Care is being conceptualised as an emotion and a labour, “largely hidden from the scrutiny of academics and policymakers, seen as both private and feminine” (Rummery and Fine 2012, p. 321), but care is also a source of tensions and inequalities of gender, age, race and immigration status. In care sector, care work is often stratified by factors associated with different experiences and working trajectories, typically gender, class and ethnicity (Yeates 2009; Cangiano and Shutes 2010; Husso and Hirvonen 2012; Hussein et al. 2013).

Joan Tronto (2010) has identified four phases of the care process: (1) caring about, i.e. recognising a need for care; (2) taking care of; (3) caring for, i.e. taking responsibility for meeting that need; (4) care giving, i.e. the actual physical work of providing care; and, finally, (5) care receiving, which

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A. P. Gil (✉)
Interdisciplinary Centre of Social Sciences (CICS.NOVA), Faculdade de Ciências Sociais e Humanas—NOVA FCSH, Lisbon, Portugal
e-mail: anapgil@fcsh.unl.pt

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implies the collaboration of the recipient in terms of the evaluation of how well the care provided meets the caring needs. For Tronto it is not possible to understand care as an action by care workers alone; rather, care institutions must consider the nature of the caring process as a whole in order to guide their actions. This requirement should focus on the needs of users and also on the needs of care workers.

The International Labour Organization (ILO) (2018) declares that the impact of poor job quality for care workers leads to poor quality care. The great majority of the paid long-term care workforce are “direct care workers” who deliver most of the hands-on, personal care and assistance with daily routines in care facilities or in private homes, sometimes as domestic workers. Personal care workers provide direct personal care, including day-to-day activities, such as feeding, bathing and carrying out basic health checks. These workers are particularly prevalent in long-term care provision, both in institutional settings and in home-based and community care. In OECD countries, they represent, on average, “over 60 per cent of the total employment in long-term care. These direct care workers receive little or no training, inadequate employment benefits, low wages and are subject to high turnover” (ILO 2018, p. 208).

Poor working conditions can lead to recruitment problems, high turnover, workers leaving the care sector (Cangiano and Shutes 2010), reduced support from managers (Trydegard 2012) and high incidence of work-related poor health, stress and burnout, leading to early retirement (Colombo et al. 2011).

Few studies have examined the perspective of the care workers themselves in terms of exploring their daily experiences, professional trajectories (Hayes 2017) and conceptualisations of care work in long-term care.

Long-term care involves multiple stages and there is a consensus definition, as a set of services required by individuals with a reduced degree of functional physical or cognitive ability who are dependent on help with basic and/or instrumental activities of daily living (ADL) for an extended period of time (Colombo et al. 2011; Directorate-General for Economic and Financial Affairs (DG ECFIN) 2018, p. 132).

The terms to describe long-term care are diverse, such as nursing homes, residential care facilities or long-term care for older people. In
Portugal, nursing homes are designed as “residential structures for older people”. “The social responses network includes nursing homes (profit and non-profit), which are more social oriented, distinguished from the National Network for Integrated Continuous Care (mainly convalescence, medium-term and rehabilitation units), with services which are more health oriented” (Gil 2019, p. 140).

Despite macro changes in the Portuguese labour market over the last decade, care work, mainly in non-profit organisations, is regulated by specific regulation regarding matters such as the type of contract, working hours, payment, social security contributions. However, women, in particular those with lower educational levels, who have experienced long periods of unemployment, including immigrant workers (Wall and Nunes 2010), are more vulnerable to precarious working conditions.

Qualitative research is needed to understand care workers’ perspectives and how their working conditions affect the care they give and exploring different symbologies in the context of care practices.

The chapter starts with a theoretical discussion of care, the ambivalent process implicit in institutional contexts and how structural violence can be a reflection of the low public investment in the care system. An overview of the long-term care provision system in Portugal and the lack of public investment over the last decade offers insight into public intervention in the care sector. The qualitative study described in this chapter involved 40 in-depth interviews with care workers in 16 Portuguese nursing homes located in one council in the metropolitan area of Lisbon.

**Care, Emotions and Violence in an Institutional Context**

“Care” has been theoretically conceived from three facets (Rummery and Fine 2012). The first facet of care is a feeling or emotion involving a disposition towards others, such as family, friends or neighbours, while the second facet of care is the work and its demand in terms of time and physical activity. Issues associated with work include workload, physical and mental health and non-recognition of care work. The third facet of
care is as a social relationship. From this facet, care is intimate, familial and personal but also complex and ambivalent, involving interdependence and power. Overall, care is a global process that involves emotion, work and interpersonal relationships (Rummery and Fine 2012).

