of recognition and accumulated strain can have on professional motivation.

Overall, the testimonies from the institutional sector show a strong presence of autonomous motivations — intrinsic, integrated, and identified — confirming a deep commitment to caregiving. However, the expressions of external regulation and amotivation, though less common, highlight how organisational pressure, lack of recognition, or poor working conditions can weaken this motivation over time.

Professional Vocation. Professional vocation is described in the testimonies as a key resource that helps sustain long-term dedication to care work in institutional settings. Rather than depending solely on formal training, vocation is rooted in a personal inclination toward caregiving, a conscious and satisfying choice to remain in the profession, and a character-based resilience to cope with the emotional and physical demands of daily tasks. This sense of purpose supports continuity in the role, especially when working conditions are challenging.

Vocation as a personal inclination and source of meaning. Vocation emerges as a sustained commitment to care work, bringing meaning to daily tasks and reinforcing the decision to remain in the profession over time. For many workers, this choice reflects a clear personal inclination: *"I frankly, towards my job, even if I have been doing it for many years, I am not tired of it [...] I work with the same passion."* (FG4 IT Target B). Some trace this desire back to early stages of life: *"Since I was a child I wanted to be a nurse [...] I am happy because I also work with the elderly."* (FG3 PL Target B and C).

Vocation as a conscious and fulfilling choice. Vocation is also described as a conscious choice, accompanied by satisfaction and a sense of pleasure in human connection, even in difficult contexts: *"It's a job I've chosen, and I love doing it. If I didn't like it anymore, I would have quit."* (FG6 IT Target C). This vocational bond often translates into daily satisfaction and a strong identification with the job: *"I want to retire in this profession because it's beautiful and I love it."* (FG7 ES Target B and C). It is also reflected in how workers value the time spent with those they care for: *"Time flies here, and I wish the clock would stop."* (FG6 ES Target B and C).

Vocation beyond training: character and resilience. Several testimonies emphasize that this disposition does not depend solely on training, but on character, empathy, and the ability to respond in demanding situations: *"You can be the best assistant in the world, but if you've got no fire, it's useless. That comes from the person."* (FG6 ES Target B and C); *"You have to like it to work in this profession. It's a difficult, demanding profession, but if you see yourself in this job, you work and you work very well."* (FG1 PL Target C).

Taken together, institutional vocation acts as a personal resource that supports long-term commitment to the sector, emotional engagement, and the ability to cope with daily challenges—as long as working conditions do not wear it down.

Meaning of Work. The meaning of work is a relevant dimension in institutional care, as reflected in the testimonies of professionals who describe this job as something more than a technical or routine occupation. Rather than focusing only on tasks or responsibilities, they refer to the value they assign to their role, the significance of their daily activities, and the place this work occupies in their lives.

Job satisfaction and everyday meaning in care work. Many care workers describe their job as a genuine source of personal and professional meaning. Despite the difficulties inherent to the setting, they express that caring for others brings them deep and lasting satisfaction. Several participants highlight that this is the job that has fulfilled them the most in their careers: *"this job is the one that fills me the most out of all the jobs I've had,"* or *"it's the one that brings me the most satisfaction when I go home."* (FG7 ES Target B and C).

Social contribution and the relational meaning of care work. Direct human contact, day-to-day support, and the sense of doing something valuable for others are key elements that give their work meaning. As one participant explains: *"we are helping. Even though you're working, you're also helping."* (FG7 ES Target B and C). This value is not limited to the concrete action but extends to a broader impact on people's lives: *"this is a job that gives you so much [...] you give so much, but it is also able to give you so much."* (FG6 IT Target C).

Professional growth and personal fulfilment. In some cases, institutional work is described as a transformative experience that not only allows them to care, but also to receive something in return in the form of learning, connection, or gratitude: *"this work has given me so much, both in terms of intellectual wealth and wealth of life [...] it has really filled me."* (FG4 IT Target B). Despite the fatigue or routine, many people say they cannot imagine doing anything else: *"the idea of doing something else does not arise."* (FG3 PL Target B and C).

Overall, the testimonies of institutional care workers show that the meaning of their work is built through their relationship with residents, the tangible impact of daily care, and the perception of doing something that truly matters. This meaningful dimension is what, for many, justifies staying in the profession even in challenging conditions.

Empathy. Empathy is articulated by institutional care workers as both a vital relational strength and a source of emotional strain. Several participants describe how they emotionally connect with patients, sometimes imagining them as relatives: "You see a young person with dementia and you think: this could be my brother, or my sister... Today it's her, but tomorrow it could be someone in my family." (FG6 ES Target B and C). This empathetic projection heightens their sensitivity and strengthens their commitment, but also requires mental fortitude. Other accounts reflect the emotional burden of building close relationships during long hospital stays: "You inevitably establish empathy, sympathy, or even antipathy... whether you want it or not." (FG6 IT Target C). While some participants describe empathy as a necessary skill—"You do this job well if you work with empathy" (FG4 IT Target B)—others highlight the emotional toll of these attachments, especially when dealing with abandonment, loss, or suffering. These narratives underline that empathy, while essential to care quality, can also intensify the emotional demands of the job, especially in under-resourced contexts where support is limited.

Cognitive Appraisal. Cognitive appraisal appears as a subtle but meaningful personal strategy to cope with the emotional impact of death and loss in institutional settings. A participant described how, after the death of a long-term resident to whom she was emotionally attached, she reframed the experience by focusing on the resident's suffering and advanced age: *"He was very sick already... now he's at rest, he was ninety-something."* (FG6 ES Target B and C). This cognitive reframing—interpreting death as relief from suffering—helps the worker regulate emotions and maintain a functional relationship with loss. While understated, this internal process illustrates a form of meaning-making that allows staff to continue working in emotionally demanding environments without becoming overwhelmed.

Task Prioritisation and Time Management. Task prioritisation and time management are essential dimensions of care work, requiring professionals to make continuous decisions about how to allocate time and attention. Following the classification proposed by Aeon et al. (2021), this process includes adapting time to residents' emotional and clinical states, protecting time to maintain professional focus, and structuring time in ways that balance efficiency with meaningful interaction. In addition to these dimensions, workers also described forms of task prioritisation—a complementary practice through which they reassess what should take precedence based on the immediacy and relational significance of care demands. Together, these practices reflect a dynamic negotiation between institutional

routines and the human complexity of care.

Adapting time involves adjusting the sequence and intensity of tasks based on the emotional and cognitive needs of residents. Workers narrated how small gestures, like painting residents' nails or organising informal activities, had become central to their daily practice: *"In the morning I do things they enjoy—some like to get their makeup done. I don't even know how to do it, but I do it, and they feel so good. I feel good because they feel good"* (FG8 ES Target B and C). This flexibility, however, required constant emotional and organisational investment, especially in contexts of high workload or unpredictable incidents: *"Even if something unexpected comes up, I carry on. You just go with the tasks as much as possible"* (FG8 ES Target B and C).

Protecting time refers to the need to set internal boundaries to prevent emotional overflow and exhaustion, especially among staff in roles with multiple responsibilities. One team leader described how she had to establish a mental cutoff point after her shift: *"From 3:00 or 3:30 pm, when I leave here, only what's important matters to me."* (FG8 ES Target B and C). This was essential to manage stress accumulated throughout the day. A physiotherapist who also coordinated a small residential living unit expressed the tension between her professional training and the broader demands of care work: *"What I studied was physiotherapy, but I don't really feel like a physiotherapist anymore. I do treatments when there's a fall or a contracture, but they're isolated cases. I can't dedicate the time I used to."* (FG8 ES Target B and C). Although she appreciated the closeness with residents, the need to juggle tasks came at the cost of professional fulfillment: *"Some treatments are left aside because I have to attend to other things"* (FG8 ES Target B and C).

Structuring time entails developing personal and collective strategies to organise the day around residents' needs rather than around rigid institutional protocols. Several participants acknowledged the mental effort required to resist institutional pressures, as one explained: *"Even though I know it by heart, I still fall into the same trap—rushing to get the chores done. It's hard."* (FG8 ES Target B and C). Organisational clarity and stability within units also played a role in reducing stress and improving the ability to be present: *"When I started, I was super stressed. But once I got settled in the unit, even if they change me one day, I'm much calmer. I know I can do my job and spend more time with them."* (FG8 ES Target B and C).

Task priorisation refers to the ability of care workers to decide which actions must take precedence in emotionally charged or clinically demanding moments. Rather than following rigid task sequences, professionals often reassess priorities based on the immediate needs of residents. One participant explained that "we leave the beds unmade, the cleaning, the dishes... everything waits. First comes the resident" (FG8 ES

Target B and C), illustrating how relational demands can take precedence over routine tasks. This flexible reprioritisation reflects a stance that may be both relational and ethical, placing the person at the centre of care—even when it disrupts institutional routines.

Overall, the ability to manage time is not only a technical requirement but also a psychosocial resource that shapes how professionals relate to residents and to themselves. Adapting, protecting, and structuring time—alongside the flexible prioritisation of tasks—enables care workers to humanise their practice, buffer the effects of institutional pressure, and uphold a relational ethic in their daily routines—even as tensions and contradictions persist.

Boundaries Management. Boundary management in institutional care settings emerges as a critical strategy to protect one's role, workload, and emotional balance. Two dimensions are particularly salient: task and emotional boundaries.

Managing task-related boundaries. Some workers assertively reject responsibilities that exceed their professional role or training. One participant recounted being pressured by a colleague to perform a medical procedure beyond her remit: *"She says to me: 'Did you go away to pull out the patient's probe and did you do the enema?' I said 'No, because my skills are up to you on the enema.'"* (FG2 IT Target B). Another care worker emphasised the importance of setting limits: *"I've learnt to say no, but to say no in a way that doesn't come across as negative, because you don't always have to say yes."* (FG3 DE Target B). These moments reflect a proactive stance to avoid being overwhelmed, safeguard patient safety, and maintain professional boundaries. However, they also highlight the ongoing pressure to comply: *"Someone comes to you and says: can you please take the patients to the toilet. And you automatically say yes because you think that's my job. But nobody knows how many colleagues have already approached you... That's why you say no, okay, I can't do it now. I have to do something else."* (FG3 DE Target B).

Managing emotional boundaries. Establishing emotional boundaries is equally complex. Workers often guard against excessive emotional involvement or exposure to residents' suffering. One participant expressed this challenge succinctly: *""They observe us, by now they know us and they also understand our mood, so we always have to choose our words carefully and avoid getting too too personal because otherwise that's not good either, because we can't take home 66 family problems"* (FG1 IT Target B). Others described building emotional distance as a form of self-protection: *"Sometimes I realise that when faced with a patient who needs to talk about his illness or his situation, I create a sort of wall for fear of saying the wrong things, and so I try to cut things short for fear of doing even worse, not because you don't want to, so maybe you limit yourself to*

professional information or try to postpone or cut the conversation short by saying 'excuse me now, I need to go to another person who is ringing the bell', things like that, as a form of defence." (FG6 IT Target C). Still, some caregivers acknowledge the difficulty of maintaining such distance, especially when emotionally involved: *"You work with people, not dolls... I can't just go home and forget, I stay here."* (FG3 DE Target B). Maintaining a respectful yet firm distance is also seen as a strategy to ensure professional stability: *"I never go over to you... It's cordial, cool, but nevertheless there is this distance... we have people who are younger and a little problematic in their behaviour."* (FG2 PL Target B and C). Emotional restraint is not viewed as indifference, but rather as a way of sustaining care without becoming overburdened. Professionals described how they manage conversations with residents in a way that maintains warmth while preserving boundaries: *"They observe and ask where you live—various things interest them. Sometimes they try to extract some information. So, not to cut them off or offend anyone, I respond politely about everything and anything we need to talk about."* (FG2 PL Target B and C).

Across both dimensions, boundary-setting is experienced as both necessary and emotionally demanding. While some care workers develop effective strategies to assert limits, others describe the psychological difficulty of refusing tasks or managing expectations, especially when faced with peer pressure or hierarchical ambiguities. These challenges underline the importance of institutional support and peer solidarity in helping workers maintain their wellbeing and protect the integrity of their role.

Proactive Behaviour. Proactive behaviour also emerged as a relevant personal and organisational resource, although it was primarily confined to the first two subtypes of the Chia and Sharon (2013) framework. Workers reported adapting to high-pressure situations, restructuring routines, and reprioritising tasks as ways to maintain both effectiveness and emotional stability in demanding settings.

