



LEAFLET
**PREVENTION AT SOURCE OF
WORK-RELATED
PSYCHOSOCIAL RISKS
IN RESIDENTIAL CARE
ASSISTANT JOB**

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LEAFLET

**PREVENTION AT SOURCE OF
WORK-RELATED
PSYCHOSOCIAL RISKS
IN RESIDENTIAL CARE
ASSISTANT JOB
TO REDUCE MENTAL HEALTH
PROBLEMS**

An approach
with a gender perspective
based on scientifically
and socially grounded knowledge

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A more detailed version containing bibliographical references (in case you need to provide scientific evidence for any of the points summarised in this leaflet),

[can be found here.](#)





INTRODUCTION

The 1º de Mayo Foundation-ISTAS, with funding from the Spanish Foundation for the Prevention of Occupational Risks (FEPRL), has conducted a **literature review on primary prevention of work-related psychosocial risks in the residential care sector.**

In order to **specify preventive measures and situate them within the Spanish social context**, the analysis focused on the role of the **residential care assistant** (i.e., professionals providing direct care to dependent individuals), which represents the **most prevalent occupation in the residential care sector** (approximately 60% of the workforce), with women being contracted in **9.5 out of 10** positions.

Scientific evidence on the measures required for the primary prevention of work-related psychosocial risks in the sector has been **integrated with knowledge obtained from workers** and their legal representatives in order to generate **evidence-based and socially grounded insight**. To that end, **in collaboration with FSS-CC00, four workshops were held in Oviedo, Santander, Valencia, and Zaragoza, with the participation of 126 workers and their representatives, to whom we extend our sincere gratitude for sharing their experiences and expertise.** Many of the preventive measures needed to avert and address work-related psychosocial risks at source, along with the associated health disorders, require **changes in labour management practices**, as highlighted in recent reports by international bodies such as the World Health Organization (WHO) and the International Labour Organization (ILO).

All contributions are intended to **guide management, occupational risk prevention professionals, workers' representatives, and residential care assistants themselves toward a healthier way of designing, organising and managing work – one that is more equitable and democratic, for these jobs which are essential for sustaining life.**

This document provides a **summary of the outcomes of this co-creative process, offered as a tool from the field of occupational health and safety to help reverse the precarious conditions and inequalities endured by these women, who care for our elderly and experience adverse health effects in the process.**

1º de Mayo-ISTAS Foundation and FSS-CC00

1. EMPLOYMENT CONDITIONS IN RESIDENTIAL CARE ASSISTANT JOB

According to Social Security data, at December 2025 there were **332,494 salaried workers** employed in the residential care sector, 277,667 of whom were women.

The **residential care assistant is the most prevalent occupation in residential care homes for older people (60%), and 9.5 of every 10 people employed in this essential life-sustaining job are women.**

The **duties** of residential care assistants, defined as assisting and caring for people with activities of daily living (ADLs), include personal **hygiene** and **nutrition** (e.g., providing and administering food, as well as receiving, distributing, and clearing meals) and maintaining order in residents' rooms. However, duties also encompass a wide range of less visible tasks: **fostering** communication



among residents to support **social interaction; facilitating participation in scheduled activities** (errands, medical appointments, outings); providing companionship; supervising, assisting, and supporting transfers; **facilitating family integration**; and collaborating **with occupational therapists** (recreational and engagement activities), **physical therapists** (supporting exercises to maintain and improve physical and motor function), and **nursing staff** (e.g., repositioning, medication administration, **blood glucose monitoring**, and administration of prescribed insulin and heparin). In addition, they **participate within interdisciplinary teams in adapting individualised care plans** and in **planning and organising occupational and leisure-based preventive activities** (VIII State Framework Agreement on Services for Dependent Persons). The cognitive and relational competencies required for these tasks are varied and complex, involving significant emotional and physical demands, as well as a high level of responsibility for meeting the needs of dependent and vulnerable residents.

According to economic and sociological research, 74% of residential care facilities are privately owned with publicly funded beds, and a further 14% are publicly owned but privately managed. In other words, the service model is characterised by **public financing of private providers**. Care work is inherently resistant to productivity gains aimed at increasing annual profits without **degrading working conditions and the quality of care provided**. This is compounded by user attachment (both physical and emotional, making relocation difficult), resulting in limited competition based on quality of care. Instead, providers tend to prioritise profit margins with constrained labour costs based on precarious employment and working conditions. These dynamics reflect a long-term care model shaped by **reductions in public services, underinvestment**, and the **privatisation and subcontracting of services to companies whose profitability depends on the deterioration of employment and working conditions**. Consequently, **labour management practices applied to the residential care assistant job** in these facilities – predominantly staffed by women – are characterised by **shift work covering 24 hours a day, 365 days a year; low wages; insufficient staffing levels; excessive availability demands in relation to working hours; high rates of part-time employment; and the standardisation of tasks and time allocations, alongside increasingly complex resident profiles**. Not only do these labour management practices reinforce **class and gender inequalities** both within and beyond the labour market, but they are also associated with **psychosocial occupational risks** and can **adversely affect workers' health**, staff **retention** and **recruitment**, as well as the overall quality of care.

2.

WORK-RELATED PSYCHOSOCIAL RISKS

What are they?

In the field of occupational risk prevention, the term work-related psychosocial risks is used to refer to **working conditions arising from deficiencies in the design, organisation, and management of work for which there is sufficient scientific evidence demonstrating their potential to harm health**. They are termed psychosocial because they affect workers through psychological pathways (i.e., various psychological mechanisms), while their origin is social, and therefore modifiable, namely, the design, organisation, and management of work. Research to date indicates that **several aspects of labour management practices – such as staffing levels, the duration and variability of working hours, work methods, job design, employment arrangements, and wage structures – are modifiable occupational determinants that lie at the origin of work-related psychosocial risks and are critical to avoid and mitigate them**.