Care is associated with a generalised consensus of social cohesion, minimising the diversity of experiences and the existence of conflicts, in a process of reciprocity between care worker and the person receiving care. Caring for someone invokes different feelings including physical and relational presence, empathy, continuity, generosity but the act of caring may also involve reflects fear, anger, frustration, effort and conflict (Lüscher 2004).

The theoretical perspective of sociological ambivalence constitutes a fruitful approach to explore consensuses and paradoxes in care practices. The perspective allows a conception of the care process with different dimensions of analysis, including personal fulfilment, as well as contradictions in relation to work (e.g. source of tensions and conflicts, desire to give up of the profession). While the emotional dimension of care is invisible, Mac Rae (1998) cited Hochschild’s expression “emotional work” (p. 138), to designate the emotional management that care, as a form of work, involves and noted that the nature of emotions is relational. Bericat (2016) emphasised that “the apparent simplicity of human emotions hides abundant complexities, problems and paradoxes” (p. 493).

The interdependence between physical tasks and the emotional component of care depends also on the affective involvement in the relationship between the care worker and the person receiving care. The caring experience is not a uniform and homogenous experience, but a multifaceted experience that includes physical tasks (i.e. care for) and emotional involvement (i.e. care about). Care, as a reciprocal process, involves organisational skills and competences, time management, physical tasks and ambivalent emotions and conflict may emerge as a form of violence (Gil 2010).

Several researchers (Drennan et al. 2012; Malmedal et al. 2014) have claimed that institutional conditions, staff characteristics and residents’ characteristics (e.g. dementia and mental impairments) are important factors of institutional violence. Banerjee et al. (2012) cited the concept
of structural violence (Galtung 1969) to raise questions about the role that organisational factors play in setting the context for violence (p. 330). Poor working conditions and inadequate levels of support in care work constitute a form of structural violence. The authors highlighted that working conditions are detrimental to the physical and mental health of care workers, and prevent care workers from providing high-quality care.

Drennan et al. (2012) showed that nursing home staff have observed acts of inadequate care and even admitted to committing such acts themselves. The most commonly observed acts were neglect and psychological abuse. Neglect in the nursing home may overlap with concepts of psychological abuse (e.g. social isolation) and disparities in quality care.

Drawing on Fulmer’s et al. (2004) conception of the quality of care, Malmedal et al. (2014) proposed an intermediate concept, inadequate care. Inadequate care may lead to loss of dignity and cause individuals to become more vulnerable to the risk of abuse and neglect.

Physical restraint and medication overdose, both of which are types of physical abuse (Hantikainen and Käppeli 2000; Melchiorre et al. 2014), reveal the ambiguity of practices which are technically acceptable in an institutional context but may be considered morally reprehensible abusive behaviours, depending on the point of view.

Melchiorre et al. (2014) also reinforced that in both domestic and institutional settings, the widespread use of physical restraints (mainly for older people with high levels of physical dependency and cognitive impairment) has emerged as potentially problematic. The use of physical restraints is not always culturally and necessarily considered a form of abuse and may indeed be perceived as more acceptable or justifiable in situations where the older person has a mental health problem and, thus, may be difficult to care for or is at risk of falling (Gil 2018). Therefore, the frontiers of bad care that can be insufficient, deficient or inadequate as a form of abuse and neglect become tenuous in an institutional context. The next section provides an overview of the long-term care context in Portugal.
Context and Background: The Long-Term Care Context in Portugal

Portugal has a mixed system of long-term care composed of a network of services including care centres, home-based services and nursing homes. Since the 1990s, the government has invested in care services for elderly through national programmes set up to develop an integrated network of services.

The Programme for the Widening of the Social Facilities Network was launched with the objectives of reinforcing and stimulating the services offered in terms of institutional care (nursing homes), especially in less covered geographical areas, and qualifying the services already existing. The goal was also to increase the availability of home-based care services and nursing homes.

Nursing homes offer support through collective accommodation, meals, health care and leisure activities, and these services are provided to the users on a 24-hour basis. Home-based services offer meals-on-wheels, house cleaning, laundry and assistance with personal care (through one-to two-hour visits per day).

These services and facilities for older people are mainly provided by non-profit institutions, known as the third sector, which are partly state-funded. These institutions have emerged through the initiative of private individuals or associations, and the Portuguese government considers them “a strategic part of the care system and formally recognised their activity almost 30 years ago” (Santana et al. 2014, p. 2).