Proactive person-environment fit behaviour takes shape through deliberate efforts to adjust to professional demands and navigate institutional complexity. One participant described her capacity to remain flexible under changing conditions: *"At work, I always manage to adapt more or less, so I don't consider myself to be a difficult person. I try to remain flexible in the face of change and the unexpected. Whether it's here or in my previous experiences, I've always found a way of coping with the challenges that come my way. Perhaps it's this ability to adapt that helps me get through the more complicated times."* (FG5 FR Target C). This adaptive mindset was also evident in the experience of a professional combining managerial and clinical responsibilities, who described how she reorganised her duties to meet both administrative and therapeutic objectives: *"I*

reorganised everything related to the psychologist's role so it fit with also being a director." (FG8 ES Target B and C). By delegating technical tasks and integrating psychological care into management, she alleviated emotional overload and role conflict.

Other forms of person–environment fit behaviour were grounded in relational sensitivity and emotional self-regulation. A participant described how recognising a resident's emotional state helped her adjust her approach and manage the shift more smoothly: *"It really helps to know the person. I know I have to sit with her because she gets upset, something happened to her. That's essential for me. Then I'm calmer during the shift, and I can handle the relationship with the older people better."* (FG8 ES Target B and C). Another care worker narrated how she deliberately incorporated emotionally meaningful activities to enhance residents' well-being, even without formal skills: *"In the morning I do things they enjoy—some like to get their makeup done. I don't even know how to do it, but I do it, and they feel so good. I feel good because they feel good"* (FG8 ES Target B and C).

These strategies reveal how proactive adjustment enables a more sustainable engagement with complex care environments.

Proactive work behaviour is reflected in the capacity to take initiative in managing daily tasks and anticipating critical situations. This is illustrated by a professional who described the need to remain constantly prepared for medical emergencies while organising routine care: *"You have to organise everything with your patient in such a way that you always have in the back of your mind that a resuscitation call could come"* (FG5 DE Target C). This quote highlights how proactive planning and vigilance are embedded in the practical routines of care work, enabling workers to maintain efficiency without compromising responsiveness in high-stakes contexts.

Overall, proactive behaviour in institutional care settings was reflected in workers' ability to respond constructively to complex or changing circumstances. Whether through individual adaptation to organisational demands or through strategic task planning in unpredictable environments, these actions helped professionals sustain care quality and emotional balance. While these behaviours do not necessarily transform structural conditions, they represent essential strategies for navigating everyday pressures and maintaining continuity in care delivery.

Non-Work Protective Factors

Figure 119. *Non-work protective factors at basic and professional care workers group*

Social Support. Family and friends' support is valued as an essential resource for coping with the emotional demands and workload in the care sector. In many cases, having close people to confide in, share concerns with, or simply feel accompanied by is considered fundamental: *"I'm lucky enough to have a great husband and great kids. So no, no, but it's good to be able to let off steam when you get home, at least to have a shoulder to lean on"* (FG1 FR Target B). The importance of communication with loved ones is also emphasised, whether to express difficulties or gain different perspectives: *"For me, it's really communication that helps. I need to talk about what I'm going through, and I'm lucky to have parents who listen to me"* (FG5 FR Target C).

However, some testimonies point out that family support has its limits, especially when relatives do not share the same professional experience and cannot fully understand the nature of the problems: *"Family members can offer emotional support, but they don't experience the same day-to-day challenges as we do, so their understanding has its limits"* (FG5 FR Target C). Therefore, connecting with friends or colleagues from the same sector is seen as a valuable complement, allowing them to share concrete strategies and feel understood: *"Fortunately, I have friends in the same profession with whom we can share our experiences. They also provide me with a lot of solutions, whether for patients or for the structure of the establishment"* (FG5 FR Target C).

Overall, support networks—family, friends, or professional peers—emerge as a key source of emotional relief, shared reflection, and reinforcement to keep coping with the daily demands of care work.

ANNEX– Illustrative Quotes from Focus Group Participants on Risk and Protective Factors

Table 1. *Illustrative quotes corresponding to different risk factors, as expressed by participants through the focus groups.*

		Home-based Care	Institutional Care
CONTEXT RISK FACTORS	Social status of the profession	-Social undervaluation and role confusion: *"They already see the mop coming in."* (FG1 ES Target A) -Professional invisibility and lack of recognition: *"We don't have any kind of rank... we don't have status. We are nothing."* (FG5 ES Target A) -Post-pandemic invisibility and personal dignity: *"During COVID we were heroes, and now we're invisible again."* (FG2 FR Target A);*"I would enjoy the job if at least I were treated like a human being."* (FG1 DE Target A) -Impact on recruitment and professional identity: *"Young people don't last with these working hours. Also because of the lack of recognition."* (FG2 FR Target A).	-Perceived devaluation and invisibility: *"the forgotten ones here"* (FG7 ES Target B and C); *"Half of them died, and we were the bad ones on top of it... and now it's all being forgotten again"* (FG7 ES Target B and C). -Lack of representation and professional parity: *"We feel that we don't speak anywhere at all"* (FG7 ES Target B and C); *"It seems like the nursing assistants are the ones who really work in the hospital... We are nursing assistants too, and they depend on us"* (FG7 ES Target B and C); *"exploited, underpaid, forgotten by everything... We are nothing and nobody!"* (FG2 IT Target B); *"The OSS is not the man or the cleaning woman at your command!"* (FG2 IT Target B); *"The profile has to be respected... when they don't respect it, we have to take action"* (FG2 IT Target B). -Emotional strain and lack of systemic recognition: *"It can be frustrating. You take it all on yourself, and you don't always feel recognised"* (FG3 FR Target B); *"things got really complicated, because we didn't get the recognition we should have had"* (FG3 FR Target B); *"You realize how everyone is stumbling, even though this job wasn't particularly well regarded at the beginning"* (FG4 DE Target C); *"they don't feel valued by the system"* (FG5 PL Target B and C). -Negative public image and barriers to recruitment: *"They are closing down training courses because people don't want to come... and yet the pay is still oscillating at the minimum wage"* (FG5 PL Target B and C); *"There are large disproportions between medical professions*

		Home-based Care	Institutional Care
			and the very similar, or actually identical, work that we do" (FG5 PL Target B and C). -Need for collective representation and long-term motivation: *"We don't have that association… that unification that would make that voice strong"* (FG5 PL Target B and C); *"with these low wages, these good hearts play the biggest role"* (FG5 PL Target B and C); *"It makes you so uncomfortable… so demotivated to study in this field or to work here"* (FG5 PL Target B and C).
	Precarious employment	-Contractual insecurity: *"There are people who start working for 6 months, then go in and don't stop, and there are people who finish and have to wait 6 months again to start working"* (FG4 ES Target A); *"Sometimes you don't even get a contract… I ask for one and they don't give it to me"* (FG9 ES Target A); *"You go through very hard times when you're not regularized… they skimp on food, they want to give you leftovers… but when I formalized and had a contract, everything changed"* (FG5 ES Target A); *"All of us here are from the substitute list… it's not the same as having a permanent position"* (FG4 ES Target A); *"I have stress here at home, I go to work, I have stress… the company just thinks of money. They don't care that at some point we'll burn out. Last year, five of my colleagues burned out and changed sectors… I'm at the edge of burnout myself"* (FG1 DE Target A). -Economic instability: *"If the care receiver goes to the doctor and you don't work that day, you don't get paid"* (FG4 ES Target A); *"One month you work the same hours and earn 600€, the next month with the same care receivers and hours, you earn 800€"* (FG2 ES Target A); *"You don't even know how much you're going to get paid at the end of the month… Every month is different"* (FG4 ES Target A); *"If the care receiver is hospitalized, I don't get paid… And at the end of the month I've been working but I don't get my full salary"* (FG4 ES Target A); *"We've all gone through hard moments when you're not formalized—like when they cut your food or give you leftovers"* (FG5 ES Target A).	*"You don't have an adequate salary because I've been a widow for eleven years, I live alone and I'd like to say that I can live on my salary"* (FG2 IT Target B).

		Home-based Care	Institutional Care
		-Low pay: *"We don't earn anything special here... and in another organisation, for example, it's even less, but you're doing exactly the same work, with the same conditions"* (FG4 ES Target A); *"Working 54 hours a week and having 1200 euros a month is very little"* (FG5 IT Target A); *"In the contract it was not this, I had 1500 euro and I worked 24 hours a day, when I say 24 hours a day it means that to be called at night maybe 4 or 5 times a night"* (FG5 IT Target A).	
ORGANISATIONAL RISK FACTORS	Staff shortage	*"Before, we had more time and fewer responsibilities. Now, with staff shortages, we have to do more in less time, which increases our stress."* (FG2 FR Target A).	*"We're always short-staffed because we're always doing double duty"* (FG1 FR Target B); *"a quick toilet is not our job... we're there to take our time with the resident"* (FG1 FR Target B); *"after a short time they decided to close it due to lack of staff and so we were shunted to various departments"* (FG6 IT Target C).
	Lack of funding	*"There are people who need more time at home, and we're running out of time to provide quality support, care or work."* (FG4 FR Target A).	*"There is this thing of being a company, of being managers on the part of the nursing coordinators which goes to emphasise giving much more importance to the budget than to the actual care... Because what matters is the budget, we even went as far as to say that she wanted to reduce the quantity of drugs ...We are a haematological department, we are a hospital department, I have to give two 20 mg tablets to the patient who takes the 40 mg tablet?"* (FG6 IT Target C).
JOB-RELATED RISK FACTORS	Physical demands	-Manual handling of people without adequate support: *"I have to carry her weight myself, whether to get her into the shower, take her to the toilet, or for any other movement I have to do with her"* (FG5 ES Target A); *"We use the body, because my back hurts at the end of the day"* (FG4 FR Target A) -Limited use of technical equipment: *"He says it's not necessary to use a hoist because she doesn't weigh much... but I do feel it"* (FG5 ES Target A) -Underestimation of physical strain as an occupational risk: *"This is not a 25 kg box of oranges... it's a person weighing 100 kilos, and you*	-Risk of musculoskeletal injuries and chronic pain: *"If you have to use a lift by rule you should be in two, but sometimes you can't... so it's at your risk"* (FG4 IT Target B); *"We have many sick leaves because of bone issues... cervical problems, lifting weight"* (FG8 ES Target B and C); *"I've been carrying them on my back for 28 years"* (FG7 ES Target B and C); *"It's a very physical job... even nurses bend down to do a dressing"* (FG7 ES Target B and C). -Staff shortages, time pressure, and unsafe practices: *"Sometimes you're in a hurry and lift someone alone... and then you carry it in your back"* (FG7 ES Target B and C); *"Back pain in intensive care is normal...*

		Home-based Care	Institutional Care
		have to move them carefully" (FG1 ES Target A). -Individual responsibility for risk prevention: *"I forgot, the biggest problem in my team is posture and back pain. Carrying the elderly... it can take its toll on your body"* (FG4 FR Target A).	*I would describe all that as negative, it's physically, emotionally, and psychologically stressful"* (FG5 DE Target C). -Ineffectiveness of prevention measures and undervaluation of physical effort: *"This is the hardest job... the one that hurts my back the most"* (FG7 ES Target B and C); *"Now the patients are heavier... and even though we have the machinery, it's not the same if you're alone"* (FG4 IT Target B).
	Safety hazards	-Biological exposures: *"I made masks out of my daughters' disposable bibs. (...) We doused ourselves in alcohol, and if you had lit a match, we would've gone up like the Fallas in Valencia."* (FG1 ES Target A). -Exposure to fire hazards: *"The grandson was smoking joints in front of me with my mask on, right in the middle of the pandemic (...). I walked out of there completely high."* (FG1 ES Target A). -Other environmental conditions: *"I got a call from coordination: 'Pack a small bag with her clothes and medication, but make sure the son doesn't see you,' because he didn't want her to be taken away (...). If that man had come in drunk and seen me packing his things, he could've done something to me."* (FG1 ES Target A).	-Biological exposures: *"We are exposed to health hazards that no one even realizes; no one sees how dangerous this profession is. We were the ones facing the new virus, we were there, keeping things going."* (FG7 ES Target B y C). -Other environmental conditions: *"I can care for patients every day or risk my life... but in the end, there's almost nothing left. I work the whole month just to be able to pay the rent, electricity, insurance..."* (FG3 DE Target B).
	Travel demands	-Cumulative burden of travel between care receivers: *"I have to work six hours, but I end up doing seven or eight—and no one pays me"* (FG1 ES Target A); *"I've been walking around this town for fifteen years... and the hills are exhausting"* (FG1 ES Target A) -Unplanned travel and schedule changes: *"Last-minute changes to schedules. Problems related to the organisation of work, such as travel between interventions, can also be a source of fatigue"* (FG6 FR Target A) -Working in unfamiliar or hard-to-reach areas: *"Sometimes I find myself in another sector where I don't know the care receivers... or it's in the forest and you can't get a signal"* (FG4 FR Target A) -Personal costs and responsibility for transport:*"It's expensive, and we're already on a low salary, so we have to cope with the wear and tear*	(Not apply)

