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Perceived Work Environment and Work-Related Well-Being in Nursing Homes: Comparison of Different Care Worker Groups

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ABSTRACT

Background: A skilled and diverse healthcare workforce is essential in nursing homes, yet recruitment and retention remain a major challenge. Gaining insight into the well-being of different care worker groups and how they perceive their work environment can highlight areas of concern and opportunities for improvement.

Aims: To compare the perceived work environment and well-being among different care worker groups in nursing homes.

Methods: This descriptive study used cross-sectional survey data from the Flanders Nursing Home (FLANH) project, collected from February–July 2023. A total of 1521 care workers from 25 Flemish nursing homes participated (64.4% response rate), including care assistants (43.7%), registered nurses (20.5%), support staff (15.4%), allied health professionals (14.8%), and team leaders (5.7%). Chi-squared tests were used to compare the percentages of the care worker groups reporting the work environment items and well-being outcomes (job satisfaction, intention to leave, burnout). Post hoc analyses were conducted to identify which groups contributed to the significant differences observed.

Results: Significant differences among care worker groups were found for almost all work environment items and well-being outcomes. Staffing adequacy was perceived least among care assistants and registered nurses. More registered nurses and team leaders perceived high workload and emotional burden compared to the other groups. Work–life interference and involvement were perceived most among team leaders. A person-centered vision, work autonomy, and salary satisfaction were reported most among allied health professionals and team leaders. Skill use and training opportunities were reported least among support staff. Work-related well-being appeared to be experienced most among allied health professionals and least among care assistants.

Linking Evidence to Action: These findings highlight key differences in work environment perceptions and well-being among care worker groups, offering valuable insights for tailored initiatives to foster a supportive workplace that benefits the well-being of all types of care workers in nursing homes.

1 | Introduction

The demographic shift toward an aging population leads to a growing demand for long-term care services, putting pressure on nursing homes (de Bienassis et al. 2020). The increasing complexity of residents' care needs requires a diverse and skilled workforce capable of delivering high-quality care while also maintaining a supportive living environment (de Bienassis et al. 2020; National Academies of Sciences, Engineering, and Medicine 2022). However, nursing homes are struggling to recruit and retain qualified professionals to meet these increasing demands (OECD 2020).

In addressing these workforce challenges, the work environment and well-being of care workers play a pivotal role. Studies have shown that factors, such as supportive leadership, work autonomy, salary satisfaction, organizational commitment, and job satisfaction, are inversely related to intention to leave, which is an indicator of actual turnover (Decker et al. 2009; Gaudenz et al. 2019; Lee 2022; Tummers et al. 2013; Zhang et al. 2014). Conversely, high workload, physical health problems, and emotional exhaustion are associated with a higher intention to leave (Gaudenz et al. 2019; Tummers et al. 2013). Hence, improving the work environment and ensuring high levels of well-being for care workers are essential for maintaining a healthy and stable workforce.

Existing research predominantly focuses on nurses and care assistants, often overlooking the broader spectrum of care workers involved in the daily routines of nursing homes, including support staff (Müller et al. 2018), allied health professionals (Aloisio et al. 2018), and team leaders (Penconek et al. 2021). Recruitment and retention of all types of care workers, however, are essential to create a safe, supportive, and homelike environment where high-quality care is provided (National Academies of Sciences, Engineering, and Medicine 2022). Understanding how these different care worker groups perceive their work environment can help identify specific areas of concern as well as opportunities for improvement. Therefore, the purpose of this study was to compare the perceived work environment and work-related well-being among different care worker groups in nursing homes.

2 | Methods

2.1 | Design

For this descriptive study, cross-sectional survey data from the Flanders Nursing Home (FLANH) project were used (Geyskens et al. 2023). FLANH is a multicenter longitudinal study that aims to comprehensively explore the relationships between key organizational factors, such as staffing level, work environment, and rationing of care, and care worker and resident outcomes in Flemish nursing homes. Ethical approval was obtained from the KU Leuven Social and Societal Ethics Committee (G-2022-5821).

2.2 | Sampling

In a convenience sample of 25 nursing homes, all care workers who understood Dutch and provided care or support to residents were invited to complete a survey. Care workers were classified into five categories: (1) care assistants, (2) registered nurses, (3) support staff, (4) allied health professionals, and (5) team leaders. Care workers on long-term leave (> 1 month), temporary employees, students, and volunteers were excluded.