The Occupational Risk Prevention Act (**Law 31/1995, LPRL**) recognises that work-related harm can arise from more than just physical hazards such as machinery, substances, premises, or installations. It also acknowledges that the way work is designed, managed, and organised can have a significant impact on workers' health and well-being. Accordingly, the Act establishes that preventive action must address not only physical working conditions but also organisational factors. The law states that working conditions capable of causing harm, and therefore subject to preventive action, include *"all characteristics of work, including those relating to its organisation and arrangement"* (Article **4.7.d**).

The Regulation on Prevention Services (**Royal Decree 39/1997, RSP**) recognises Psychosociology as a mandatory discipline (Articles **18.2.a and 34.c**).

For nearly two decades, the World Health Organization (WHO) has defined psychosocial occupational risks as **social determinants of health**, given the extensive and high-quality scientific evidence on the health-related problems attributable to exposure to such risks. This evidence is based on longitudinal studies and complex analyses of large datasets that reliably

rule out chance and other non-occupational factors. Examples from this body of literature include systematic reviews and meta-analyses linking work-related psychosocial risks to highly prevalent health conditions such as **anxiety and depression, myocardial infarction, and stroke**. More recently, associations have also been identified with **suicide and suicidal ideation**, as well as with the use of **psychotropic medication and analgesics**. These risks are also considered among the most significant causes of more proximal health effects, such as **(chronic) work-related stress, burnout syndrome, sleep disturbances or fatigue**, and sickness-related **absenteeism and presenteeism**. They are likewise associated with an increased likelihood of certain types of **musculoskeletal disorders**.

Research has shown that exposure to psychosocial risks varies significantly by **occupational class and gender, resulting in unequal health outcomes**. These disparities arise because labour management practices are not applied uniformly across the workforce, even within the same organisation. Consequently, psychosocial risk assessments must present results disaggregated, at a minimum, by job or groups of jobs (Article 4.1, RSP) and by sex (Article 5.4, LPRL; Article 27, LOIEMH), in accordance with the applicable legal requirements.

How to address them?

From an occupational risk prevention perspective, **work-related psychosocial risks** are the harmful **exposures** that must be **avoid** or **assessed** in the workplace, and subsequently **reduced or eliminated combating them at source**. The source of these risks lies in **deficiencies in the design, organisation, and management of work**, which must be **addressed in order to eliminate, reduce, or control harmful exposure**. The resulting effects may include work-related stress, burnout syndrome, anxiety, depression, cardiovascular **disease**, and other health disorders associated with work-related psychosocial risks.



EXAMPLE

To illustrate this distinction, scientific evidence shows that **quantitative demands** are work-related **risk factor**, whereas **high quantitative demands** constitute the psychosocial risk itself, as they are associated with a 23% increase in the likelihood of diagnosed depression. **Depression** is the **resulting health outcome, arising from a combination of factors that may include working conditions characterised by excessive quantitative demands**. Preventive action at workplace level should therefore focus on addressing the risk at its **source** by reducing **workload** through measures such as increasing **staffing** levels, improving organisational **processes**, or modifying **materials and technology**.

From an occupational health and safety perspective within an organisation or institution, **work-related psychosocial risks are harmful working conditions and direct causes of adverse health outcomes. Their underlying source—deficient labour management practices—is modifiable through organisational preventive measures.** Most researchers studying the relationship between work-related psychosocial risks and health conclude that reducing these risks requires **organisational change, particularly improvements in workplace management practices, thereby decreasing the proportion of disease attributable to work. For example, it has been estimated that 30.6% of depression cases among women in Spain could be prevented if exposure to certain work-related psychosocial risks were eliminated.**

The most recent joint guidance issued by the World Health Organization (WHO) and the International Labour Organization (ILO) on addressing **mental health in the workplace**, together with the ILO's latest global report, advocate the same approach: prioritising the **prevention of work-related psychosocial risks through the implementation of organisational measures.** Such measures can also **facilitate employees' return to work following sickness absence** and help prevent relapse, as workers would return to a work environment in which the **unhealthy employment and working conditions** that may have contributed to their illness **had been addressed.** Furthermore, by ensuring healthy working conditions from a psychosocial risk perspective, organisations lay the foundations for a more **inclusive workplace.** Individuals living with mental health conditions or cardiovascular diseases can therefore be employed in work environments that support, rather than undermine, their health and well-being.



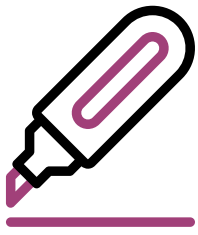
This approach is also **required by the Occupational Risk Prevention Act** (Law 31/1995), which establishes that **preventive action should prioritise to avoid risks (Article 15 (a)) or evaluating them and addressing risks at the source (Articles 15 (b and c)) by modifying the design, organisation, and management of work in order to eliminate or reduce occupational risks. Furthermore, the Act requires work to be adapted to the individual through organisational measures (Article 15 (d)),** including changes to job design, the selection of equipment, and working and production methods.

Furthermore, the legislative framework views prevention as a sociotechnical process in which the **participation** of management, workers, and their legal representatives is a fundamental requirement. The **scientific and technical expertise provided by occupational risk prevention professionals** (Article 38.2, LPRL) complements the practical knowledge and **experience of management, workers, and their representatives.** Both forms of knowledge are essential to the preventive intervention process. Their active involvement is also a prerequisite for effective prevention since management and labour are ultimately the ones with the ability to take decisions and implement changes within the organisation or institution.



The Act strengthens the role of workers' representatives by granting them rights to **information**, **prior consultation**, and the submission of **proposals** on any matter that can affect workers' health and safety. This specifically includes issues relating to technology, work organisation, and production processes. Furthermore, where an employer rejects proposals put forward by workers' representatives, the employer is required to provide a **reasoned justification** for that decision. This obligation promotes meaningful dialogue and **negotiation** throughout all stages of the preventive process (**Articles 14, 18, 33, 34, and 36, LPRL**).