		Home-based Care	Institutional Care
		on the car" (FG2 FR Target A); "*I spend an awful lot of time on the road… it takes up all my free time"* (FG7 FR Target A and C) -Effects on well-being and daily exhaustion: *"The constant commuting and irregular working hours can be exhausting, and I completely agree that it affects my energy outside work too"* (FG7 FR Target A and C).	
	Workload pressure	-Increased workload due to staff shortages: *"For example, last Saturday there were only three care assistants instead of five. We had to reorganise our day and deal with the pressure"* (FG6 FR Target A); *"They tell you: 'I need you to do this, you have to do it, I don't have anyone else,' and you get home at nine o'clock at night saying, I can't take it anymore"* (FG4 ES Target A). -Accumulation of responsibilities and administrative overload: *"In my role, the stress of responsibility and the workload can be overwhelming"* (FG7 FR Target A and C); *"you have one person in the morning with a very difficult character […] then you have another with Alzheimer's […] another one has a deep depression […] you have to adapt, cheer her up… At 9:00 p.m., when I get home […] my head can't process anymore."* (FG2 ES Target A). *"I'm responsible for the person's well-being, the paperwork, plus my training, which I'm putting aside because it's too much at the moment"* (FG4 FR Target A). -Emotional strain linked to workload pressure: *"You feel obliged to do everything, but you end up wearing yourself out"* (FG2 FR Target A); *"I was mentally very tired in the evenings because I had a lot of administrative stuff to deal with for my job"* (FG4 FR Target A).	*"There are moments when you need more staff because you just can't meet all their needs"* (FG6 ES Target B and C); *"The main problem is when a colleague is missing… then the tasks can't be done as they should, and you have to reorganise everything"* (FG8 ES Target B and C); *"If nursing assistants are missing, everything gets delayed—activities, nursing work, everything"* (FG7 ES Target B and C); *"It's the unexpected—a fall, someone getting sick, family demands… those are the worst days"* (FG6 ES Target B and C); *"You find yourself having to compensate for what a colleague or two have not done"* (FG1 IT Target B); *If I can't do it today, I'll do it tomorrow—or even at home, it's not a big deal"* (FG8 ES Target B and C); "*We come in the morning with very few people and have 50 patients… by the end of the shift you're exploding"* (FG6 IT Target C).
	Work pace	*"In a nursing home, each staff member does their job… everything is structured and organised"* (FG4 ES Target A); *"In home care, you might spend three hours with one person and then have to run with the next one"* (FG4 ES Target A); *"We have to go at their pace, not ours… everything is more delicate, more gentle, more slow"* (FG5 ES Target A); *"Sometimes we have to move as quickly as possible, but we know that*	*"So there the workload is different because it's all faster, much faster…"* (FG1 IT Target B); *"We stay as long as we have to, and if I have to stay more than a quarter of an hour, I'll stay more than a quarter of an hour, and I don't want to be told anything because there are people who need more, and maybe that's reassuring for them."* (FG1 FR Target B).

		Home-based Care	Institutional Care
		some patients need more time" (FG8 FR Target C).	
	Time pressure	*"We don't have enough time to do our job properly. For example, half an hour to get someone up, feed them and dress them is a very short time. When the person needs more time, we're forced to rush things. This can be particularly stressful, especially at weekends, when you're alone with the patients."* (FG2 FR Target A)	*"Politically there's a ratio, but it's not made by people who know what a nursing home is like… they say you have 13 minutes per resident. Sorry? Can you bathe someone with reduced mobility in 13 minutes? That's impossible"* (FG7 ES Target B and C); *"We don't have enough staff and we end up working like a factory. Because we have to move fast, we don't take the time. A quick toilet is not our job. We're there to take our time with the resident"* (FG1 FR Target B); *"We'd like to be able to spend time with each resident… but unfortunately, this isn't always possible"* (FG3 FR Target B); *"The main difficulty for me is the lack of time. You're always running out of time… It puts a strain on us"* (FG3 FR Target B).
	Schedule demands	*"Reconciling work and private life. It's a bit complicated, even though we work in shifts because we finish quite late and start earlier at 7.30am-12pm and 4pm-8.30pm."* (FG7 FR Target A and C); *"I leave at 8 a.m. and get back at 7:30 p.m.... with lots of gaps in between"* (FG1 ES Target A); *"You're working 11–12 hours every day… and you come home saying: I can't take it anymore"* (FG4 ES Target A); *"After two weeks like that, your body doesn't hold up"* (FG4 ES Target A); *"I've had to wait an hour or two in the car… and obviously, I didn't get paid"* (FG4 ES Target A); *"Sometimes they don't even ask… they just assume you'll cover"* (FG4 ES Target A); *"I worked 24 hours a day… they would call me four or five times a night"* (FG5 IT Target A); *"The irregular hours disrupt my life… it's partly because of this that I separated from my husband"* (FG7 FR Target A and C)	*"On the positive side, I work days now, whereas I used to work nights, which has improved my social life. I work three days and have four days off, so it's a good balance."* (FG5 FR Target C); *"I work four days a week, which allows me to take my children to school… This flexibility is a company policy"* (FG5 FR Target C); "*Sometimes I have early shift today, late shift tomorrow, then again late, then a night shift… it's exhausting"* (FG3 DE Target B); *"Working six days a week with changing shifts… by the end, you're exhausted"* (FG3 DE Target B); *"I'm supposed to have my shift, but in reality I never do"* (FG1 IT Target B).
	Task beyond duties	-Household tasks outside the scope of care work: *"Let me give you an example, on 24 December, family dinner at home and when you arrive the next day you find a mountain of dishes in the kitchen… They ask you to pick it up when it's not our job at all. But you have to fight with them*	*"It's my business! Because it's not written in my competence that I have to go and put in the drip! And how arrogantly do you expect me to go and put in the drip! (…) They're playing with fire"* (FG2 IT Target B); *"We are often asked to do much more than what we are responsible for"*

		Home-based Care	Institutional Care
		not to do it" (FG1 ES Target A). -Role misuse and overstepping by family members: *"They see you enter and say: 'The cleaner is here'... you explain it again and again, but they don't get it"* (FG1 ES Target A); *"When the live-in left, I was the one who had to clean the room after three months... that wasn't my job"* (FG1 ES Target A). -Emotional pressure to comply with extra tasks: *"If another caregiver has done everything the family wanted for months, when I refuse, I'm seen as the bad one"* (FG4 ES Target A). -Performing medical tasks without proper authorisation: *"We end up doing things we shouldn't be doing, like dressing ulcers... if I don't do it, no one will, but that's not my job"* (FG4 ES Target A); *"If the company doesn't stand behind you, there's serious criminal liability... even for things like compression stockings or dressings"* (FG2 DE Target A).	(FG6 IT Target C); *"Unfortunately there are things I shouldn't do... but if you have a nurse for fifty patients, you end up giving a hand"* (FG2 IT Target B); *"Everything is now done on the ward... in addition to the actual work, and it's really exhausting"* (FG 4 DE Target C).
	Role ambiguity	-Mismatch between contractual information and actual care needs: *"They give you a contract for a self-sufficient person, and when you arrive, you see that the person is not really self-sufficient"* (FG5 IT Target A); *"These contracts that say 'autonomous' need to be revised—no elderly person is really autonomous"* (FG5 IT Target A). -Unforeseen tasks and undefined working conditions: *"Night duties are only supposed to be at home, not at the hospital"* (FG5 ES Target A); *"In the morning, after not sleeping or sleeping just a few hours, I'd feel dazed all day"* (FG5 ES Target A). -Lack of clear information on patient conditions and expectations: *"We don't always have the necessary information on the patients' pathologies or precise expectations"* (FG6 FR Target A); *"It's about not finding yourself alone with complex problems"* (FG6 FR Target A); "*The information we are given is not always clear or sufficient, which complicates our work even more"* (FG2 FR Target A). -Role stretching and unacknowledged responsibilities: *"I had a lady with depression and psychosis who refused any medications—it was*	(Not apply)

		Home-based Care	Institutional Care
		mental torture… and the problem was also the lack of contact with the family" (FG2 DE Target A).	
	Emotional demands	-Display: *"all I try to do is to remain, first of all, stoically calm with my charges and not show, for example, my irritation, even when I'm sick or feeling bad."* (FG1 DE Target A) -Sensitivity: *"you end up taking all the crap they've been bottling up…".* (FG1 ES Target A); *"what would I do without you?"* (FG1 ES Target A); *"acting as a psychologist"* (FG3 ES Target A) -Sympathy: *"I prefer to tell them that I am X"* (FG7 FR Target A and C); *"It's no good, but at least I can do my job"* (FG7 FR Target A and C) -Involvement: *"I haven't been able to detach from her, because I give myself so fully to her."* (FG5 ES Target A); *"I care for them, I love them, I don't want anything bad to happen to them. So when he treats you badly, you think: look at all I've done, and still he treats me this way?"* (FG3 ES Target A); *"You're always left with that uneasiness about what you'll find the next day."* (FG1 ES Target A).	-Display: *"With a smile, while we suffer."* (FG7 ES Target B and C);*"You have to keep your game face on and keep going. So, it's not always easy."* (FG5 DE Target C); *"They're like sponges. When you have personal worries, even if you try to hide them behind a smile, they see it."* (FG3 FR Target B). -Sensitivity: *"the difficulty is to understand the patient's state of mind, to say the right word and to calm him down."* (FG1 IT Target B); *"I'd rather leave knowing that everyone is fine"* (FG3 FR Target B); *"I create a sort of wall for fear of saying the wrong things and I cut it short."* (FG6 IT Target C). -Sympathy: *"you necessarily establish a relationship of empathy, sympathy or antipathy, whether you like it or not."* (FG6 IT Target C). -Involvement: *"I still do not know if he will be able to, it is difficult to create this barrier that then leads you to think about your life […] because if not, we really could not do it for as many years"* (FG6 IT Target C); *"when I'm involved somewhere, it's not to become a reference point […] I think it's important, whether or not there's a shortage of staff, to get involved, not less but more"* (FG1 FR Target B); *"The facts are that depending on the degree of emotional involvement with the resident more difficult. And that sometimes this work is brought home"* (FG2 PL Target B and C).
	Exposure to suffering and death	-Emotional impact of end-of-life situations and patient suffering: *"It's hard when someone tells you again and again that they're tired of living… and you have to keep encouraging them"* (FG5 ES Target A). -Exposure to traumatic events and unsafe situations: *"I saw him hanging from the window… He jumped. He'd been crying out for help"* (FG3 ES Target A); *"I stepped in and told him, 'You may not love her, but that doesn't give you the right to hit her'"* (FG3 ES Target A).	*"We care for them… we love them… and when they die, or we face aggression, we have to smile and carry on, but we suffer too"* (FG7 ES Target B and C); *"There are complicated days… deaths… and I used to come home and cry. I couldn't sleep at night"* (FG1 FR Target B); *"This stays with us, even on our days off, and it's emotionally hard to bear"* (FG5 FR Target C); *"We deal with human lives… you can't shield yourself completely. Even if you try, it stays with you"* (FG6 FR Target

		Home-based Care	Institutional Care
		-Emotional toll and lack of support mechanisms: *"Some situations are harder to forget than others... There are times I've come home and couldn't hold back the tears"* (FG8 FR Target C); "*What I often do is create little routines to relax. I do yoga in the morning before I start my day, which helps me to stay zen. But sometimes I realise that it's not enough. It's when there are really difficult situations, like patient deaths, that it becomes complicated. At times like this, I call on the services of a therapist to help me through these periods."* (FG7 FR Target A and C).	C); *"We should actually see a psychologist every day. But that's not how it works"* (FG5 DE Target C); *"I also rely a lot on my colleagues... but difficult days still make for complicated evenings"* (FG7 FR Target B).
	Exposure to violence	"*Then the grandmother would chase me, she would chase me to hit me, she told me 'get out of here, I'm going to call the police'... I would hide and lock myself in the room, scared, because it was my first time, I hadn't worked with people with dementia before."* (FG9 ES Target A).	*"After the operation, many patients are also aggressive because of the medication... This is not normal and extremely, extremely stressful"* (FG5 DE Target C); *"It's us who spend eight hours at the bedside... We have to talk to the patients and repeat everything several times. And then we are confronted with these patients, which makes it difficult and has a negative impact"* (FG5 DE Target C); "*Our employees are exposed to all sorts of behaviour... even violence... but it is difficult to call it violence, because these are often uncontrollable behaviours resulting from disease entities... Our employees are a little bit too little protected"* (FG5 PL Target B and C).
	Exposure to abuse	*"It was still with sexual overtones...It's really awful. But this company knew it... This company knew everything... but acted as if it wasn't happening"* (FG2 DE Target A); *"Come touch me'... I told him I'd call his children. 'No, no, I won't do it again,' he said"* (FG9 ES Target A); *"I take a deep breath and say, 'I'm leaving, I'll pick up my things and go,' and then he says, 'no, no, don't go, I'll die'"* (FG9 ES Target A).	(Not apply)
	Exposure to discrimination	*"There are Italians who don't accept you... even racists... and also certainly good families who accept you and value the work we do"* (FG5 IT Target A); *"Then the fact that you are a foreigner... a bit of racism... a bit of a lot of things"* (FG5 IT Target A).	"*I've seen all kinds of mockery... but I responded politely."* (FG2 IT Target B).