In 2001 the proportion of older people living in institutional settings in Portugal was 3.6% (corresponding to 50,607 individuals). In 2011, according to the last census, 71,219 people lived in collective dwellings of social support (4%), and 72% of these were women over 80 with severe care needs including cognitive and physical impairments (Instituto Nacional de Estatística [INE] 2011), a tendency also identified in the social profile of those who live in nursing homes in Portugal (72.5% over 80 years) (Gabinete de Estratégia e Planeamento [GEP] 2017).

From 2000 to 2015, there was a 65% increase in the number of nursing homes from 1469 to 2418 and a 69% increase in the number of users from 55,523 to 94,067 (GEP 2017; Gil 2018, p. 554). In 2017,
occupancy rates in nursing homes, determined by the number of users and the total number of vacancies available, reached 93% (GEP 2018) and this increased demand reflects the accelerated ageing pattern of the Portuguese population.

Despite public investments in the long-term care system, in the last decades, and some convergence towards the European Union (EU) in coverage rates for formal care provision, Portugal allocated 0.5% of its Gross domestic product (GDP) to the public provision of long-term care, less than the average across OECD countries (1.7%) in 2015 (OECD 2019).

The coverage rates of long-term care workers and human investment alone do not correspond to appropriate coverage. Portugal has the lowest concentration of care workers, reporting “less than 1 worker per 100 people aged over 65” (compared to Scandinavian countries, such as Norway and Sweden, with 12.8 and 12.4 per 100 respectively [see Fig. 8.1 in OECD 2019]), below the reference range for adequate service delivery, which is from 4.1 to 4.5 full-time paid workers per 100 persons aged 65 and over (Scheil-Adlung 2016).

In Portugal, the majority of formal long-term care (LTC) workers in institutions are care workers (70%) and 30% are nurses (OECD 2016). Institutional care is provided by care workers with no training (OECD 2013), and the shortage of Portuguese care workers is indicated in the lower worker density. It means 0.8 workers per 100 people (OECD 2019).

Lopes (2017) noted that Portugal has been undergoing some convergence towards the EU average in coverage rates for formal care provision, but this does not mean appropriate coverage. The low average still leads to excessive workloads and long working hours, “poor working conditions [that] are coupled with high rotation of staff” (Lopes 2017, p. 70).

Poor working conditions lead to difficulties that result in limitations in the delivery of quality care and failure to attract and retain skilled personnel (Scheil-Adlung 2016; Dubois et al. 2019; ILO 2018).

The working conditions in the social care sector are shaped by national workplace policies, education and labour policies. In terms of the care workforce, the lack of public investment in education, qualification,
**Fig. 8.1** Long-term care workers per 100 people aged 65 and over, in 2011 and 2016 (*Source* OECD Health Statistics 2019, p. 235)
working conditions improvement and innovative care practices promotion has resulted in quality of care remaining absent from the public debate on long-term care in Portugal. Therefore, it is important to shed light on how care work is carried out by care workers, sometimes in adverse working conditions, with impacts on the health and wellbeing of users as well as care workers’ physical and mental health, job satisfaction, feelings and emotions.

**Methods**

This paper presents results of a multimethod research project entitled “Ageing in an Institution: An Interactionist Perspective of Care”.¹

**Participants**

This study was carried out in one council in the metropolitan area of Lisbon. Of 32 for-profit and not-for-profit nursing homes invited to participate, 16 agreed to participate (12 not-for-profit and 4 for-profit). In the nursing homes surveyed, the number of users varied between 9 and 84, and the majority of users were physically and mentally dependent with 80% having dementia.

In total, 40 care workers gave informed consent and were interviewed. Participants were given identifiers (E1–E40) to protect their anonymity. The interviews varied between 30 and 90 minutes.

Of the participants, 39 were women and one was a man, and their age varied from 24 to 64 years. The average time working in the profession ranged from 3 months to 25 years, with an average of 10 years. Educational background varied between primary education (1st to 4th grade) and the upper secondary education (12th grade). Most of the participants had performed other jobs in the past, and they reported similar personal trajectories characterised by long-term unemployed and low-skills jobs.
Out of the 40 participants, 9 began their work in the nursing homes as cleaning staff and after some months, were hired as care workers without training upon switching positions.

31 participants were hired as care workers, out of which only 7 stated they had training upon starting the job. The training provided varied from sessions that lasted only a few hours or addressed specific topics (e.g. first aid) to courses with a theoretical/practical component, lasting from 3 to 6 months.