The New Corporate Makeover: Are You Going to Fall for It?

The current trend is to train workers to become more resilient, offer tai chi or yoga classes to help them relax and improve their emotional well-being, or organise marathons, excursions, and barbecues to improve workplace morale. Some organisations even pay professionals to spend a few hours listening to workers whose problems are said to “come from home.” Yet none of these activities eliminates work-related psychosocial risks or addresses them at their source. They may be negotiated as “social measures” if desired, **but such initiatives do not change the fact that workers may still be expected to perform more work than can reasonably be completed within working hours, forcing them either to extend their working day or to work at an unsustainably high pace. Nor do they resolve situations in which workers do not know how much they will earn each month under part-time contracts or are unable to predict their work schedules because the notice given for frequent changes is inadequate. The underlying causes of work-related psychosocial risks remain unchanged, and the risks themselves are not being prevented.** This is the new occupational health industry: **the mental health commercial boom.**

Resilience training provides a clear example. It is often based on the idea that people cannot choose what happens to them, but they can choose how they respond. They are encouraged to develop optimism, maintain a sense of humour, and adapt to circumstances—in other words, to resign themselves. The principal criticism of resilience-based approaches is that they **require workers, as individuals, to assume responsibility for managerial decisions and systemic or organisational failures, and to do so with a smile.** Numerous studies, particularly in the healthcare sector, have examined such interventions and concluded that techniques based on relaxation, mindfulness, resilience, and similar approaches have no measurable effect on mental health outcomes such as depression, anxiety, and stress.

What this approach does achieve is avoiding any challenge to existing workplace management practices, **transforming mental health disorders that originate in working conditions into a matter of individual responsibility and public health. In doing so, it leaves untouched ways of designing, organising, and managing work that may be harmful to health while remaining economically profitable. As the ILO and WHO have argued, improving mental health in the workplace requires first addressing employment and working conditions,** reshaping labour management practices to promote **decent work that is fairer, more democratic, and therefore healthier.** There is extensive experience in this area, as reflected in sectoral collective agreements, national and regional social dialogue agreements, and company-level agreements, both within and beyond the field of occupational health. This is a cross-cutting issue, and further progress is needed with greater urgency and ambition.

3.

PREVENTING AT SOURCE WORK-RELATED PSYCHOSOCIAL RISKS IN RESIDENTIAL CARE ASSISTANT JOB

A selection of the **work-related psychosocial risks** most commonly encountered in residential care assistant job has been identified. For each risk, a summary is provided of the scientific evidence from the residential care sector regarding its **relationship with mental health outcomes**, together with research on **preventive measures** aimed at addressing the risk at its source. The document also presents **prevention proposals** developed through a **co-creative dialogue** between scientific knowledge and the **experience-based insights of more than one hundred workers in this job**. These contributions are intended to guide occupational health and safety professionals, management, workers' representatives, and residential care assistants themselves towards healthier approaches to the design, management, and organisation of work.

High Quantitative Demands

What does the evidence say about the what of this work-related psychosocial risk?

This risk is defined as an imbalance between the volume of work and the time available to complete it. It may manifest in the form of excessive workloads, time pressures, fast work pace, and/or extended working hours. It is also associated with other work-related psychosocial risks, including high role conflict arising from the inability to meet professional standards, low levels of co-worker support due to insufficient time to assist colleagues, and work-family conflict. Research conducted within the sector indicates that high quantitative demands increase the likelihood of depression, work-related stress, burnout syndrome, long-term sickness absence, presenteeism, and disability.

What does the evidence say about its origin in the sector?

The origins of this risk lie in understaffing resulting from inadequate staffing levels, tightly calibrated staff-to-resident ratios, and the failure to guarantee staff coverage, often driven by budgetary austerity measures and profitability strategies focused on controlling labour costs. It is also influenced by Taylorist and traditionally masculinised management practices, which tend to overlook a significant proportion of the tasks that are essential to person-centred care. As these tasks are often not reflected in workforce planning, they contribute to excessive workloads and high time pressure. In addition, newer models of person-centred care and small household-style living units may also generate high quantitative demands where residents' preferences are not translated into planned tasks and work is not organised collaboratively through effective teamwork. Other sources of risk include the increasingly severe and complex care needs of residents, which require additional work while staffing ratios remain unchanged.

What does the evidence say about prevention measures at source in the sector?

The evidence points to the need to increase staffing levels and ensure that all sickness absences and other forms of absence are covered through replacement hires, thereby guaranteeing the presence of the staff required for each shift in accordance with residents' levels of dependency and care needs. It also highlights the importance of distributing residents equitably based on their dependency profiles. Research further indicates that prioritising only basic care tasks, at the expense of providing holistic and comprehensive care, is not an effective solution, as this approach has been associated with higher levels of work-related stress among care assistants. Several countries have implemented measures aimed at addressing this risk. Countries such as Finland have introduced higher mandatory minimum staffing ratios to mitigate this risk. In Denmark, the government allocated substantial funding to increase wages in the sector with the aim of attracting and retaining staff and addressing workforce shortages. In Spain, the Government of the Balearic Islands took similar action in 2023 by supporting increases in sectoral pay scales and reductions in working hours under the autonomous community's collective agreement for the sector.