		Home-based Care	Institutional Care
	Perceived exploitation	*"I had to iron every day. Five people. For 900€. I went out every fifteen days, they didn't pay me holidays or rest days"* (FG9 ES Target A) -Abusive recruitment and informal intermediaries: *"He charged 1600€, gave us 600€, and didn't pay social security. He told us we were registered"* (FG9 ES Target A); *"They didn't respect me, they would come at 11 p.m. asking me to iron pyjamas. [...] Even if it's your room, it's not respected"* (FG9 ES Target A). -Overwork and insufficient resources for quality care: *"Even if you are a very good worker, you cannot provide quality care under those conditions"* (FG9 ES Target A). -Lack of respect for rest time: *"A day off? None of them ever asked for that"* (FG2 DE Target A); *"Basically I couldn't go out. Families pretend. They treat us like modern slaves. [...] It's written '24-hour help' in the documents"* (FG2 DE Target A). -Legal vulnerability and impunity for abuse: *"The company disappeared. The case went to court and then to a bailiff"* (FG2 DE Target A); *"This is human trafficking—hard work without pay"* (FG2 DE Target A).	*"For me, it's important to be useful without feeling exploited. It's sometimes hard to see how the elderly are treated, and I don't want to be part of that."* (FG3 FR Target B).
	Cognitive demands	*"We ask ourselves questions: Has the situation been well managed? Did we take our responsibilities properly? Sometimes we'd like a doctor to reassure us, but that's not always possible"* (FG8 FR Target C); *"We always think after we've seen a care receiver... I sometimes even think about it at night or during the journey"* (FG4 FR Target A); *"At home, responsibilities are less shared than in hospital... this mental burden is sometimes heavy"* (FG8 FR Target C).	(Not apply)
RELATIONAL RISK FACTORS AND CONFLICTS	**Conflicts with coworkers**	*"A substitute arrives and does tasks that don't belong to her [...] and then there's trouble. She's doing tasks that I don't do"* (FG3 ES Target A).	*"You don't have that on all wards. It really depends on which colleague is working."* (FG5 DE Target C); *"I am always the one who has to cover the shift."* (FG1 IT Target B); *"When the shift does not turn and there is little communication or continuous spite... that's the problem."* (FG4 IT Target B);*"Every week you don't know who you're working with... you*

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			know everyone, but basically you don't know anyone." (FG6 IT Target C); *"If you try to point something out, they say: 'You want to command, who do you think you are?'"* (FG4 IT Target B); *"You've consumed your patience with them, and then who pays the consequences is the guest."* (FG4 IT Target B).
	Conflicts with care receivers	-Role conflicts: *"if I did it, it was bad, and if I didn't do it, it was also bad,"* (FG5 ES Target A); *"she says to me: 'here, take the bucket with the cloth…'"* (FG4 ES Target A); *"don't come to my house tomorrow, because if you're not going to bleach that, what do I need you for?"* (FG2 ES Target A); *"the other one did it for me, this one doesn't want to,"* (FG3 ES Target A) -Task-related conflicts: *"if the husband is not home, I'm not supposed to do anything,"* (FG3 ES Target A); *"I was stuck in the middle."* (FG3 ES Target A); *"you're the one who has to lift me."* (FG3 ES Target A). -Emotional conflicts: *"she tells him, and he passes it on… tell that to the caregiver,"* (FG3 ES Target A); *"how can I react like this? If you're saying all of that to me"* (FG3 ES Target A); *"he needed to talk… but it wasn't possible, because she didn't want it."* (FG3 ES Target A).	*"they want to be understood, but not understand our working situation."* (FG 1 IT Target B);*"the tone… has become very demanding… and there is a lot of incomprehension."* (FG4 DE Target C); *"they don't want to understand, even when they are referred to other centers."* (FG4 DE Target C) *"these are things that take you out of your day-to-day work."* (FG4 DE Target C).
	Conflicts with relatives of care receivers	-Role conflicts: *"the family members don't understand that all the mother needs is a daily phone call… and they make you feel responsible if she cries."* (FG5 ES Target A); *"I can't leave at the time I'm supposed to, but I have to be back at the exact time he says."* (FG5 ES Target A); *"they want me to clean the entire kitchen so they don't have to."* (FG2 ES Target A). -Task-related conflicts: *"I clean the grandfather's room… what's yours, you do yourself."* (FG1 ES Target A); *"the regular one does it every day, and now I show up and everyone is protesting."* (FG4 ES Target A). -Emotional conflicts: *"the family watches everything you do, you've got cameras pointed at you… it stops being a job and becomes something unbearably difficult."* (FG9 ES Target A); *"if the mother says the caregiver*	-Excessive demands: *"they demand more than what can be provided at that moment."* (FG6 ES Target B and C); *"kiwi at 8 a.m."* (FG6 ES Target B and C); *"we're inviting them… and then they ask why their father wasn't taken out,"* (FG6 ES Target B and C) -Procedural misunderstandings: *"everything here is washed at very high temperature."* (FG6 ES Target B and C); *"one relative tells you he wants the pillow placed a certain way, and another comes later asking who changed it."* (FG6 ES Target B and C). -Relational level: *"if something bad happens, the blame is placed on us."* (FG5 PL Target B and C); *"they want everything… in an hour, they won't wait a day."* (FG4 PL Target B and C).

		Home-based Care	Institutional Care
		steals, who do they believe? The mother." (FG9 ES Target A); *"my care receivers are like family to me, but the relatives are not."* (FG3 ES Target A); *"If the family doesn't like me or treats me badly, I respond! [...] Because it's been many years that I've been silent."* (FG3 IT Target A).	
	Expectations from relatives	*"The main challenges I face relate to organisation and the sometimes unclear expectations of care"* (FG7 FR Target A and C); *"The challenges I face even include having to manage the expectations of patients and families, which is very complicated at times"* (FG7 FR Target A and C).	*"Some families believe that their mother or grandfather can have someone by their side 24 hours a day, and that's just impossible,"* (FG7 ES Target B and C); *"There are expectations that are just not real,"* said one worker (FG6 ES Target B and C); *"They come and say: my father is worse than before. What's going on here?"* (FG6 ES Target B and C); *"We are a bit of a punching bag for a lot of people and situations, and that is indeed one of the most thankless parts of this job."* (FG6 ES Target B and C); *"My father doesn't do anything,"* they say, forgetting that *"he's been locked at home watching TV for years."* (FG6 ES Target B and C).
	Dysfunctional or adverse family environments	*"It was a very large family [...] the care receiver was the mother, and the poor mother was kind of pushed aside [...]. You went there to care for her, but you had to fight your way through to reach her."* (FG1 ES Target A) -Unsafe environments linked to substance abuse and aggression: "*The grandson smoked joints in front of me while I wore a mask in the middle of the pandemic,"* (FG1 ES Target A) -Family neglect and emotional impact on care workers: *"That feeling, that absence of the son who doesn't call [...] we are the ones who have to face that situation"* (FG5 ES Target A); *"they just say: look, there's your caregiver, she'll take care of you, we'll handle the payment and that's it."* (FG5 ES Target A).	*"The siblings don't speak to each other... each one has different ideas... and who's in the middle? Us. And the grandfather."* (FG6 ES Target B and C); *"Some families understand... others say: 'This jacket isn't my mother's.' And I tell them: please, understand we are human and can make mistakes"* (FG6 ES Target B and C); *"When they don't come to visit, they lose their appetite, stay in bed, stop attending sessions... They simulate symptoms or health decline to get their family to visit."* (FG6 ES Target B and C); *"They think something has happened... and they make themselves sick. They get nervous, and then they make us nervous."* (FG6 ES Target B and C); *"This isn't abandonment... this is their home, and the doors are open 24 hours a day... this is not family abandonment."* (FG6 ES Target B and C); *"She was perfectly fine here... but the family completely abandoned her... The family was the one causing the problems."* (FG6 ES Target B and C).
PERSONAL RISK	**Overcommit-**	-Be available: *"We have a life, and when they change the schedule*	-Be available: *"I don't have a knife at my throat, but in conscience, how*

		Home-based Care	Institutional Care
FACTORS	ment	*without warning, it's frustrating."* (FG2 FR Target A); *"I know I could say no, but if I don't accept, they don't have anyone else and I'm thinking mainly of the care receivers, so I accept."* (FG2 FR Target A). -Sense of responsibility at work: *"We always try to do our best, even if we know that perfection is not always possible. We have a lot of resources at our disposal, but it's important to know how to use them effectively and to remain open to exchanges with other professionals"* (FG8 FR Target C).	*can I not go?"* (FG1 IT Target B); *"being too available is not good"* (FG1 IT Target B). -Perseverance at work: *"You learn to ignore the pain and fatigue, but it can really catch up with you. Even if you're exhausted, you tell yourself you still have to keep going"* (FG3 FR Target B). -Sense of responsibility at work: *"Today I see this sense of duty as an essential part of our professional commitment [...] even though it can lead to burnout"* (FG3 FR Target B).
	Foreign language	*"For me it was when I arrived that I didn't know a single word of Italian. This was a door in the face for me"* (FG5 IT Target A); *"I have this impression that if we don't know German well, we don't know German law well and we won't demand something... that's why you have to fight for your rights"* (FG2 DE Target A); *"There were no translators... I didn't know the language when I started this job, so I had to learn care, learn the language, and work 16 hours a day"* (FG1 DE Target A); "*Communication must be absolute... You have to know the language"* (FG2 DE Target A).	(Not apply)
NON-WORK RISK FACTORS	Family care responsibilities and work-life conflict	-Family care responsibilities and emotional burden: *"I have a signed reduction in my working hours because I'm responsible for my young daughters [...]. There are so many of us in the same situation"* (FG1 ES Target A); *"You're being pulled in every direction just to be able to breathe [...] there aren't enough hours in the day"* (FG1 ES Target A); *"Sometimes work really wears you out [...] between the problems you have at home and the problems the care receivers bring you — they want to take everything from you"* (FG1 ES Target A); *"the family overload is just awful"* (FG1 ES Target A); *"I come home to another 92-year-old, how am I supposed to disconnect from this job?"* (FG1 ES Target A); *"When I arrive at the care receiver's home, I leave everything behind. But when I come back home, it catches up with me [...] I'm arriving, even today, I'm arriving and I'm very tired mentally"* (FG4 FR Target A).	-Emotional overlap between personal and professional life: *"It is true that you have to try to get on with your life"* (FG6 ES Target B and C); *"It's a job that eats you up inside... if you've had a bad day, you feel it at home too"* (FG3 FR Target B); *"These events don't just stop when you leave work... they keep weighing on you, even at home"* (FG5 FR Target C). -Impact on family and personal relationships: *"Our husbands are a bit fed up with us"* (FG7 ES Target B and C); *"Sometimes I don't even see my husband all day"* (FG7 ES Target B and C); *"After all, I'd rather be at work than at home, so I'm better off here than at home. [...] I'm too stressed, too angry, too anxious, my children feel it so when I'm at work I'm calm. The work is therapeutic, and after that we're lucky to have good solidarity in the team."* (FG1 FR Target B).