Data Analysis

All interviews were recorded and fully transcribed. The transcription and English translation of the quotations are intended to preserve the original form of the oral language used by participants to share their experiences and trajectories of care work.

A three-stage thematic content analysis was employed: (1) coding, the process of assigning categories and subcategories reflecting previously defined themes as well as new ones; (2) storage, the compilation of all excerpts from the text subordinate to the same category in order to permit comparison; and (3) interpretation, through an analytical induction method (Patton 2002; Gil 2018, p. 557).

The analysis explored different meaning of care practices (tasks, time, work team, organisational system), emotions and conflicts, and solutions to combat and prevent institutional violence. The analysis focused on those meanings and how they are portrayed throughout care workers’ narratives.

Results

Working Conditions in Nursing Homes: The Perspective of Care Workers

Care work encompasses a set of tasks that concern the wellbeing and comfort of the users, as well as responding to basic needs: washing,
cleaning, dressing, grooming, feeding and providing basic health care (e.g. medication, pads). Aside from these tasks, care work in some homes also entails cleaning rooms, hallways and bathrooms as well as assisting in the kitchen and laundry room.

While describing their daily life, the participants highlighted the diversity of tasks, the heavy workload and the lack of time. Participants described their work as a “mad rush” (E27), “a hustle and bustle” (E34) and “a race against time” (E9). Furthermore, they noted that the lack of time and inadequate personnel ratios do not allow for extra-activities: simply chatting, walking for exercise or collaborating on occupational activities. Besides these daily activities, some participants also performed the roles of shift coordinator, supervisor and trainer for the newest members. In this process, participants identified the difficulties inherent to care work: dealing with illness and dementia of users, conflicts inside teams, poor working conditions, stressful job experiences and risks to workers’ health and wellbeing.

For E2, the worst thing was having to wake up the users every day at 7 a.m. due to institutional rules regarding waking times, sleeping times and eating times. E16 agreed, stating:

Sometimes there are 4 people and we have to wake up 40 users, and then there are the medical appointments. Today, for example, we are 7, but there are days when some are absent and call in sick or that their child is sick. We have to wake [users] up at that time, or else they’ll eat breakfast at noon […] and from the 40 only 1 doesn't need care. (E16)

For E16, the hardest part of care work is “always being in a rush”. The daily rush, due to the lack of staff, leads to care being provided in a hurry, without there being a personalisation of care. E16 explained the difficulties of addressing “hygiene itself”:

Sometimes we don't even have time to look at them […]. The hardest part is doing everything in a rush […]. I clock-out frustrated that I couldn't do what I think is important: combing their hair, applying facial cream, putting on perfume. There’s no time for that! (E16)
The care organisation also has underlying different meanings of time: time to care, time to rest and time to be occupied. The little leisure time care workers enjoy smoking a cigarette or drinking a cup of coffee is subject to censorship and forbidden, often the target of criticism by other care workers who do not smoke and who refuse to continue the care work on their own. These times are seen by the organisations as a “waste of time”. However, some of participants recognised time should be spent in providing care which should be done slowly. Despite the “race against time”, participants noted there are “idle times” that could be used in extra activities such as training, going for a walk in the hallway or in the garden.

E29 also identified a need to do more physical exercise but noted the difficulties caused by the lack of human resources: “It’s impossible because there’s no time”.

The requirement of pre-established rules is related with the workload and the main problem: the lack of staff. Staff fluctuations caused by high turnover, absences motived by health or family reasons and leaving the sector without prior notice as well as conflicts inside care teams are incompatible with providing individual care for a dependent population that needs round-the-clock assistance.

E3 identified the worst problem in the profession as the alternating shifts (morning, afternoon and nights). As shift coordinator, E3 had trouble “managing absences; today, for example, two people are absent and it’s a work overload”. To E13, the lack of staff leads to the shifts being taken over when someone is absent, and the shift gets longer. E13 mused, “there is fewer staff, and I’ve had eight days without rest because of lack of staff”. These workers pile up work hours and lose out on rest times without any recognition or differentiation. This is one of the main reasons behind conflict in work teams.

For example, E2 listed various reasons for early retirement: “It’s a lot of work, it gets very little recognition and there’s always staff shortage”.

Lack of care workers, long working hours, work overload, lack of team cooperation, absence of leadership, low wages and alternating shifts make care work an unappealing profession and people eventually leave the sector.
E17 described the average working conditions by stating on the morning shift there are “seven to eight, rarely nine of us for 68 users” and on the afternoon shift “we are even less, six or seven for the same number of people. At night we are three or two, for three floors”. The lack of staff worsens over holidays or bank holidays; for example, E17 stated, “during holidays we are usually six in the morning shift for 68 users, and when it’s Christmas or Easter, there’s always someone who goes on leave or calls in sick”.