What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Hire more staff

Addressing this risk would require the implementation of measures aimed at increasing staffing levels in residential care facilities, ensuring that **sufficient personnel are available on each shift to meet workload demands** while accounting for holidays and routine contingencies such as discretionary leave and sickness absence. Achieving this objective would require action extending beyond the individual organisation:

1. **Increase the per-resident funding paid by public authorities** to private residential care providers, bringing it into line with the costs of public residential facilities. **Procurement and contracting specifications should require that additional funding be allocated to staffing** and should be accompanied by **appropriate monitoring and auditing mechanisms**.
2. **Reform public procurement practices so that tender specifications prioritise compliance with labour rights over price considerations.** This would involve introducing and giving greater weight to social and employment-related criteria, such as compliance with collective bargaining agreements, maintaining the required number of frontline care staff on all shifts, reducing reliance on part-time and temporary employment, and ensuring replacement of absent staff. The current emphasis on price competition among providers plays a central role in contract awards and should be reduced.
3. **Introduce financial penalties for each unfilled position or uncovered absence per shift** where minimum staffing presence requirements are not met, in a manner comparable to penalties imposed for the unlawful use of temporary employment contracts.
4. **Monitor compliance with minimum staffing presence requirements** for care assistants on every shift. This could be achieved through a review of time sheets or on-site inspections by the Labour Inspectorate. A dedicated **reporting channel** to the relevant public authority is also proposed, with a response time of no more than 72 hours.
5. **Exclude**, for a minimum period of five years, companies or foundations that have been fined for non-compliance from participating **in public procurement procedures**.
6. Revise the way **staffing ratios are established** by public authorities so that minimum staffing requirements are **based on the number of care staff by occupational group who must be physically PRESENT in the workplace on each shift**. This would replace the current approach, which calculates ratios based on the total number of employees across all occupational groups, regardless of their actual presence. The objective is to establish a sufficient minimum number of care assistants physically present on each shift, excluding staff from other occupational groups, employees on leave, and those absent due to sickness or other reasons.
7. Establish more **specific staffing ratios linked to the severity of residents' dependency** levels, ensuring that the number of care assistants present on each shift reflects the actual care needs of residents.
8. **Maintain up-to-date assessments of residents' dependency status, both within the facility and at the administrative level.** This would require the **introduction of automatic review mechanisms** for dependency assessments and for the corresponding **staffing ratios** applicable to each shift.

Change task planning

1. **Involve care assistants in the periodic planning of tasks, including rotations between floors or household units with higher and lower quantitative and emotional workloads.** Care assistants should be able to contribute their views regarding actual workload levels and the feasibility of meeting them while ensuring comprehensive care and service quality. This may be achieved by appointing a rotating spokesperson for each floor or household unit from among the care assistants, with dedicated time allocated within that person's workload, and/or by involving a workers' representative in order to avoid favouritism.
2. **Adjust the time allocated to tasks according to the actual needs of residents and the available resources, equipment, and materials.** Once this assessment has been completed, staffing levels should be increased where necessary. The time required for tasks should be reviewed periodically, at a minimum on a monthly basis and whenever residents' circumstances or care needs change.
3. Reduce the administrative burden placed on care assistants by eliminating unnecessary electronic, paper-based, or verbal reporting requirements, or alternatively by formally **recognising these activities within workload calculations** and allocating time for them when determining staffing presence ratios. Staffing levels should be increased where necessary following this assessment, and the administrative workload should be reviewed periodically.
4. **Implement a participatory process to set guidelines for prioritising tasks** that support the delivery of comprehensive, person-centred care, rather than focusing solely on the completion of essential tasks.

Work in pairs and ensure adequate quantities and conditions of material resources

1. **Work in pairs.**
2. **Provide ergonomic materials** such as sliding sheets for beds, flexible clothing for residents, disposable soapy sponges, no-rinse bathing wipes, and similar items.
3. **Provide sufficient ergonomic equipment**, including ceiling-mounted hoists, standing and transfer hoists, turning discs, transfer boards, adjustable profiling beds, wheeled shower chairs, motorised medication and treatment carts, zero-threshold access, and armchairs with electric lifting mechanisms and compact, stable armrests.
4. **Plan and implement equipment maintenance**, which requires sufficient maintenance staff to repair breakdowns as soon as they occur and to carry out scheduled preventive maintenance of equipment.
5. **Implement a planned programme for updating equipment and materials.**

High Work-Family Conflict and Job Insecurity

What does the evidence say about the what of these work-related psychosocial risks?

Work-family conflict is defined as the negative impact of work demands on the time and energy required for unpaid domestic and caregiving responsibilities at home (double burden), as well as the need to respond simultaneously to the demands of paid work and care responsibilities (double presence). High job insecurity is defined as a lack of stability in fundamental working conditions, particularly working hours. Research conducted within the sector indicates that exposure to these risks increases the likelihood of chronic work-related stress and cardiometabolic disorders.

What does the evidence say about the origins of these risks in this sector?

The primary work-related causes are frequent changes to working hours, often communicated on very short notice as a result of scheduling practices that prioritise labour cost management. Other contributing factors include the inability to disconnect from work-related communications outside working hours, the lack of worker participation in decisions relating to working hours arrangements (including the number of hours, scheduling, and modifications to working hours), and limited advance notice and specificity regarding individual schedules.



What does the evidence say about prevention measures at source in the sector?

Work-family conflict and insecurity regarding working hours can be reduced by increasing workers' participation in decisions concerning work time arrangements, including daily working hours, shift start and end times, and the procedures governing changes to schedules. This can facilitate greater alignment between work time arrangements and workers' caregiving responsibilities at different stages of their lives. Additional measures include increasing staffing levels to reduce the need for schedule changes, ensuring strict compliance with established work schedules, and introducing longer shifts to reduce the number of working days, increase earnings (particularly where involuntary part-time work exists), and facilitate disconnection from work. However, such longer shifts should be accompanied by adequate rest periods in order to prevent fatigue and reduce the risk of adverse health outcomes.