2.3 | Context

Nursing homes in Flanders (i.e., Dutch-speaking region in Northern Belgium) are residential facilities where care-dependent older adults live and receive care and support from various types of care workers (Flemish decree on residential care of 15 February 2019). Care assistants, who make up the largest group of care workers, perform supportive care tasks under the supervision of registered nurses (Bruyneel et al. 2019). They obtain their certificate after a specialization year following secondary schooling, which corresponds with level 4 of the International Classification of Education (ISCED) (Bruyneel et al. 2019; OECD 2018). For registered nurses, there are two educational pathways: diploma-level nurses completed a 3-year vocational program (ISCED level 5), whereas bachelor-level nurses completed a 3-year (up until 2016) or a 4-year university college program (ISCED level 6) (Bruyneel et al. 2019; OECD 2018). Both degrees lead to the same position and scope of nursing practice. Allied health professionals include physiotherapists, occupational therapists, speech therapists, dieticians, social workers, psychologists, and staff responsible for facilitating meaningful daytime activities. Their various educational degrees range from a specific certificate of secondary schooling to a bachelor's or master's degree (ISCED levels 4–7). Support staff handle tasks such as preparing and serving meals, housekeeping, and assisting visitors. No specific educational requirements are set for support staff. Nursing homes are typically organized into care teams led by a team leader who is responsible for staff planning, monitoring quality of care, assessing residents' needs, and following up on care plans. While this position is commonly executed by nurses, known as head nurses, it has been expanded to also include non-nursing professionals as team leaders (Flemish decree on residential care of 15 February 2019).

2.4 | Data Collection

Data were collected from February to July 2023. Nursing home characteristics were provided by a management representative, whereas care worker characteristics, perceived work environment, and well-being outcomes were collected through an online care worker survey. Care workers completed the survey after providing electronic informed consent.

The survey was developed based on a literature review, existing organizational surveys, and expert advice. Relevant scales and items regarding the work environment and work-related well-being outcomes were selected. These were adapted for use in the nursing home setting and translated into Dutch if necessary. To reduce survey burden, a subset of items from established scales was chosen for certain constructs. Item selection was informed by factor analysis results from the original validated scales and through discussions with a panel of experts to ensure face validity and contextual relevance. The survey was pretested with care workers from all groups to assess clarity, feasibility, and appropriateness. The full survey consisted of 110 items and took approximately 15 min to complete. For analysis in this study, we used a subset of 60 items. More details on the sampling, survey development, and data collection procedure are described elsewhere (Geyskens et al. 2023).

2.5 | Measures

2.5.1 | Nursing Home and Care Worker Characteristics

Nursing home characteristics included ownership status (i.e., public, private for-profit, private non-profit) and size (i.e., number of beds).

Care worker characteristics included gender, age, employment percentage, usual work shift, and number of years of work experience in the nursing home.

2.5.2 | Perceived Work Environment

The items used to capture the perceived work environment were selected from validated scales or were investigator-developed (Table 1). All items were adapted to be rated by care workers on a 5-point Likert scale (i.e., *strongly disagree, disagree, neutral, agree, strongly agree*). Responses were dichotomized as (strongly) agree versus neutral or (strongly) disagree.

2.5.3 | Work-Related Well-Being

Job satisfaction was assessed using a single question: "How satisfied are you with your current job?" (Dolbier et al. 2005). This was rated on a scale from 1 to 10, where a score of 7 or higher was considered high job satisfaction.

Intention to leave was surveyed using three items that assessed thinking of quitting, intention to search, and intention to quit (Mobley et al. 1978). Each item was rated on a 5-point Likert scale (i.e., *strongly disagree*, *disagree*, *neutral*, *agree*, *strongly agree*) and was considered present if care workers agreed or strongly agreed.

Burnout was assessed using the short version of the Burnout Assessment Tool (BAT), consisting of 12 items each rated on a 5-point Likert scale (i.e., *never*, *rarely*, *sometimes*, *often*, *always*) (Hadžibajramović et al. 2022). A total score ranging from 1 to 5 was obtained by averaging the scores of all 12 items. The Cronbach alpha of the BAT-12 in our sample was 0.88. Based on the validated cut-off point in Flanders, care workers with an average BAT score of 2.54 or higher were considered at risk for burnout or likely suffering from burnout (Schaufeli et al. 2023).

TABLE 1 | Overview of the work environment items.

Construct	Work environment items used
Staffing adequacy	Three items from the subscale "Staffing and Resource Adequacy" of the "Practice Environment Scale of the Nursing Work Index" (PES-NWI) (Lake 2002)
High workload	All items of the 3-item subscale "Pace of work" from the "Short Inventory to Monitor Psychosocial Hazards" (SIMPH) (Notelaers et al. 2007)
Emotional burden	All items of the 3-item subscale "Emotional workload" from the SIMPH (Notelaers et al. 2007)
Work–life interference	Three items from the 'Interrole conflict' scale (Kopelman et al. 1983)
Involvement	Three items form the subscale "Involvement" of the "Organizational Climate Measure" (OCM) (Patterson et al. 2005)
Person-centered vision	Two items from the subscale "Extent of personalizing care" of "the Person-centered Care Assessment Tool" (P-CAT) (Edvardsson et al. 2010) and all items of the 3-item subscale "Patient and next of kin focus" of the "Brisbane Practice Environment Measure for Nursing Homes" (B-PEM-NH) (Norman et al. 2019)
Autonomy	Four items from the "Autonomy and Control Scale" (Haynes et al. 1999) and one item from the de "Nursing Work Index-Revised" (NWI-R) (Aiken and Patrician 2000)
Salary satisfaction	One item from the subscale "Payment" of the "Questionnaire on Perception and Judgement of Work" (Veldhoven and Meijman 1994)
Skill use	All items of the 3-item subscale "Skill use" from the SIMPH (Notelaers et al. 2007)
Training opportunities	Three items investigator-developed
Social support of colleagues	All items of the 4-item "Colleagues Support" Scale (Peeters et al. 1995)
Social support of supervisor	All items of the 4-item "Supervisor Support" Scale (Peeters et al. 1995)