Across the board, participants identified turnovers, unjustified absences, rotative shifts (especially at night) and the consequences of the years of care work as some of the problems that affect care workers’ health and lead to issues such as depression, tendinitis and back pain, often due to lifting heavy loads with bad lifting positions.

For example, E1 stated, “I have no doubt that, yes, the psychological part is the worst”, while E9 said, “It’s really hard physically and psychologically” (E9). At the time of the interview, E39 was taking medication for depression because “I stopped eating, I wasn’t sleeping, I felt tired and couldn’t hear people, I heard voices in my head and struggled with anguish and anxiety”. E39 felt that this condition was due to repeated years of hard work.

The Tenuous Frontiers of the Concepts
“Good and Bad Care”

When asked what “quality care” means, participants offered various answers. Good care is associated with care personalisation and respect for the person. E27 specified that “it means being well treated” and added that “we want them all to be well treated, well dressed, well-groomed. We bathe them every day, apply cream every day. If the bedridden users have a little sore – there’s been fewer each time! – we perform treatment”. E35 defined good care this way: “It starts with their intimacy (i.e. hygiene). It’s not doing it and there, done. We have to respect the person”.
Good care also involves respect for the person’s individuality and the fulfilment of their needs. Additionally, care practices can include a generalised consensus of social cohesion through “attention, comprehension and respect” (E5) but also conflicts.

E17 cautioned that care workers might “despite, ignore, be indifferent” to nursing home users. When asked to describe bad care, E15 offered some examples of what workers might say:

“I don’t like that one [resident], and I’m not going to lift him up”; “Want to go to the bathroom? Then do it in your pad”. I’ve worked nights, and then when I arrive early in the morning and people are in the same position, they have marks on their bodies from being in the same position and pads aren’t changed; they are full of pee. Sometimes, colleagues wait for the next shift, and people get all soaked and pads or underwear aren’t changed. Or, other times, people may not like meat or fish, and I often hear, “You have to eat that or there will be no dessert for you”. You know, I’ve seen a lot of stuff […]

According to the participants, bad care can include abrupt movements, screaming, ignoring, using the wrong type of language (e.g. childish or slang), inadequate diaper usage, leaving people bedridden for long hours by themselves and without care, using physical containment to prevent falls and work overload. Bad practices are aggravated when the accumulation of tasks coincides with team conflicts and when the care is performed by only one worker. A resident’s weight or unwillingness to cooperate as well as a lack of cooperation between the various team members increase the risks of abruptness and inadequate movements. To E11, that is the worst problem in care work: “the abruptness of movements and gestures”. For E33, “it’s not hitting, it’s the attitudes, the words, the omissions”. E10 summed up: “With these conditions of work, it is humanly impossible to have quality care”.

Although it is difficult to recognise mistreatment or neglect situations, some narratives revealed daily care omissions. Participants excused these attitudes by the adversity of the working conditions and justified by a “highly stressful job experience” (E12), “physical and psychological exhaustion” (E6) and “lack of patience” (E21). Omissions of care, the overuse of diapers and physical restraint, in an institutional context, are
normalised practices that are justified to minimise workloads or in cases of a shortage of care workers. A third factor mentioned by participants to explain omissions of care was the absence of emotional characteristics to provide care.

Participants defined “good care worker” as a mix of vocation, personality traits and relational skills. Intuition, sensitivity, a spirit of selflessness, patience, courage, empathy and affection are necessary ingredients for care work and are conceived essentially as feminine characteristics.

Lack of qualified staff, adverse working conditions and inadequate levels of support in care work (e.g. work overload, staff ratio deficit, low wages) have consequences on the high incidence of work-related poor health (physical and emotional burnout), early retirement and high turnover of care workers. All these factors explain the organisational conflict and constitute a form of structural violence (Banerjee et al. 2012). This concept is particularly relevant to highlight the role that organisational factors play in setting the context of violence that affects both old people and their care workers in a vicious circle (see Fig. 8.2).

The last question posed to participants concerned what solutions should be implemented to combat and prevent institutional violence.