		Home-based Care	Institutional Care
		-Life circumstances of vulnerable women: *"I've been alone for 14 years"* (FG3 IT Target A); *"I couldn't stand for 12 hours anymore, so my kitchen work came to an end"* (FG5 IT Target A); *"I have stress at home, I go to work, I have stress [...] I can't remember the last time I had a moment to rest"* (FG1 DE Target A). -Unpredictable schedules and constant availability: *"You can't plan ahead because you don't know when you'll be on call [...] So you cancel your plans and cover the shift"* (FG4 ES Target A); *"That's how it is, and on weekends, when you're supposed to have time off, you end up doing everything you couldn't do during the week"* (FG4 ES Target A); *"They asked me if I would cover for holidays. I said no. Then they started pressuring me [...] but my contract is for 30 hours, they can't ask me for more"* (FG4 ES Target A); *"I had a free morning to go to the pool with my kids and they called me right at that moment"* (FG4 ES Target A); *"They change our schedule without warning. You feel obliged to accept it, and it's burdensome. Sometimes I have my weekend planned with my family and then I have to cancel everything because they need me"* (FG2 FR Target A). -Emotional spillover and missed family time: *"The accumulated fatigue can really affect us. When we get home, there's a certain amount of tension that can affect our family relationships"* (FG6 FR Target A); *"There are days when I start super early and finish late, and that hardly leaves me any time for my family. Like the time I missed my child's birthday because I was stuck at work... That's hard to swallow"* (FG7 FR Target A and C).	-Strategies to preserve boundaries and personal space: *"As soon as I go out the door, I have my family—so, outside of here, nothing"* (FG4 IT Target B); *"There are times when I manage it better and times when I manage it worse. When I realize it, I try to do something relaxing before going home"* (FG2 IT Target B); *"I also need my space, because otherwise, it's not good enough"* (FG1 IT Target B); *"Because if you bring problems at home or home problems at work, it is a big problem [...] it's also dangerous for your well-being and then for colleagues and guests, especially for guests."* (FG4 IT Target B); *"I leave here and the job is finished here; I don't take anything home, I leave my personal life."* (FG4 IT Target B); *"maybe even for the years it's a bit more difficult but you have to work on it"* (FG4 IT Target B); *"I went back to work three months after my pregnancy, and it was mentally difficult. I had a mini-depression and took three months off, which really helped me to regain my balance."* (FG3 FR Target B). -Scheduling constraints and limited leisure: *"The three shifts and working weekends and public holidays are negative. Which also puts quite a strain on a private life."* (FG4 DE Target C); *"I went down from 40 to 32 hours because I just couldn't do it anymore"* (FG4 DE Target C); *"I was able to spread my 32 hours over four days thanks to a very considerate director"* (FG5 FR Target C); *"I wish I could live on my salary,"* (FG2 IT Target B).

Table 2. *Illustrative quotes corresponding to different protective factors, as expressed by participants through the focus groups.*

		Home Care Workers	Basic and Professional Care Workers
CONTEXT PROTECTIVE FACTORS	Stakeholders support	-Trade unions as limited support channels: *"If you have a problem, you call the union and if it can be solved, it is solved. Some things can be solved, and others can't"* (FG2 ES Target A); *"I'm a member of the trade union and sol told my colleague, look, we have to do something about our conditions, because there are many things that are totally illegal"* (FG4 ES Target A). -Migrant support associations as key resources: *"She was the one who told me about the foundation… I had never taken a bus here… it was the first time"* (FG9 ES Target A); *"They welcome us in a way that makes us feel good, like a family… they support us, and we know they are always there for us when we need something"* (FG9 ES Target A).	*"Sometimes even only for legal support… the contact with the unions… works quite well, at least in the hospital"* (FG1 IT Target B). -Limited impact of trade unions: *"we don't have that association… we don't have some kind of unification that would make that voice strong"* (FG5 PL Target B and C). -Absence of collective voice and visibility: *"in our case, we don't have the kind of support like teachers, for example, who can go out and strike. In our case, we don't have the kind of support like the nurses who pitched tents outside the Diet"* (FG3 Target B and C). -Disconnection and passivity among professionals: *"We accept everything that is imposed on us… we don't even know some kind of fight… we don't even know where"* (FG3 PL Target B and C); *"no sort of efficiency at all in social welfare… zero efficiency… I used to be in a labor union… and zero efficiency"* (FG3 PL Target B and C). -Sector invisibility and lack of advocacy: *"teachers, for example, are more in the media… and about social welfare they don't say good things… maybe that's the explanation for the lack of unions"* (FG3 PL Target B and C).
ORGANISATIONAL PROTECTIVE FACTORS	Respect for legal regulations	-Formal contracts as protection: *"Once the contract changed, the whole story changed. The content of the contract was different—they respected my schedule more, and the contract stated that they had to provide food. […] Before, they wanted to give you stale bread or leftovers, as if you should eat whatever they didn't want. I've lived through that. But once I had formalised everything and had a contract, the story changed. […] You really notice the difference—how hard things can be when you're not regularised or formally employed by a family."* (FG5 ES Target A). -Breaches of contractual agreements and labor rights: *"My contract says I work twenty-four hours but I work more"* (FG3 IT Target A); *"With a miserable salary not to pay… I am still in trial with them, with this*	(Not apply)

		Home Care Workers	Basic and Professional Care Workers
		cooperative" (FG3 IT Target A); *"For four years I've been in different parts of Germany... and this was the first place where I had a day off"* (FG2 DE Target A). -Irregular practices and legal fraud: *"The companies change the name to avoid paying social security"* (FG1 DE Target A); *"There is no such thing as German terms... just some Polish civil law contract"* (FG2 DE Target A); *"German families also cheat in contracts"* (FG2 DE Target A).	
	Organisational support	*"I usually always call the agency who are always available who always try to reassure me, they always find a way to reassure you"* (FG5 IT Target A); *"There's also often a lack of more formal support, a kind of resource for stress management"* (FG7 FR Target A and C); *"I'm not happy about this. Given my seniority in the company, they could take my wishes into account"* (FG7 FR Target A and C). -Psychological care and institutional protection: "Having access to psychological support sessions is an important resource that helps me cope with difficulties" (FG7 FR Target A and C); "Companies are not always supportive either. I can't say about mine, but I hear from colleagues who work in this industry that the company does not help" (FG1 DE Target A); "If the German family fails me, I'm out in the cold, because when I call the company they threaten them with fines only and I don't know what else" (FG1 DE Target A). -Material support and resource provision: "*We are going to try to take as long as possible to give it, because if I have this year's uniform with next year's, then I can save two uniforms for the whole team"* (FG1 ES Target A).	*"Sometimes we get the impression that the management doesn't support us enough and favours the families. And yet we too need to be listened to"* (FG3 FR Target B). -Lack of managerial responsiveness: *"We have a lady psychologist. After all, we also talk to her and discuss the problems of residents."* (FG2 PL Target B and C)*; "I think it's a very cool thing. I for one regret that it's so rare."* (FG3 PL Target B and C); *"Now we have a project. [...] You come, this is a psychologist, because such a task that this is to give us support."* (FG3 PL Target B and C). -Sporadic well-being measures: *"They gave one of our team physiotherapists an extra hour to attend to staff members who want to make an appointment. [...] I think it's a good initiative."* (FG7 ES Target B and C).
JOB-RELATED PROTECTIVE FACTORS	**Workplace ergonomics and assistive devices**	-Availability and use of hoists and lifting devices: *"thank God, in heavy work we use the hoist"* (FG5 ES Target A); *"that person weighed 95 kg, of course, my back was cracking"* (FG3 ES Target A); *"he says that since she doesn't weigh much, a hoist isn't necessary [...], but a man's strength isn't the same as a woman's"* (FG3 ES Target A).	-Lifting and transfer equipment: *"we have good beds, we can move them properly"* (FG8 ES Target B and C); *"care receivers were lifted with our arms"* (FG4 IT Target B); *"if you have to use a lift, by rule you should be in pairs, but if you're alone, it's at your own risk"* (FG 4 IT Target B). -Other ergonomic resources: *"with fewer staff, fewer grants, and less*

		Home Care Workers	Basic and Professional Care Workers
		-Lack of other ergonomic devices and supportive materials: *"she doesn't have a proper wheelchair [...] I'm really afraid that she might fall when I take her out"* (FG5 ES Target A). -Physical strain linked to repetitive tasks and job design: *"one has a dropped shoulder, another has a bulging disc, another a herniated disc [...] this comes from repetitive work: mop, mop, mop"* (FG3 ES Target A).	*equipment"* (FG3 FR Target B). -Job design and physical demands: *"It seems they are beginning to understand that this is not an eight-hour-a-day job, because it's very physical, very repetitive, and very exhausting"* (FG7 ES Target B and C).
	Respect for time off	*"Three days a week off, so I can afford to really take a breather, reset myself mentally... I can sleep all day. Nobody bothers me here, I can invite friends"* (FG1 DE Target A); *"Yesterday was my birthday, so I went out all day"* (FG5 IT Target A); *"Tomorrow is Saturday, they'll give me half a day on Monday... for me there's no problem either Saturday or Monday"* (FG3 IT Target A) -Unstable and interrupted rest periods: *"I can't leave at the time I'm supposed to... I have to leave her completely ready—showered, with lunch prepared, everything"* (FG5 ES Target A); *"I've never left at 12 on a Saturday, it's always been two hours later or just a little more, or the daughter is on her way..."* (FG5 ES Target A); *"They don't respect the time of rest, neither the time of the day, nor the time to sleep, nor anything else."* (FG5 ES Target A). -Cumulative impact of disrupted rest and lack of recovery: *"At night I stay awake... and in the morning, without sleep or with just a few hours, I feel like dumb all day"* (FG5 ES Target A); *"That has lasted a week or two, sometimes two or three months"* (FG5 ES Target A). -Barriers to accessing holidays and personal days: *"I went two years without a vacation, until they saw I wasn't changing my contract"* (FG2 ES Target A); *"They make us submit a written request, go into the employee portal, and do more computer stuff, and some of us don't know how. Some of us are totally lost with those things"* (FG3 ES Target A). -Systematic noncompliance with legal rest: *"They only give Sundays off, and Sundays are no good!"* (FG3 IT Target A); *"When it concerns*	-Benefits of time off: *"when you come back from a rest day, you feel like new"* (FG7 ES Target B and C); *"they are few... they're worth it"* (FG7 ES Target B and C); *"We're lucky enough to work 12 hours and that means we only have to work one weekend a month. That gives us one week's rest a month... it's all positive"* (FG1 FR Target B); *"three days off on the weekend is really good"* (FG1 FR Target B) -Barriers to disconnection: *"It's very difficult to disconnect. I'd say impossible"* (FG7 ES Target B and C); *"You're at home resting, and the night shift calls, the afternoon shift writes... it's impossible to rest"* (FG7 ES Target B and C); *"Then we need our days off, to really rest [...] It's impossible because mentally, for us it's not physical it's mental, when you come out of it you're drained and when I say drained it's drained of tears, drained of brain. It's drained everywhere."* (FG1 FR Target B); *"We feel that our presence is indispensable... we always want to be there, even if it means putting our own well-being on hold"* (FG3 FR Target B). -Limits to recovery: *"You work six days a week, one day off, then shifts again... I'm exhausted"* (FG3 DE Target B); *"One solution was shortening working hours. That's an important point: that you don't work 100%, but 80% and that you don't have so many shifts in a row. Because you immediately notice when you have seven shifts or five and then four days or three or two off."* (FG5 DE Target C); *"During the vacations? No, that's two weeks to yourself"* (FG3 PL Target B and C); *"I was supposed to be resting today... I woke up with an unbearable backache... morally, it's exhausting"* (FG3 FR Target B).

		Home Care Workers	Basic and Professional Care Workers
		holidays… you have to talk at least two weeks in advance with family members as well as with the agency… and if a family member doesn't want to talk to the agency, that's their problem, not the home caregiver's" (FG3 IT Target A) -Disempowerment through agency discourse: *"I didn't know I could object… the agency never took my side. They even told me: 'And what will you do on your break? If you go into town, to Berlin, you'll get lost'"* (FG1 DE Target A).	
	On-the-job learning	-The need for ongoing and practical training to face real care challenges: *"Even though we have training, we still have difficulties with certain groups of people. How do you deal with people who have Alzheimer's or Parkinson's at a very advanced stage?"* (FG7 FR Target A); *"It's important for new employees. You have to train them"* (FG6 FR Target A). -Limits of formal training and the search for alternative knowledge: *"I gained so much information… about the rights of caregivers, what we can, what we can't… sometimes the coordinator is helpful, but often I learn from forums or my own search on the internet"* (FG2 DE Target A); *"At school I learned how to deal with such patients… how to be assertive in this profession… First my needs, then the care receiver's"* (FG2 DE Target A). -Learning by doing: *"You go to a care receiver's home and learn something new from every person you see"* (FG4 ES Target A); *"In the end, our training comes from experience"* (FG4 ES Target A); *"I cared for my mother with dementia for eight years… I know how to treat someone with Alzheimer's"* (FG2 ES Target A); *"Training and support between colleagues are essential to deal with difficult situations. Even with experience, it's important to continue training and to ask for help"* (FG6 FR Target A); *"Some patients share slices of life that put our own existence into perspective"* (FG8 FR Target C).	-Limits of formal training: *"We are so much obliged to do continuing education and training… but I think it is totally ineffective. I've learned much more from practice than from these courses… and if you really want to take a meaningful refresher course, it's very expensive and totally at your own expense"* (FG6 IT Target C); *"We must have a course that can give us all the same skills, in line with the work we do, because otherwise it becomes very difficult to collaborate on an organisational level"* (FG6 IT Target C); *"This training course was created to make up for the shortage of care assistant staff"* (FG1 FR Target B). -Learning through experience: *"That comes from experience. It's the day-to-day. It's not teaching—it's practice, the person, and common sense"* (FG6 ES Target B and C); *"Today, I discover new aspects of my role as a care assistant every day"* (FG3 FR Target B); *"I guess the brain finds a way to deal with it on its own… over time, we learn how to deal with it and move on"* (FG2 PL Target B and C). -Learning from coworkers and interdisciplinary collaboration: *"I learn every day, not only from my work but from my colleagues, from the physiotherapist, from everyone"* (FG8 ES Target B and C).