What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Establish fixed annual work schedule and allow shift swapping

The objective is to develop a fixed ANNUAL work schedule through a PARTICIPATORY process, with the following characteristics:

1. **Publish** the annual schedule/roster by **15 January** each year. The schedule should **include working days, start and finish times, weekly time off, public holidays, annual leave, and shift allocations.**
2. Organise work time arrangements considering **workers' needs at different stages of their lives.**
3. Guarantee **at least one full weekend off per month (Saturday and Sunday), or two full weekends where required for work-life balance purposes. Public holidays, special holidays, and daily working hours** should be rotated among care assistants according to life-stage needs and in alphabetical order so as to avoid favouritism. Annual leave periods should also be rotated on a yearly basis.
4. **For each one of the 14 public holidays worked, employees should be compensated with two working days off** (resulting in fewer annual working days and hours for those employees), in addition to any differential established under the applicable collective agreement.
5. Establish **continuous shifts** and prohibit split shifts, both for full-time and part-time employees. Daily shifts should be **at least six hours long**, and the use of part-time contracts should be minimised wherever possible.
6. **Allow workers to swap shifts among themselves, with such arrangements managed directly by them.**
7. **Allocate all annual working hours within the annual schedule/roster.**

Ensure adequate staffing levels

Ensure sufficient staff presence to avoid changes to work schedules: staffing levels should be **planned for each shift in accordance with the existing workload and the required quality of care, taking into account annual leave and scheduled rest periods included in the annual roster, as well as expected contingencies based on previous years' experience, such as sickness absence, leave entitlements, discretionary leave days, and the replacement of workers released from duties for trade union activities.**

Protocol for regulating and compensating inevitable scheduling changes

If, despite the implementation of the above measures, unplanned changes to work schedules cannot be eliminated, they should be **regulated and compensated as follows**:

1. Publish a **calendar** identifying vacant shifts that any member of staff may voluntarily choose to cover. **Assignment** among volunteers should follow a **formalised** procedure designed to avoid uncertainty and favouritism, with shifts assigned on a **rotating basis in alphabetical order**. Workers assigned to cover a vacancy should be placed on **availability status and receive the corresponding availability allowance for each shift, regardless of whether they are ultimately required to work**.
2. Other **unavoidable schedule changes (whether or not they fall within the regulatory framework governing overtime, irregular distribution of working hours for full-time employees, or supplementary hours under part-time contracts) should be subject to the following conditions**:
 - **24 hours advance** notice.
 - **Assignment should follow a formalised procedure designed to avoid uncertainty, and favouritism, with assignments made on a rotating basis in alphabetical basis among all care assistants**. Shift swaps should be permitted and managed directly by the workers themselves. Workers with reduced working hours due to caregiving responsibilities, situations involving gender-based violence, health and safety limitations, or similar circumstances should be excluded.
 - Each additional hour should be **compensated at double the standard rate**.
 - Workers should **decide how and when excess hours are compensated, whether through time off, financial compensation, or a combination of both**. Additional hours should be calculated on a monthly basis and taken or compensated within the following three months.
3. **Where minimum staffing presence requirements are not met, each hour worked by colleagues who assume the workload** of absent or non-replaced workers should be **compensated at three times the standard rate**.
4. **Respect the right to digital disconnection and daily and weekly time off**. Service-related requirements of any kind should not be communicated to workers via WhatsApp or similar channels outside their working hours.

Reduce annual working hours, increase holiday and personal leave

The **First Collective Agreement for Residential Care Homes and Day Centres for Dependent Persons in the Autonomous Community of the Balearic Islands** (2023–2026), published in the Official Gazette of the Balearic Islands (BOIB No. 47, 2023), provides a good example of the feasibility of such measures. Under the agreement, annual working hours are reduced from 1,792 hours in 2023 to 1,774 hours in 2026; annual leave entitlement increases to 32 days from 2025 onwards; and four discretionary leave days are introduced. The shorter the annual full-time work schedule, without any reduction in pay, the lower the potential for work–family conflict.

Low Control

What does the evidence say about the what of this work-related psychosocial risk?

This risk is defined as the inability to influence how one's own work is carried out, a lack of autonomy in the performance of work, and limited opportunities to apply existing skills and knowledge or to acquire new ones. Research conducted within the sector indicates that low levels of control increase the likelihood of depressive symptoms and sickness absence.

What does the evidence say about its origin in the sector?

This risk arises from the design of repetitive and standardised tasks based on Taylorist methods that exclude care assistants from decision-making regarding how care is provided to residents. The rigid hierarchical separation between the design and execution of work prevents those delivering direct care from participating in the development and evaluation of care plans, thereby hindering the effective implementation of person-centred care models and household-style living units.



What does the evidence say about prevention measures at source in the sector?

The implementation of consultative approaches and self-managed interdisciplinary teams has been shown to improve job control and reduce stress. Experiences in France and Belgium indicate that both delegated direct participation and group-based consultative participation increase workers' levels of control. However, participatory practices implemented in contexts characterised by understaffing and excessive workloads may undermine the benefits of such approaches, as they can increase quantitative demands unless sufficient time is allocated for participation within workload planning.

What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Within the context of person-centred care models, which seek to tailor care to the needs of each resident rather than relying on standardised approaches, and household-style living units (small residential units within a larger care facility), **residential care assistants play a key role.** They are the workers who provide direct care and spend the most time with residents on a day-to-day basis, whether working collectively as part of a team or on an individual basis. Even where these care models have not been formally implemented, care assistants remain the staff members who have the greatest day-to-day contact with residents and should therefore be recognised as key reference professionals in their care.

Participation through the delegation of decision-making authority to care assistants in relation to the day-to-day performance of their tasks

Specific issues regularly arise during the performance of care assistant duties and often need to be resolved in real time, reflecting the nature of work with older people, whose care and support cannot be fully standardised through task cards, work schedules, or predefined timings for activities such as bathing, meals, or other daily tasks. This requires management to view care protocols as a flexible framework that care assistants are empowered to adapt when necessary, recognising and valuing their training, experience, and knowledge acquired both through daily practice and through collaboration with colleagues in horizontal or interdisciplinary meetings.