**Devising a Strategy to Prevent Institutional Violence**

Professionalisation would be a way of performing a selection and dignifying the profession. E12 agreed with establishing the requirement of a mandatory professional card through the fulfilment of a specific set of skills. E12 stated, “There really should be one” and justified this statement by explaining such a card would reward good practices and make the profession more attractive to the young. As E12 noted, “There should be incentives for young people to take on this profession”. For E30, “there should be a professional card” which could bestow the profession with “a different social value”. Along the same lines, E36 identified two groups in the profession: the people who are working because they enjoy it and have the right profile for the job and the people who are working for the salary and because of a lack of work alternatives.
However, professionalisation alone is not enough, according to most of the participants. Training and having a caring profile are essential to guarantee quality of care. This profile involves having a vocation, personality traits, relational skills and physical strength as well as enjoying learning, working with an older population and the technical aspects related to health.

When asked about mandatory training, E3 asserted it should be mandatory and explained that care workers are sometimes called to perform health-related tasks including positioning users, feeding normal
food through a nasogastric tube, administering insulin and providing medication and recording it in the resident’s care plan. Performing these tasks entails their delegation from health professionals, particularly from nursing.

E39 explained that there is little recognition for the profession and stated, “This profession is under-appreciated”. With no professional career, no performance assessment and no reward for experience or seniority, even the role of trainer or care supervisor is sometimes informally undertaken. This participant explained, “I’ve been here for 25 years and I get 674€, now that I’ve got a raise. A colleague of mine, who just started, earns 20€ less than me. Go figure, there is no recognition!”

More demanding recruitment processes, an accredited training process, better work conditions and dignity in the care worker profession are measures proposed by participants to prevent institutional violence.

Discussion

From the responses of the participants, a typology of factors (see Fig. 8.2) that influence the quality of care provision was created. This typography highlights the interdependence between work conditions and quality of care practices. Facing a progressively more dependent population, care is performed by care workers, sometimes by themselves. With time, health problems (physical and mental) surface and become motive for sick leave, given the state of physical and mental burnout. Absenteeism and early resignation affect the human resources available, which results in not having the ratio established by the Portuguese legislation (1 care worker for every 5 dependent users) and is a breeding ground for work overload for those in active duty. The problem aggravates yearly, and the organisations struggle on a daily basis with the serious problem of a lack of workers interested in the profession.

The insufficient human resources that would want to take on a socially unrecognised and unattractive profession is identified across-the-board in every nursing home. The profession involves arduous physical and mental labour as well as difficult working conditions (e.g. poorly paid, long working hours, rotating shifts, few break times). Health problems
caused by years of hard work and little social protection in terms of occupational health have inevitable effects on care workers and in the ratio of workers to resident. These ratios are inadequate given that they have not followed demographic and epidemiological changes in the institutionalised population. This is a population in a situation of great physical and mental dependence, in which dementia has taken a considerable toll as the main pathology, and with demographic projections estimating the exacerbation of the numbers. According to the OECD (2019), there were more than 20 people with dementia in Portugal per 1000 individuals in 2019, and it is estimated that this figure will increase to 40.5% in 2037, which means that more than one in 25 people will be living with dementia.

All these factors combined contribute to a consensual care model among participants, which is characterised by establishing collective needs, standards and task routines. The collectivisation of care which is provided within an institutional context is incompatible with good care and a person-centred model.

Researchers have noted that personalisation, humanity, attention, respect for individuality and dignity of care are required to satisfy basic needs but also maintenance of the individual’s capacities and the relational dimensions of care (i.e. the need for communication). Staff shortages and workload pressures are constraints on the development and continuity of care relationships (Cangiano and Shutes 2010).

The satisfaction of this set of needs suggests two key phrases: the human factor and the time factor. While the human factor involves improvement and professionalisation, the time factor addresses the long time that is necessary for care to be exercised in an individualised and timely manner. Without these two factors guaranteed, a single organisational context can exhibit both good and bad care practices.

Some of these bad care practices are institutionally recognised as inadequate, but are hardly contested in practice because abuse and neglect problems are invisible in an interventive organisational culture under current policies. This problem’s invisibility is attributed and justified by the lack of trained human resources with a skilled profile in an unattractive and socially undignified profession. Lack of care workers, inadequate ratios of care workers to attend to the care needs of dependent people,
and low public investment in the long-term care system, mainly in the professionalisation of care workers, are factors which promote institutionalised violence. It is not possible to provide good care for old persons with the current resources, which contributes to a vicious cycle and leads to insufficient care.

Heightening the existing difficulties, the Covid-19 pandemic has had serious impacts on care practices in Portuguese nursing homes and domiciliary services, structures that already had weaknesses. The social visibility caused by Covid-19 has uncovered several problems in the care sector, including lack of care workers, difficult working conditions, inadequate ratios (staff/users), workload, burnout situations and staff turnover, all of which have serious impacts on elder abuse, mainly neglect and users’ abandonment.