		Home Care Workers	Basic and Professional Care Workers
	Autonomy	*"The positive side that I like is the autonomy you have when you're working at home. You can make decisions and put things in place"* (FG7 FR Target A and C);*"I like this autonomy, the fact that I don't have to work in a team like in a hospital or elsewhere with everyone around"* (FG7 FR Target A and C);*"I don't feel alone, even though you're on your own at home"* (FG7 FR Target A and C); *"For me, autonomy is essential, but it shouldn't mean isolation"* (FG7 FR Target A and C); *"We always do the same things for certain care receivers, but we still have a small margin of creativity... Today we're going to do it like this, for a change, and that's what I like"* (FG4 FR Target A).	(Not apply)
RELATIONAL PROTECTIVE FACTORS	Coworkers' support	-Self-management strategies and mutual aid in crisis situations: *"It was us, the committee, who organised the work schedules for our coworkers [...] We were the ones who went looking for masks, gowns, asking around... Knocking on the doors of all the companies. Basically, the company just stepped aside."* (FG1 ES Target A); *"I worked wearing black garbage bags. My husband made me aprons, and I bought a roll at the supermarket and, whenever I ran into coworkers, anyone really, I'd say: 'here, take a bag, take a sack.'"* (FG1 ES Target A). -Emotional support and coworker solidarity: *"It's a real psychological support to have someone who understands exactly what you're going through and with whom you can share these difficult moments."* (FG8 FR Target C); *"Just talking to a colleague when things aren't going well helps enormously"* (FG8 FR Target C); *"The debriefing sessions with my colleagues are really nice."* (FG6 FR Target A). -Communication, teamwork, and care continuity: *"I always call, I always call and ask what they do here. What needs to be done? I always, always call."* (FG3 ES Target A); *"She sends you a PDF and tells you to figure it out yourself. But figuring it out on your own doesn't make sense—especially not for the care receiver."* (FG4 ES Target A). -Coworker tensions and mistrust. *"That has a name: lack of camaraderie"; "Let's see if I can take your position and stay on, or get*	*"We vent to each other, that's how I see it"* (FG7 ES Target B and C). -Emotional release and trust among coworkers: *"Informally, informally. For example, you run into her in the hallway and we start venting to each other, because there's no other way, no other way"* (FG7 ES Target B and C); *"When we can, we go out for beers"* (FG7 ES Target B and C); *"Many times we yell at each other, but we're not really yelling—we just need to let off steam"* (FG7 ES Target B and C); *"If I cry, it will be with my partner with whom I want to cry. That's how I see it. I couldn't have done this job with someone I didn't get on with"* (FG1 FR Target B); *"There are complicated days, there have already been deaths, so I used to come home and cry. And I couldn't sleep at night [...] so it's good to have a good group of people around you"* (FG1 FR Target B). -Operational support and teamwork: *"Colleagues are always the resources"* (FG1 FR Target B); *"If we have a good atmosphere, colleagues like them who are tolerant, who listen, who are there to teach us the right things to do, who are there to tell us what to do, then that's a plus in my book"* (FG1 FR Target B); *"we have amazing camaraderie"* (FG7 ES Target B and C) -Barriers to mutual support: *"Some colleagues believe they have the more right than others to take time off at home and if they are denied for some reason [...] they simply call in sick [...] and being the only*

		Home Care Workers	Basic and Professional Care Workers
		more hours for myself." (FG2 ES Target A); *"It's true that we have a very close-knit team. We've known each other for quite a long time [...] It's our main resource. [...] it's this solidarity that makes the job more bearable, especially when the days are tough."* (FG8 FR Target C).	*person who does part time I am always the one who has to cover the shift"* (FG1 IT Target B); *"The new generation of nurses are quite like: I do mine and the OSS does his. The old generation of nurses, on the other hand, give you a hand no matter what, even if you don't need it"* (FG1 IT Target B); *"They've given us such a head for precisely working in teams, for the importance of teamwork, for building relationships with colleagues, and then it's not valued at all"* (FG6 IT Target C). -Impact of instability and rotation: *"You see that it works, it becomes difficult for you to get used to it again, but this happens all the time [...] there's not enough staff, and then the department is closed, you are sent to another"* (FG6 IT Target C). For some, rotation brings growth: *"Learn different things, new things, to change a point of view"* (FG6 IT Target C); *"If I don't know well the colleague next to me I can't create that relationship of trust [...] you're basically alone"* (FG6 IT Target C). -Professionalism and everyday collaboration: *"We are first of all colleagues, if we get on well with each other, fine [...] we work even better, if we don't get along well [...] we work together but that's the end of it"* (FG4 IT Target B); *"It depends who is on duty, if we are not those people who communicate well you don't do it, everyone has to rely on himself"* (FG4 IT Target B); *"between ourselves we support each other"* (FG5 PL Target B and C); *"digest certain things [...] if we are able to talk it through with each other somehow"* (FG2 PL Target B and C). -Informal support structures: *"The support group behind you creates such a community [...] the best panacea for all these problems and difficulties that you face every day"* (FG2 PL Target B and C); *"a conversation or joke"* (FG3 FR Target B)
	Coworkers' cohesion	*"I think that team cohesion is the key to overcoming difficulties. [...] When we come across a problem with a care receiver, we usually call each other to find solutions"* (FG6 FR Target A).	(Not apply)

		Home Care Workers	Basic and Professional Care Workers
	Inter-teams coordination	-Mutual adjustment: *"If we don't coordinate among ourselves..."* (FG2 ES Target A); *"They say: 'I've been waiting for you to put her on the toilet.'"* (FG3 ES Target A); *"They don't want to waste time explaining things and they tell you to figure it out on your own"* (FG4 ES Target A); *"Some colleagues have contacted me privately and I've solved it"* (FG2 ES Target A). -Direct supervision: *"When you report this to your coordinator, they say: 'Tomorrow I'll take the care receiver away... but then you'll owe me hours'"* (FG1 ES Target A); *"We have a ghost service... The coordinators don't come, they don't visit"* (FG1 ES Target A); *"They change our timetable in the evening for the following day"* (FG6 FR Target A). -Standardisation: *"Now we have to go through an app... but sometimes it doesn't work, and some people don't even know how to use it"* (FG3 ES Target A); *"Sometimes you're misinformed with the application, that's just what needs to be reviewed"* (FG4 FR Target A); *"They should at least give us a meeting and explain it, because I don't understand it"* (FG3 ES Target A). -Higher-order mutual adjustment: *"Coordination with doctors is often problematic"* (FG8 FR Target C); *"We have meetings between care assistants, but not with other professionals"* (FG6 FR Target A).	-Mutual adjustment: *"Every day we read the notifications and the incident reports [...] That's the first thing we have to do. You come in the morning and read the notifications from the night and afternoon shifts."* (FG6 ES Target B and C); *"Communication is almost always constant."* (FG6 ES Target B and C); *"We have a tablet where we enter the resident's progress [...] like, this resident has a fever today, so be careful or consult the nurses."* (FG 6 ES Target B and C); *"As we get to know each other, that's it."* (i.e., it works out naturally) (FG6 ES Target B and C); *"We have to rethink it and get help [...] from whoever is more available in another unit."* (FG8 ES Target B and C). -Direct supervision: *"We ask her, 'Look, could it be done this way?' and she tells us: 'Yes, no, or maybe better this other way' [...] Between what we propose and what she organises, it gets done."* (FG8 ES Target B and C); *"There is a lack of that person who is responsible and who will help us and tell us."* (FG4 PL Target B and C). -Standardisation: *"We have a treatment team and then all the problems of the residents are discussed. Conclusions are drawn along with the program that comes up, and we try together."* (FG3 PL Target B and C); *"We work in a team that is quite good, how we divide the tasks and take care of the patients 24 hours with different hands. Each shift has to do the task very well so that the other shift can work as well."* (FG5 DE Target C). -Higher-order mutual adjustment: *"There are different working groups that have to work with the patient at the same time [...] And we also have to coordinate this number and organise this time: when is what done and when does everything fit? [...] But in the end, I have to say that in my experience and from my ward, this is what works very well [...] Everyone is open and everyone is willing to adapt."* (FG5 DE Target C).

		Home Care Workers	Basic and Professional Care Workers
	Emotional bonds	*"How do you not get attached to someone who tells you everything because they can't say it to their relatives?"* asked one worker (FG1 ES Target A). -Long-term care relationships and emotional bonds: *"After seven or eight years,"* one caregiver shared, *"they become like family."* (FG1 ES Target A); *"He's dying. I already feel that pain."* (FG1 ES Target A); *"Every time I walked in, he'd say, 'Here comes one of my daughters.'"* (FG1 ES Target A). -Reciprocal bonds with care receivers and families: *"I can't let go of her. I give myself completely."* (FG5 ES Target A). -Respect, appreciation, and mutual support: *"The family respects me. If I have a problem, they're flexible. We sit at the table and talk."* (FG3 IT Target A). -Emotional burden and personal coping strategies: *"There are pros and cons. You feel like part of the family, but you also carry their burdens with you."* (FG3 IT Target A);*"I cry, then it gets better."* (FG4 FR Target A).	*"It's really hard for me to say goodbye,"* (FG3 DE Target B); *"They treat us like family …It's basically our family."* (FG4 PL Target B and C); *"you can see this joy of theirs, it's so joyful"* (FG4 PL Target B and C); *"Sometimes you arrive in a bad mood and leave in a bad mood… we're human, and it depends on how the day hits you."* (FG8 ES Target B and C).
	Recognition by care receivers	*"There are care receivers who can't even speak, but when they see your face, they're saying it all."* (FG1 ES Target A) *"From trying to hit me to asking for a kiss before I leave—that's something else,"* (FG1 ES Target A).	*"They give you a hug, say a word of affection and you have already forgotten everything you carry inside"* (FG7 ES Target B and C); *"to see a grandfather with a smile on his face […] oh daughter, oh how good you are, these are great satisfactions that you take with you"* (FG6 ES Target B and C); *"I got a little smile from a gentleman from the protected unit just now […] that's my resource."* (FG1 FR Target B); *"seeing a smile or receiving a word of recognition from them can really make a difference."* (FG3 FR Target B); *"you hear such a sincere thank you and that the patients trust me above all […] you can see how the patients trust us day after day."* (FG3 DE Target B); *"I am glad that the patients give me this feeling, that they are grateful to me. And that's the best thing."* (FG3 DE Target B).