Self-managed teams should be permitted to make decisions regarding the organisation of service tasks and provided with dedicated time each week to adapt care to residents' changing needs, based on interdisciplinary agreement regarding essential daily tasks. Teams should be able to adjust task duration, task frequency, staffing arrangements (including working in pairs), and other aspects of work organisation. They should also be encouraged to test and develop new ways of working. As workers themselves describe it, this means being able to "decide how the work is done."

Evaluate changes implemented through self-managed working teams on an interdisciplinary basis and keep written records of recommendations.

Under no circumstances should self-management involve the delegation of critical tasks, such as decisions relating to medication or other activities falling within the scope of healthcare professionals' responsibilities.

Participation of residential care assistants in interdisciplinary meetings

This measure involves including care assistants in the interdisciplinary coordination meetings between the various professionals within residential care facilities, including physiotherapists, nurses, social workers, occupational therapists, physicians, and management staff. The time allocated to these meetings should be formally recognised as part of the care assistant job and incorporated into workload planning in order to avoid increasing workload demands. The matters discussed should include changes to care protocols for the residents they routinely support, ongoing assessments of residents' cognitive and physical condition and functional abilities, task prioritisation where workloads become excessive, and the acquisition of materials and equipment required for daily care activities. Where it is not feasible for all care assistants involved in a resident's care to participate directly, participation should take place through a care assistant acting as a spokesperson, with this role rotating among workers at subsequent meetings.

Participation through hierarchical channels or by means of written input does not increase workers' influence over their work or enhance opportunities to apply, develop, and expand their skills and knowledge.



Obstacles to the widespread implementation of these participatory formulas. Several barriers were identified that would need to be addressed before these measures could be implemented. First, participants highlighted the **current staffing** ratios and the need to reduce the number of residents assigned to each care assistant, as well as to **increase staffing levels, in order to implement participatory management approaches within the care assistant job.** The current workload is already highly demanding, leaving little scope to expand responsibilities. Participation in consultative or delegated decision-making processes would therefore represent an additional task unless sufficient staffing resources were provided. Second, concerns were raised regarding **developments in management practices** that may undermine the existence of face-to-face participatory spaces. The **reception and exchange of information, both vertically (with managers and other professionals) and horizontally (among care assistants working in different units or shifts),** is increasingly being **automated** through information systems that facilitate traceability and reduce the need for synchronous communication. However, such systems **eliminate direct interaction and opportunities for participation.** Information is a necessary condition for participation, but it is not sufficient in itself. Third, participants identified **accountability as a specific obstacle to delegated decision-making.** Care assistants expressed concern about making decisions that deviate from established protocols and being held responsible for any resulting **errors**, particularly where no **safeguards** are in place. This concern could be addressed either through **protocols** clearly defining the areas in which care assistants are authorised to exercise discretion or through the implementation of **group-based consultative decision-making processes.** **In all cases, participants emphasised that staffing levels would need to be increased to ensure that participation does not become an additional source of workload and pressure.**

Task enrichment

In addition to the enrichment achieved through self-managed care assistant teams and their participation in interdisciplinary meetings, it is proposed that care assistants collaborate in activities carried out by other professionals, such as physiotherapists and occupational therapists, in order to develop new skills and knowledge and increase task variety. This measure requires additional staffing resources and a formal allocation procedure. For example, participation opportunities could be offered to all interested care assistants according to alphabetical order by surname, while allowing shift swaps between workers, in order to avoid discretion and the potential for favouritism.

Task rotation

Rotation between floors or household-style living units in order to apply different skills and knowledge or acquire new ones. Such rotation should be governed by a formalised procedure. For example, opportunities for rotation could be offered to all care assistants according to alphabetical order by surname, while allowing shift swaps between workers, with the aim of eliminating discretion and reducing the potential for favouritism.

Low Support

What does the evidence say about the what of this work-related psychosocial risk?

This risk is defined as the absence of practical support from colleagues when assistance is needed to carry out tasks. Research conducted within the sector indicates that low levels of co-worker support increase the likelihood of anxiety and depressive disorders, as well as occupational burnout syndrome.

What does the evidence say about its origin in the sector?

Low levels of co-worker support are primarily associated with a lack of time to provide mutual assistance and feedback among colleagues, resulting from excessive workloads, as well as the individualised design of work processes.



What does the evidence say about prevention measures at source in the sector?

All measures aimed at avoiding or reducing excessive quantitative demands would also contribute to addressing this risk, given the factors identified as its underlying causes. Additional measures include brief meetings at the beginning and end of each shift to review the current situation and identify any support needs among staff in relation to their assigned tasks. Time should be formally allocated within each worker's schedule to participate in these meetings and to assist colleagues, with workload planning adjusted accordingly. Weekly meetings should also be held to discuss and resolve workplace issues through a participatory process. As with the shift meetings, dedicated time should be allocated within workload planning to enable participation without increasing workload demands. Finally, tasks and responsibilities associated with each job should be clearly defined in order to prevent the unfair allocation of work.

What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Ensure adequate staffing levels and staff presence, as well as sufficient time to enable mutual support among colleagues (see the specific measures in the section on high quantitative demands).

Promote team-based work and group self-management (see the specific measures in the section on low job control), or, at a minimum, working in pairs.

Facilitate the participation of residential care assistants in interdisciplinary meetings in order to strengthen support from other professional groups (see the specific measures in the section on low job control).

Eliminate discretionary decision-making practices in order to prevent favouritism (see the specific measures in the sections on high work-family conflict and high job insecurity, and on low recognition).

High Emotional Demands

What does the evidence say about the what of this work-related psychosocial risk?

This risk is defined as the requirement to manage the emotions experienced in day-to-day interactions with residents and their relatives, as well as in response to difficult situations involving suffering, death, or aggressive behaviour. Research conducted within the sector indicates that high emotional demands increase the likelihood of depression, anxiety, and occupational burnout syndrome.