The root of the problem stems from the absence of an education and employment policy that clearly defines a skills profile, progression and careers.

Johansson and Muhli (2018) point out four main objectives concerning the professionalisation process: (1) to ensure competence levels and to promote skills development; (2) to promote higher status for the care work performed; (3) to ensure future recruitment to care services; and (4) to consolidate a particular area of competence and expertise within an undergraduate level. Defining a skills profile would be the first step to regulate the work system and integrate qualified human resources, with a professional career that rewards good practices, measures that will inevitably have positive influence on the long-term quality of care provided and in prevention of institutional violence.

Note

1. The aim is to analyse the relationships between the organisation of nursing homes and the interpersonal features of care providers and their relation with the residents’ quality of life, where elder abuse and neglect is one of the areas analysed.
References

Banerjee, A., Daly, T., Armstrong, P., Szebehely, M., Armstrong, H., & Lafrance, S. (2012). Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia. Social Science & Medicine, 74(3), 390–398 (2012). https://doi.org/10.1016/j.socscimed.2011.10.037.

Bericat, E. (2016). The sociology of emotions: Four decades of progress. Current Sociology, 64(3), 491–513 (2016). https://doi.org/10.1177/0011392115588355.

Cangiano, A., & Shutes, I. (2010). Ageing, demand for care and the role of migrant care workers in the UK. Journal of Population Ageing, 3, 39–57 (2010). https://doi.org/10.1007/s12062-010-9031-3.

Censos da população—2011. (2011). Instituto Nacional de Estatística. https://ine.pt/xportal/xmain?xpid=INE&xpgid=ine_publicacoes&PUBLICACOESpub_boui=148275789&PUBLICACOEStema=00&PUBLICACOEStodo=2. Accessed 11 February 2020.

Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). Help wanted? Providing and paying for long-term care. OECD Health Policy Studies, OECD Publishing. https://doi.org/10.1787/2074319x.

Directorate-General for Economic and Financial Affairs (DG ECFIN). (2018). The 2018 ageing report: Economic and budgetary projections for the 28 EU member states (2016–2070) (Institutional Paper). Publications Office of the European Union. https://doi.org/10.2765/615631.

Drennan, J., Lafferty, A., Treacy, M., Fealy, G., Phelan, A., Lyons, I., & Hall, P. (2012). Older people in residential care settings: Results of a national survey of staff–resident interactions and conflicts. NCPOP, University College Dublin. https://www.lenus.ie/handle/10147/301725. Accessed 12 February 2020.

Dubois, H., Leončikas, T., & Molinuevo, D. (2019). Quality of health and care services in the EU (Report). Eurofound. https://doi.org/10.2806/5643.

Fulmer, T., Guadagno, L., & Connolly, M. T. (2004). Progress in elder abuse screening and assessment instruments. Journal of the American Geriatrics Society, 52(2), 297–304 (2004). https://doi.org/10.1111/j.1532-5415.2004.52074.x.

Gabinete de Estratégia e Planeamento (GEP). (2017). Carta Social – Rede de Serviços e Equipamentos 2017 (Report). Ministério da Solidariedade,
Emprego e Segurança Social. http://www.cartasocial.pt/pdf/csocial2017.pdf. Accessed 12 February 2020.

Gabinete de Estratégia e Planeamento (GEP). (2018). Carta Social – Rede de Serviços e Equipamentos 2018 (Report). Ministério da Solidariedade, Emprego e Segurança Social. http://www.cartasocial.pt/pdf/csocial2018.pdf. Accessed 12 February 2020.

Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research, 6*(3), 167–191 (1969). https://doi.org/10.1177/002234336900600301.

Gil, A. P. (2010). *Heróis do quotidiano: Dinâmicas familiares na dependência*. Lisbon: Calouste Gulbenkian Foundation.

Gil, A. P. (2018). Care and mistreatment—Two sides of the same coin? An exploratory study of three Portuguese care homes. *International Journal of Care and Caring*, 2(4), 551–573 (2018). https://doi.org/10.1332/239788218X15411703595128.

Gil, A. P. (2019). Quality procedures and complaints: Nursing homes in Portugal. *The Journal of Adult Protection*, 21(2), 126–143 (2019). https://doi.org/10.1108/JAP-09-2018-0018.