		Home Care Workers	Basic and Professional Care Workers
	Recognition by care receiver's relatives	-Feeling unappreciated and undervalued by care receiver's relatives: *"I've given everything, more than I should've... and they didn't even say thank you. I'm not asking for inheritance, just a 'thanks'."* (FG1 ES Target A). -The emotional value of gratitude and recognition: *"When we receive sincere thanks from service care receivers or their families, that offsets the negative aspects."* (FG6 FR Target A); *"We must be respected as other people are respected in any workplace. We respect their relatives, but we also wish to have the same response from them."* (FG3 IT Target A).	*"They understand the decline, they appreciate it. They say: I don't know how you can do this work, and we're so grateful."* (FG6 ES Target B and C); *"they underestimate this work of ours and expect too much."* (FG3 PL Target B and C).
	Support from care receiver's relatives	*"She's available 24 hours a day; if I have to call her at 3 a.m., she's ready."* (FG9 ES Target A); *"the daughter came at seven in the morning to see if everything was okay, just to make sure I didn't have any problems."* (FG2 DE Target A); *"you have to ask for pampers, for basic things [...] the daughter is very stingy."* (FG1 DE Target A).	*"There are some families who are fun to work with, who understand us and support us in this somewhat difficult work of ours."* (FG3 PL Target B and C); *"we are very much nurturing this from the moment we are admitted, to maintain these relationships."* (FG5 PL Target B and C);*"if something bad were to happen, it would probably often be the fault that would somehow be ceded to us."* (FG5 PL Target B and C).
	Supervisor support	-Feelings of abandonment and inaccessibility of supervisors: *"We are very, very, very abandoned, very neglected. We're just a number."* (FG1 ES Target A); *"You have a problem and you can spend, I don't know, three days calling and maybe they'll pick up one of these years"* (FG1 ES Target A); *"I'm going to cover the day-to-day, and I won't bother looking at this colleague's empty slot in the schedule."* (FG1 ES Target A); *"Your coordinator says, 'Tomorrow I'll take her off your schedule (referring to the care receiver).' Okay, so what will you give me from eight in the morning onwards? And then they say, 'Well, I don't know, maybe you'll end up owing hours.' Excuse me?"* (FG1 ES Target A). There is also a sense of structural vulnerability: *"If you refuse to say yes to something, you're already seen as the bad one — they call the organisation, and you get into trouble"* (FG2 ES Target A). -Lack of support in critical situations: *"We don't have the support.... If*	-Feelings of abandonment and inaccessibility of supervisors: *"I can count on the management or our superiors. [...] We're lucky to have a director who listens"* (FG1 FR Target B); *"The coordinator listens to you, but then his response is 'yes, we'll have a meeting'. In the meeting, he brings in management who replies 'these are the funds'. Don't give me the satisfaction of saying you held a meeting to listen to us if in fact you didn't listen to us at all"* (FG6 IT Target C). -Lack of support in critical situations: *"There are cases in which the superior should intervene because you can't always solve the situation with your abilities [...] if you have a wall in front of you [...] if there was an intervention from them... also because they are figures that are predisposed for this... otherwise there would be anarchy"* (FG4 IT Target B); *"You arrive at the end of the morning exploding, maybe you even answer badly and you arrive at home starting to get angry with the*

		Home Care Workers	Basic and Professional Care Workers
		we had coordination that was in place, I think we would be much better off" (FG1 ES Target A); *"There are very complicated things, but if you had support from your coordination... For example, in that house, I did it because coordination told me to—and they called me stupid, and I still did it"* (FG1 ES Target A); *"Instead of defending you as a worker, she defends the care receiver, even though she knows she already told you there's a manual outlining what you're supposed to do as a worker"* (FG3 ES Target A). -Positive experiences and the limits of reactive support: *"As soon as there's a problem, I call her and we try to find solutions"; "We have occupational therapists, we have a neuropsychologist... all the staff are very well looked after"* (FG4 FR Target A); *"I don't think we should have to ask for help, it could come from them too"* (FG2 FR Target A).	*person in front of you because you want to vent because you can no longer manage the situation"* (FG6 IT Target C); *"Managers don't always give us enough recognition for our work. We do a lot, sometimes even outside the scope of our duties, such as handing out medication when that's not our role. This lack of support creates tension between the carers and management"* (FG3 FR Target B). -Positive experiences and the limits of reactive support: *"Not yet. There hasn't been such a need. If there was, I'm sure the director would help us with that, because we also have to say that we have great support"* (FG4 PL Target B and C).
PERSONAL PROTECTIVE FACTORS	Coping strategies	-Avoidance: *"Holding on, holding on, holding on"* (FG2 ES Target A). -Distancing: *"Over time I've learnt to put things into perspective, to stand back"* (FG2 FR Target A). -Expressing emotions: *"I try to be clear from the outset and to maintain open communication with the families and with the patient, because it's the patient who matters most to me"* (FG7 FR Target A and C). -Humour: *"I use humour as a strategy to lighten difficult situations. [...] This doesn't always solve the problem, but it helps to maintain a calmer, less stressful atmosphere"* (FG6 FR Target A).	-Distancing: *"At a certain point you create a shield... otherwise you can't live"* (FG6 IT Target C); *"I think about my day during the journey... and when I get home I can finally let go"* (FG3 FR Target B); *"You have to know how to protect yourself while remaining professional"* (FG5 FR Target C); *"you have to act quickly... you had your other ten patients you had to care for as well. You have to keep your game face on and keep going"* (FG5 DE Target C) -Expressing emotions: *"If there's a problem with someone, tell them... because if you keep it inside, you don't know how to manage it anymore"* (FG4 IT Target B). -Humour: *"We sometimes find ourselves ironising about situations... probably also as a defence mechanism"* (FG6 IT Target C).
	Emotional self-regulation	*"To be able to help someone emotionally, we must first be emotionally prepared ourselves"* (FG5 ES Target A); *"At some point, the older person will be gone—the one you laughed with, ate with, cared for like a father—and we go through that loss too"* (FG5 ES Target A); *"If she cries, you can't cry too; you have to try to stay strong, even if your heart is*	*"You really have to be sure, don't panic, know what you have to do, because then it's a person's life at stake"* (FG4 IT Target B); *"you have to have nerves of steel"* (FG1 FR Target B); *"We hold his hand as he just passes to the other side. [...] I guess I get the impression sometimes that the brain is designed in such a way that it just finds some kind of*

		Home Care Workers	Basic and Professional Care Workers
		breaking" (FG5 ES Target A); *"There are emotions that can be difficult to manage. When you see a patient in pain or at the end of life, it affects you"* (FG8 FR Target C); *"Personally, the main difficulties lie in managing the emotional burden. To cope with it, I make sure to take time for myself outside of work and do relaxing activities"* (FG7 FR Target A and C).	*alternative and way to deal with it on its own"* (FG2 PL Target B and C); *"The facts are that depending on the degree of emotional involvement with the resident, it's more difficult. And that sometimes this work is brought home. But also we have to delineate and we know that we have our own lives and we live our lives"* (FG2 PL Target B and C).
	Disconnection from work	-The persistent mental burden of care work: *"I've seen nights when I couldn't fall asleep because I was thinking about what I had to do for the care receiver the next day"* (FG2 ES Target A); *"The patients' stories run round and round in my head and it keeps me awake at night"* (FG7 FR Target A and C); "*You enter a loop and can't get out... I spend the whole Sunday thinking tomorrow is Monday again"* (FG2 ES Target A); *"When I go on holiday, it takes me a few days to really relax"* (FG7 FR Target A and C). -Emotional weight and blurred boundaries: *"My work follows me home and even at night... I ask myself: did I do it right?"* (FG4 FR Target A); *"I used to come home with this burden, it was eating me up inside"* (FG4 FR Target A); *"In a small town, you never really leave the job behind"* (FG2 ES Target A). -Personal strategies for disconnection: *"I go to the care receiver's house, I take care of him 100%, once I leave, there's nothing left"* (FG4 FRTarget A); *"Once I leave work, I don't think about people anymore, but it took a long time to achieve that"* (FG7 FR Target A and C); *"When I get home, I switch off"* (FG2 ES Target A).	*"It's very difficult to disconnect. I would say impossible"* (FG7 ES Target B and C); *"I often arrive home and before I even open the door, my phone is already ringing"* ; *"The night shift calls you, the afternoon shift calls you... it's impossible to rest"* (FG7 ES Target B and C); *"You always take something from work home, whether you want to or not"* (FG1 IT Target B); *"Some situations are harder to forget than others"* (FG5 FR Target C); *"I try to disconnect, I don't want to know... I try not to be 24/7"* (FG8 ES Target B and C); *"It's not always easy to wipe the slate clean from the previous day, depending on what happened. And that really has an impact on our psychological well-being"* (FG3 FR Target B).
	Recovery strategies	-Self-care and personal time: *"I take time out for myself. This allows me to recharge my batteries and come back to work with more energy. I think that's essential if you want to last in this profession"* (FG2 FR Target A); *"I try to stay calm and breathe deeply. When I feel the pressure building, I take a few minutes to myself"* (FG2 FR Target A). -Sport: *"Sport helps me to disconnect from work"* (FG4 ES Target A). -Music: *"When I get home, I put on loud music to clear my head and*	-Selfcare: *"When I have my things, I say no to the head nurse without worrying, because I can't save everything myself"* (FG1 IT Target B); *"I also need time for myself, not just for others, I'm there too"* (FG4 IT Target B); *"I try to implement some strategy that leads me to relax and then start again"* (FG2 IT Target B). -Sport: *"Sport frees me up"* (FG1 FR Target B); *"Sport helps me a bit, sport helps me de-stress"* (FG7 ES Target B and C).

		Home Care Workers	Basic and Professional Care Workers
		relax" (FG6 FR Target A); *"I play music in the car to relax... it helps me get rid of the stress I've built up"* (FG2 FR Target A). -Social outings and leisure time: *"And at the weekend, you go out and have a good time"* (FG2 ES Target A).	-Leisure activities: *"For me, it's reading"* (FG 7 ES Target B and C).
	Motivation	-Intrinsic motivation: *"I love it. I enjoy my job very much, and the gratitude it gives me"* (FG1 ES Target A); *"It's vocational. I love it. I truly love it"* (FG1 ES Target A); *"At the beginning I used to say I love my job, and I still love it despite all the downsides. I still like it, because otherwise, I don't think we would last here, even if we went hungry"* (FG1 ES Target A); *"I hit rock bottom in this job. I started with the most beautiful excitement you can imagine. Right now, I don't feel it. Honestly, I used to love my job, but right now, I don't"* (FG1 ES Target A). -Integrated regulation: *"We keep going because we have a vocation. Otherwise, I don't think we could take it"* (FG1 ES Target A); *"a job that has to be done with love"* (FG5 IT Target A). -Identified regulation: *"Helping people in their personal environment is very rewarding"* (FG7 FR Target A and C); *"It gives me incredible energy when my patient at some point says thank you. For me, it's such a boost"* (FG1 DE Target A). -External regulation: *"Forgive me, but we need the job more than we like it"* (FG1 ES Target A); *"Unfortunately, I don't have anything else to do... as long as I'm here, I have to do it"* (FG3 IT Target A). -Amotivation: *"I think I've lost a bit of empathy"* (FG1 ES Target A).	-Intrinsic motivation: *"Working here is worth it for me because this job gives me a lot of satisfaction. I like it. And in the end, it's really worth it."* (FG7 ES Target B and C); *"The good thing is that I've always loved this job, so it's a real pleasure"* (FG1 FR Target B); *"I love my job, the human contact, it's a powerful thing"* (FG3 FR Target B); *"I frankly towards my job even if I have been doing it for many years I am not tired of it [...] I work with the same passion"* (FG4 IT Target B). -Integrated regulation: *"In any case, it is a job that I have chosen, that I love to do"* (FG6 IT Target C); *"It's something you carry inside, it's about who you are — your temperament, your mindset"* (FG6 ES Target B and C). -Identified regulation: *"Positively, we feel useful, we help and support people, and it feels good to feel that we are supporting them"* (FG5 FR Target C); *"For me, the job is rewarding when you manage to make a difference to patients. We're happy with what we do and we know that it's good for them"* (FG5 FR Target C); *"The positive thing about the job is that you get to know lots of people, lots of characters [...] There are also grateful patients"* (FG4 DE Target C). -External regulation: *"However, on the negative side, I'm bored with some of the work and I don't get the full benefit of it. I'd like to be closer to the people I work with, but I have a comfortable working environment that I may not find elsewhere"* (FG5 FR Target C). -Amotivation: *"I mean, for God's sake, I chose this job. I chose it with full knowledge of the facts, but today if they were to ask me about young people, I would tell them 'don't do it'"* (FG2 IT Target B); *"I'm bored with some of the work and I don't get the full benefit of it"* (FG5 FR Target C); *"I think this disparity between how important the work is and [...] the*