What does the evidence say about its origin in the sector?

The source of this risk is inherent to care work. Working with and for vulnerable individuals inevitably involves emotional demands, including the need to manage emotional involvement appropriately and, at times, to regulate or refrain from expressing genuinely felt emotions. However, these demands are also intensified by organisational factors. Inadequate staffing levels and time pressures may prevent workers from providing care in accordance with professional standards, thereby contributing to role conflict. Emotional demands are further increased by the absence of specific and up-to-date training on the health conditions and needs of residents.

What does the evidence say about prevention at source measures in the sector?

This risk cannot be prevented at source, as it is the only psychosocial risk that arises directly from the nature of the work itself. The measures supported by the evidence are therefore protective in nature. These include training in coping strategies, communication skills, and the health conditions and needs of residents; the provision of forums in which workers can share experiences; and access to supervision and psychological support. Additional measures include rotating between tasks with different levels of emotional demand and reducing exposure time through adequate staffing ratios and staff presence levels.

What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Training

Regular and ongoing training should be provided through a structured **training programme** tailored to the **actual needs** of each residential care facility. It should be accessible to all workers, **delivered within the residential care setting**, and offered **during working hours**.

Training **topics** should include residents' **health conditions** and their management (for example, anxiety and depressive disorders), **emotional management skills, coping** with situations involving suffering and trauma, effective **communication** with older people and their families, the management of **aggressive behaviours** associated with conditions such as Alzheimer's disease or **psychiatric disorders**, and safe physical restraint techniques that minimise the risk of injury to both residents and workers.

Effective implementation requires not only the provision of training opportunities but also **sufficient staffing levels to cover workers attending training sessions**, thereby avoiding any increase in quantitative demands or work intensity for the remaining workforce. Delivering training during working hours is essential to prevent the creation of additional psychosocial risks, particularly work–family conflict, given that workers have responsibilities not only for the care of residents but also for caregiving and domestic responsibilities within their own households.

Rotation between tasks with higher and lower emotional demands

In most residential care facilities, care activities are organised according to residents' levels of dependency. This measure involves **rotating** workers between different floors, household-style living units, or care areas, or alternatively **designing** a balanced **allocation** of residents to each care assistant with regard to emotional demands, in the same way that physical workload demands would be distributed.

Reducing the number of residents assigned to each worker and increasing rest time for those caring for residents with particularly high emotional demands

Sufficient time must be available to enable workers to manage emotionally demanding situations effectively. This requires the implementation of the measures proposed to **reduce excessive quantitative demands and high work intensity**.

Working in pairs when caring for residents with a history of aggressive behaviour on all shifts

This measure **alleviates the fear** of aggressive outbursts, **facilitates containment** in situations where aggression occurs, **prevents workplace accidents**, and **guards against emotional and physical isolation of care assistants**.

Supervision by psychological support services

The emotional wellbeing of workers exposed to high emotional demands should be **monitored**, with **therapeutic** support provided where necessary. Such support should be available during working hours.

Conflict resolution protocols

Clear guidance should be developed setting out the actions to be taken by workers, managers, and colleagues in response to each identified critical situation arising from residents' health conditions. **They should be reviewed on a quarterly basis**.

Where critical situations arise from **sexist, racist, or anti-LGBTQ+ behaviour by residents or family members, including verbal abuse, discrimination, or harassment**, clear response procedures should be established for workers, managers, and colleagues. In addition, a **zero-tolerance protocol should be implemented, which may include the administrative discharge of the resident or restrictions on access for the family member concerned**.

Furthermore, in cases of physical aggression, **the employer should cover the costs of legal advice and psychological support for affected workers, as well as any other expenses arising from the incident, such as the replacement or repair of damaged personal items** (for example, glasses or dentures).





Low Recognition

What does the evidence say about the what of this work-related psychosocial risk?

According to the scientific evidence, this risk is characterised by low reward, high insecurity, insufficient appreciation, and unfair treatment in relation to the demands of the job. Research conducted within the sector indicates that low levels of recognition increase the likelihood of anxiety and depressive disorders, as well as occupational burnout syndrome.

What does the evidence say about its origin in the sector?

This risk is rooted in low pay, wage increases that fail to keep pace with inflation, the deterioration of other working conditions, the undervaluation of the technical competencies required to perform care assistant duties, and the perception of care work as a “feminine” attribute rather than a professional skill. In Spain, wages in this sector are significantly lower than the average across other sectors, reaching their lowest levels among care assistants, whose gross salary is €1,160.37 per month for full-time employment paid over 14 instalments.

What does the evidence say about prevention measures at source in the sector?

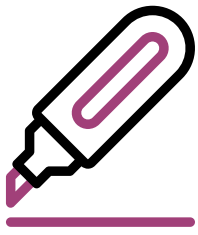
The literature highlights the need to improve compensation by assigning appropriate economic value to the professional competencies genuinely required to perform the care assistant job, including the cognitive, relational, and interpersonal skills needed to manage emotional demands, physical workloads, and the responsibility associated with meeting the daily needs of vulnerable and dependent individuals. Both the Danish Government and the Government of the Balearic Islands in Spain have allocated specific funding to support wage increases aimed at improving pay levels and enhancing the status of workers in the sector.

What are the most appropriate preventive measures?

Drawing on the intersection of scientific and experience **grounded** measures presented below, **IDENTIFY THE PREVENTIVE ACTIONS TO PROPOSE IN YOUR ORGANISATION AND JOBS.**

Compensation

Increase base salaries by assigning appropriate value to the competencies required to perform the care assistant job and to the actual demands and responsibilities associated with it. This includes recognising the cognitive, relational, and interpersonal skills required, the emotional and physical demands of the work, and the responsibility for meeting a broad range of the daily needs of vulnerable and dependent individuals.