Hantikainen, V., & Käppeli, S. (2000). Using restraint with nursing home residents: a qualitative study of nursing staff perceptions and decision-making. *Journal of Advanced Nursing*, 32(5), 1196–1205 (2000). https://doi.org/10.1046/j.1365-2648.2000.01590.x.

Hayes, L. J. B. (2017). *Stories of care: A labour of law—Gender and class at work*. London: Palgrave Macmillan.

Hussein, S., Stevens, S., & Manthorpe, J. (2013). Migrants’ motivations to work in the care sector: Experiences from England within the context of EU enlargement. *European Journal of Ageing*, 10(2), 101–109 (2013). https://doi.org/10.1007/s10433-012-0254-4.

Husso, M., & Hirvonen, H. (2012). Gendered agency and emotions in the field of care work. *Gender, Work and Organization*, 19(1), 29–51 (2012). https://doi.org/10.1111/j.1468-0432.2011.00565.x.

International Labour Organization (ILO). (2018). *Care work and care jobs for the future of decent work*. Geneva: International Labour Office. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf. Accessed 11 February 2020.

Johansson, R., & Muhli, U. (2018). Developing care professionals: Changing disability services in Sweden. *Professions & Professionalism*, 8(2), 79–94 (2018). https://doi.org/10.7577/pp.2017.
Lopes, A. (2017). Long-term care in Portugal—Quasi-privatization of a dual system of care. In B. Greve (Ed.), *Long-term care for the elderly in Europe—Development and prospects* (pp. 59–74). London: Routledge.

Lüscher, K. (2004). Intergenerational ambivalence: Further steps in theory and research. *Journal of Marriage and Family, 64*, 585–593 (2004). https://doi.org/10.1111/j.1741-3737.2002.00585.x.

Mac Rae, H. (1998). Managing feelings—Caregiving as emotion work. *Research on Aging, 20*(1), 137–160 (1998). https://doi.org/10.1177/0164027598201007.

Malmedal, W., Hammervold, R., & Saveman, I. (2014). The dark side of Norwegian nursing homes: Factors influencing inadequate care. *The Journal of Adult Protection, 16*(3), 133–151 (2014). https://doi.org/10.1108/JAP-02-2013-0004.

Melchiorre, M., Penhale, B., & Lamura, G. (2014). Understanding elder abuse in Italy: Perception and prevalence, types and risk factors from a review of the literature. *Educational Gerontology, 40*(12), 909–931 (2014). https://doi.org/10.1080/03601277.2014.912839.

OECD. (2013). A good life in old age? Monitoring and improving quality in long-term care. *OECD Health Policy Studies*. Paris: OECD Publishing. https://doi.org/10.1787/9789264194564-en.

OECD. (2016). *Long-term care data: Progress in data collection and proposed next steps. 2016 data collection review*. Directorate for Employment, Labour and Social Affairs Health Committee. http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/HD(2016)3&docLanguage=En. Accessed 12 February 2020.

OECD. (2019). *Health at a glance 2019: OECD indicators* (pp. 217–239). Paris: OECD Publishing. https://doi.org/10.1787/4dd50c09-en.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Rummery, K., & Fine, M. (2012). Care: A critical review of theory, policy and practice. *Social Policy and Administration, 46*(3), 321–343 (2012). https://doi.org/10.1111/j.1467-9515.2012.00845.x.

Santana, S., Szczygiel, N., & Redondo, P. (2014). Integration of care systems in Portugal: Anatomy of recent reforms. *International Journal of Integrated Care, 14*. http://doi.org/10.5334/ijic.989.

Scheil-Adlung, X. (2016). *Health workforce: A global supply chain approach: New data on the employment effects of health economies in 185 countries* (Working Paper). *Extension of Social Security Series, 55*. Geneva: International Labour Organization. http://doi.org/10.13140/RG.2.2.31169.35684.
Tronto, J. (2010). Creating caring institutions: Politics, plurality and purpose. *Ethics and Social Welfare, 4*(2), 158–171 (2010). https://doi.org/10.1080/17496535.2010.484259.

Trydegard, G. B. (2012). Care work in changing welfare states: Nordic care workers’ experiences. *European Journal of Ageing, 9*, 119–129 (2012). https://doi.org/10.1007/s10433-012-0219-7.

Wall, K., & Nunes, C. (2010). Immigration, welfare and care in Portugal: Mapping the new plurality of female migration trajectories. *Social Policy and Society, 9*(3), 397–408 (2010). https://doi.org/10.1017/S147474641000114.

Yeates, N. (2009). *Globalizing care economies and migrant workers: Exploring in global care chains*. London: Palgrave Macmillan.