		Home Care Workers	Basic and Professional Care Workers
			fact that the prestige of the social work profession is virtually none" (FG5 PL Target B and C).
	Professional vocation	-Vocation as a personal inclination and source of meaning: *"At the beginning I used to say that I love my job, and I still love it despite all the downsides we face."* (FG1 ES Target A); *"This is a job with a lot of heart."* (FG4 ES Target A); *"This is a job that really requires a passion and a love for people above all. I do it with love because I have a predisposition for the elderly, because I grew up with grandparents and I have an overwhelming love for them."* (FG5 IT Target A). -Vocation as a protective factor for endurance and retention: "*Yeah, but I think we also endure because we have a vocation. Without it, I don't think we could hold on.*" (FG1 ES Target A) -Social perceptions and emotional tensions surrounding vocation: *"They say I've taken it all to heart, as if they were my own family. So I suffer... but I do like it."* (FG5 ES Target A).	-Vocation as a personal inclination and source of meaning: *"I frankly, towards my job, even if I have been doing it for many years, I am not tired of it [...] I work with the same passion."* (FG4 IT Target B); *"Since I was a child I wanted to be a nurse [...] I am happy because I also work with the elderly."* (FG3 PL Target B and C). -Vocation as a conscious and fulfilling choice: *"It's a job I've chosen, and I love doing it. If I didn't like it anymore, I would have quit."* (FG6 IT Target C); *"I want to retire in this profession because it's beautiful and I love it."* (FG7 ES Target B and C); *"Time flies here, and I wish the clock would stop."* (FG6 ES Target B and C). -Vocation beyond training: character and resilience: "*You can be the best assistant in the world, but if you've got no fire, it's useless. That comes from the person."* (FG6 ES Target B and C); *"You have to like it to work in this profession. It's a difficult, demanding profession, but if you see yourself in this job, you work and you work very well."* (FG1 PL Target C).
	Meaning of work	-The meaning of care work as human connection: *"we don't work with papers, we work with people,"* as one participant put it, highlighting how this changes everything (FG4 ES Target A); *"we give light, we give families light, we give well-being, we give, a cuddle, a caress, to be listened to — this is what the elderly need."* (FG5 IT Target A). -Social contribution and the relational meaning of care work: *"I feel that I'm doing social good and that makes me feel so good [...] it's a beautiful job."* (FG5 IT Target A); *"what I love about my job is the exchange with the elderly. They give us as much as we give them."* (FG2 FR Target A). -Professional growth and personal fulfillment: *"I have found my dimension [...] I am really doing something good, something good for*	-Job satisfaction and everyday meaning in care work: *"this job is the one that fills me the most out of all the jobs I've had,"* or *"it's the one that brings me the most satisfaction when I go home."* (FG7 ES Target B and C). -Social contribution and the relational meaning of care work: *"we are helping. Even though you're working, you're also helping."* (FG7 ES Target B and C); *"this is a job that gives you so much [...] you give so much, but it is also able to give you so much."* (FG6 IT Target C). -Professional growth and personal fulfillment: *"this work has given me so much, both in terms of intellectual wealth and wealth of life [...] it has really filled me."* (FG4 IT Target B);*"the idea of doing something else does not arise."* (FG3 PL Target B and C).

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		myself that gives me peace and gives peace to others." (FG5 IT Target A); *"it's a rewarding job, because you go home feeling that you've done something useful."* (FG8 FR Target C).	
	Empathy	*"I'm not his blood, I'm just someone who takes care of him, but he has a son, a brother, and still no one visits him. That weighs on me, it makes me feel pity."* (FG5 ES Target A); *"They live it with all the emotional and sentimental implication… we live it with professionalism, but we must make both the patient and the family feel understood."* (FG5 IT Target A); *"There are times when you manage to put a smile back on someone's face, and that's really nice"* (FG8 FR Target C).	*"You see a young person with dementia and you think: this could be my brother, or my sister… Today it's her, but tomorrow it could be someone in my family."* (FG6 ES Target B and C); *"You inevitably establish empathy, sympathy, or even antipathy… whether you want it or not."* (FG6 IT Target C); *"You do this job well if you work with empathy"* (FG4 IT Target B).
	Compassion	*"It hurts when someone tells you they're tired of living… I just look at her and say: let's keep going, let's get through this"* (FG5 ES Target A).	(Not apply)
	Cognitive appraisal	*"I concentrate on the positive aspects of the job. When I finish a difficult day, I take the time to think about the successes, however small…"* (FG7 FR Target A and C); *"I don't compartmentalise… when they die, well, it's like Niagara."* (FG4 FR Target A)	*"He was very sick already… now he's at rest, he was ninety-something."* (FG6 ES Target B and C).
	Task prioritisation and time management	*"Your priority is the person you care for. Then everything else will come later."* (FG1 ES Target A).	-Adapting time: *"Before, it was task, task, task. Now, after being in this unit, I'm much calmer, and I manage better—I have more time to be with them."* (FG8 ES Target B and C); *"Even if something unexpected comes up, I carry on. You just go with the tasks as much as possible"* (FG8 ES Target B and C). -Protecting time: *"From 3:00 or 3:30 pm, when I leave here, only what's important matters to me."* (FG8 ES Target B and C); *"What I studied was physiotherapy, but I don't really feel like a physiotherapist anymore. I do treatments when there's a fall or a contracture, but they're isolated cases. I can't dedicate the time I used to."* (FG8 ES Target B and C); *"Some treatments are left aside because I have to attend to other things"* (FG8 ES Target B and C).

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			-Structuring time: *"Even though I know it by heart, I still fall into the same trap—rushing to get the chores done. It's hard."* (FG8 ES Target B and C); *"When I started, I was super stressed. But once I got settled in the unit, even if they change me one day, I'm much calmer. I know I can do my job and spend more time with them."* (FG8 ES Target B and C). -Task priorisation: *"We leave the beds unmade, the cleaning, the dishes… everything waits. First comes the resident."* (FG8 ES Target B and C);
	Boundaries management	-Managing task-related boundaries: *"I clean the grandfather's bedroom, I wash him and do everything I have to do for him, because he's my care receiver. But if you have the sink full of dishes, I will wash one plate, one glass, one spoon—what I need to give him breakfast—and that's it. You do the rest yourself."* (FG1 ES Target A); *"They told me to go up on a ladder to clean chandeliers. When I said no, for some it was like the end of the world—'why are you even here?' they said"* (FG1 ES Target A); *"Then someone comes for a few days as a replacement and cleans the lamps, scrubs the tiles… and then the care receiver tells you: 'why don't you do this? She did.' And you feel bad. You feel guilty."* (FG2 ES Target A); "*They ask me to take the flowerpots outside while it's raining… I feel incapable of saying no."* (FG3 ES Target A); *"You know you shouldn't do it, but you feel bad, especially if they can't do it themselves"* (FG 3 ES Target A); "*We are incapable of saying no, because you're my neighbour, or I've known you since you were a child—it's a small town."* (FG3 ES Target A). -Managing emotional boundaries: *"We must not let ourselves be trampled on"* (FG1 ES Target A); *"This job is beautiful, it gives you satisfaction… but it's also very painful. If you don't truly love it, you can't take it."* (FG1 ES Target A). -Managing personal time: *"If I want to stay in bed and rest, I stay there, I lock myself in my room. If I want to go out, I go out. Freedom costs us too."* (FG3 IT Target A); *"I love my work and it doesn't spill over into my*	-Managing task-related boundaries: *"She says to me: 'Did you go away to pull out the patient's probe and did you do the enema?' I said 'No, because my skills are up to you on the enema.'"* (FG2 IT Target B). Another care worker emphasised the importance of setting limits: *"I've learnt to say no, but to say no in a way that doesn't come across as negative, because you don't always have to say yes."* (FG3 DE Target B); *"Someone comes to you and says: can you please take the patients to the toilet. And you automatically say yes because you think that's my job. But nobody knows how many colleagues have already approached you… That's why you say no, okay, I can't do it now. I have to do something else."* (FG3 DE Target B). -Managing emotional boundaries: *"They observe us, by now they know us and they also understand our mood, so we always have to choose our words carefully and avoid getting too too personal because otherwise that's not good either, because we can't take home 66 family problems"* (FG1 IT Target B); *"Sometimes I realise that when faced with a patient who needs to talk about his illness or his situation, I create a sort of wall for fear of saying the wrong things, and so I try to cut things short for fear of doing even worse, not because you don't want to, so maybe you limit yourself to professional information or try to postpone or cut the conversation short by saying 'excuse me now, I need to go to another person who is ringing the bell', things like that, as a form of defence."* (FG6 IT Target C); *"You work with people, not dolls… I can't*

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		personal life too much... but maybe if my children were younger it would be more complicated." (FG7 FR Target A and C).	*just go home and forget, I stay here."* (FG3 DE Target B); *"I never go over to you... It's cordial, cool, but nevertheless there is this distance... we have people who are younger and a little problematic in their behaviour."* (FG2 PL Target B and C); *"They observe and ask where you live? Various things interest them... So not to cut them off, not to offend anyone, but politely about everything and anything we need to talk...Sometimes they try to extract some information"* (FG2 PL Target B and C).
	Proactive behaviour	-Proactive person-environment fit behaviour: *"To overcome the difficulties I encounter in my work, I try to follow a method and adapt to each situation. When something happens, like an accident or something I start by assessing everything based on my experience, taking into account not only the physical aspects but also the psychological ones. If the situation is very complex, I know I can call the people in charge and, in extreme cases, the fire service"* (FG6 FR Target A). -Proactive work behaviour: *"I try to maintain my inner calm so as not to aggravate the situation [...] if I can be with a colleague, I don't hesitate to contact her."* (FG6 FR Target A); *"I try to remain flexible and anticipate the unexpected. I plan my days according to priorities..."* (FG7 FR Target A and C); *"to overcome difficulties [...] I start by assessing everything based on my experience, taking into account not only the physical but also the psychological aspects."* (FG6 FR Target A).	-Proactive person-environment fit behaviour: *"At work, I always manage to adapt more or less, so I don't consider myself to be a difficult person. I try to remain flexible in the face of change and the unexpected. Whether it's here or in my previous experiences, I've always found a way of coping with the challenges that come my way. Perhaps it's this ability to adapt that helps me get through the more complicated times."* (FG5 FR Target C); *"I reorganised everything related to the psychologist's role so it fit with also being a director."* (FG8 ES Target B and C); *"It really helps to know the person. I know I have to sit with her because she gets upset, something happened to her. That's essential for me. Then I'm calmer during the shift, and I can handle the relationship with the older people better."* (FG8 ES Target B and C); *"In the morning I do things they enjoy—some like to get their makeup done. I don't even know how to do it, but I do it, and they feel so good. I feel good because they feel good"* (FG8 ES Target B and C). -Proactive work behaviour: *"you have to organise everything with your patient in such a way that you always have in the back of your mind that a resuscitation call could come"* (FG5 DE Target C).
	Knowledge of legal regulations	-Rights awareness and boundary setting. *"I send a complaint by email... the next day I already have a reply from the clerk who contacts the family"* (FG2 DE Target A); *"If the contract says I leave at nine on Saturday, the family members know they have to be there at nine*	(Not apply)

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		because I'm leaving" (FG5 ES Target A); *"Most people are afraid of the contractual penalties. They are under mental pressure"* (FG1 DE Target A). -Legal knowledge versus actual enforcement: *"The law is not that the home caregiver has to do everything — nurse, cook, driver… But we all do it"* (FG4 IT Target A); *"I crossed out what I didn't like in the contract… I communicated it to my boss that it was signed, but I crossed out the illegal parts"* (FG1 DE Target A). -Impact of legal status on rights enforcement: *"Nobody wanted to make me a contract… I was badly paid, with no rights"* (FG9 ES Target A); *"Giving us a contract is a lesser burden for the country because we pay social security"* (FG9 ES Target A).	
NON-WORK PROTECTIVE FACTORS	Social support	*"I try to share time with my daughter and my grandson, and play with them for a while"* (FG5 ES Target A); *"If I stay at home, my husband on the sofa and me in the armchair with my feet up and a bag of popcorn watching a movie… total disconnection"* (FG2 ES Target A); *"You take a walk in your free hours. You can call a friend or relative, go out to a café and have a coffee"* (FG3 IT Target A); *"We have a really nice group that meets often… they are still there for me today"* (FG1 DE Target A).	*"I'm lucky enough to have a great husband and great kids. So no, no, but it's good to be able to let off steam when you get home, at least to have a shoulder to lean on"* (FG1 FR Target B);*"For me, it's really communication that helps. I need to talk about what I'm going through, and I'm lucky to have parents who listen to me"* (FG5 FR Target C); *"Family members can offer emotional support, but they don't experience the same day-to-day challenges as we do, so their understanding has its limits"* (FG5 FR Target C); *"Fortunately, I have friends in the same profession with whom we can share our experiences. They also provide me with a lot of solutions, whether for patients or for the structure of the establishment"* (FG5 FR Target C).
	Psychological help	*"At times like this, I call on the services of a therapist to help me through these periods"* (FG7 FR Target A and C); *"You have to ask for it to have a psychologist you can consult when you're not feeling well"* (FG4 FR Target A).	(Not apply)

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