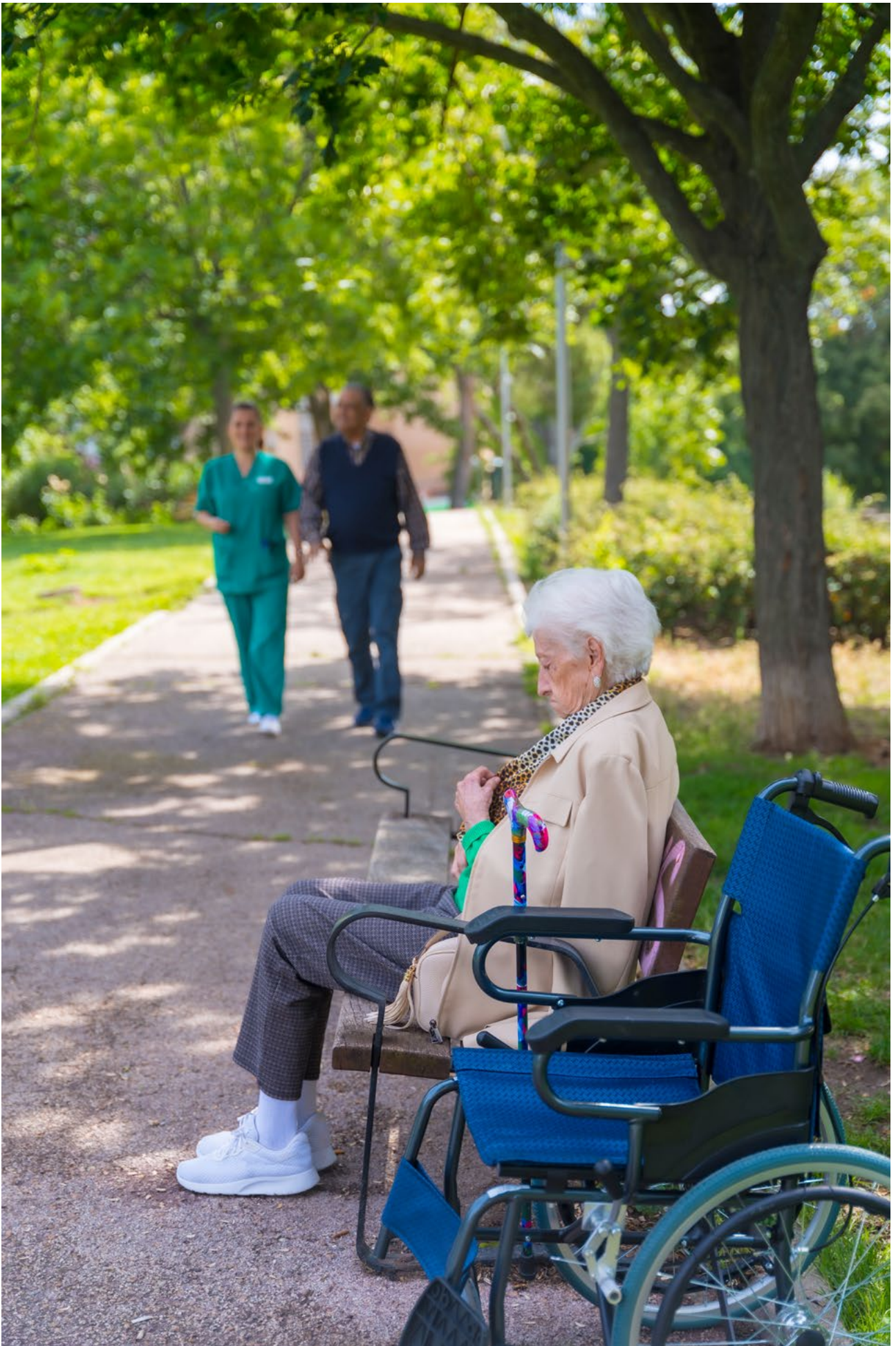
In Spain, the **duties** of care assistants are defined as assisting and caring for dependent older persons in activities of daily living. These duties encompass a wide range of tasks of varying complexity, including personal **hygiene, nutrition** and feeding (for example, receiving, distributing, serving, and collecting meals), and keeping residents' rooms **tidy**. They also include promoting residents' **communications** and social **relationships**; facilitating **participation in planned activities** such as appointments, administrative procedures, and outings; providing **companionship, supervision, and support during transfers**; assisting with the **integration of family members**; collaborating with occupational therapy services in **recreational and engagement activities**; supporting physiotherapy interventions by accompanying residents and assisting with exercises aimed at **maintaining or improving physical and motor abilities**; and assisting nursing staff with tasks such as **repositioning residents, administering medication, and carrying out prescribed blood glucose, insulin, and heparin procedures**. In addition, care assistants **participate with the interdisciplinary** team in adapting individualised care plans and in the **planning and organisation of preventive, occupational, and leisure activities** (Eighth State Framework Collective Agreement for Services for Dependent Persons).

Introduction of additional pay supplements. In addition to the enhanced payments associated with working hours (see the section on reducing work–family conflict and work time insecurity), additional supplements should be introduced, including a **night shift allowance** (in addition to any premium already provided under the applicable collective agreement for working night shifts) and a **dependency-level allowance** for workers providing care to residents classified as dependency grade 2 or above.

Protection of pay supplements from being absorbed or offset against increases in the statutory minimum wage or individually protected remuneration entitlements.

Higher staffing levels and adequate material resources, a fixed annual schedule established through a participatory process, shift swapping, respect for breaks and leave time, direct participation in the organisation of care, and the reduction of discretionary practices and favouritism

Recognition of professional expertise also requires addressing deficiencies in the management and organisation of work through the **implementation of the measures set out in this document to prevent or reduce other work-related psychosocial risks**. Together with measures aimed at increasing pay, these actions contribute to enhancing the value and status of the care assistant job.



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