2.6 | Data Analysis

SPSS version 29.0.1.0 for Windows was used for statistical analyses. Descriptive statistics, including frequencies and percentages, were calculated. As no work environment item or well-being outcome had more than 7% missing data, listwise deletion was applied, and valid percentages were reported. Chi-squared tests were conducted to compare work environment items and well-being outcomes among the five care worker groups. When significant differences were observed ($p < 0.05$), post hoc analyses using adjusted standardized residuals (ASRs) were conducted to identify specific cells where observed frequencies were either higher or lower than expected under the null hypothesis of no difference (MacDonald and Gardner 2000; Sharpe 2015). To account for multiple comparisons within the 2×5 contingency tables, a Bonferroni correction was applied, and ASRs with an absolute value greater than 2.8 were considered significant, rather than the conventional threshold of 2.0 (MacDonald and Gardner 2000; Sharpe 2015). More details on the post hoc analyses using ASRs are provided in Supporting Informations.

3 | Results

3.1 | Sample Characteristics

A total of 1521 care workers from 25 nursing homes completed the survey, resulting in a response rate of 64.4%. Most nursing homes were private non-profit (52.0%) and public (40.0%) facilities, and only two (8.0%) were private for-profit facilities. In addition, 52.0% were large-sized (> 120 beds), 40.0% were medium-sized (80–120 beds), and 8.0% were small-sized (< 80 beds) facilities. The majority of care workers were care assistants (43.7%), followed by registered nurses (20.5%), support staff (15.4%), allied health professionals (14.8%), and team leaders (5.7%). The characteristics of the care worker groups are presented in Table 2.

3.2 | Perceived Work Environment

Table 3 shows the percentages of care workers in each group who (strongly) agreed with the work environment items, along with the results of the comparisons and post hoc analyses. Specific ASR values are provided in Table S1. Chi-squared tests revealed significant differences among care worker groups for almost all items. Hence, not all results are discussed in detail.

3.2.1 | Staffing Adequacy

Staffing adequacy was perceived significantly differently among the care worker groups. Post hoc analysis showed that significantly fewer care assistants (16.7%, ASR −5.5) and more team leaders (46.5%, ASR 5.2) agreed that there was enough staff to get the work done compared to the other groups. Additionally, fewer registered nurses (30.8%, ASR −3.0) felt that there was enough time to discuss care problems with colleagues.

3.2.2 | High Workload and Emotional Burden

A high workload was perceived more among registered nurses and team leaders, who, for instance, more frequently reported often having to work extra hard (66.7% and 76.7%, ASRs 3.8 and 3.8, respectively). Conversely, high workload was reported less by support staff and allied health professionals compared to the other groups. Emotional burden was also perceived most among registered nurses and team leaders, whereas fewer support staff reported emotional challenges.

3.2.3 | Work–Life Interference and Involvement

Significantly more team leaders reported difficulties in relaxing at home due to work (44.7%, ASR 4.6) and the interference of their work schedule with their personal life (43.5%, ASR 3.2) compared to the other groups. In contrast, work–life interference was perceived least among support staff and allied health professionals. Also, more team leaders reported involvement in decision-making (65.9%, ASR 4.7) and information sharing (71.8%, ASR 3.1).

3.2.4 | Person-Centered Vision, Autonomy, and Salary Satisfaction

A person-centered vision was perceived most among allied health professionals and team leaders. For instance, the ability to alter work routines based on residents' preferences was reported significantly more among allied health professionals (70.5%, ASR 5.3%) and team leaders (76.5%, ASR 4.2), whereas this was reported significantly less among care assistants (46.5%, ASR −5.2). Also, more allied health professionals and team leaders perceived autonomy, particularly in planning their own work (84.9% and 88.2%, ASRs 12.8 and 8.1, respectively) and having a say in their work schedule (83.6% and 88.2%, ASRs 9.7 and 6.6, respectively). In contrast, fewer care assistants and registered nurses reported autonomy in planning their own work (30.0% and 37.9%, ASRs −10.6 and −3.1, respectively) and having a say in their work schedule (43.6% and 44.7%, ASRs −6.9 and −3.6, respectively). Following this trend, more allied health professionals and team leaders felt adequately paid for their work (51.1% and 56.5%, ASRs 8.1 and 5.8, respectively) compared to care assistants (16.7%, ASR −8.9), registered nurses (24.3%, ASR −1.9), and support staff (35.8%, ASR 2.6).

3.2.5 | Skill Use and Training Opportunities

Fewer registered nurses and support staff perceived skill use in their roles compared to the other groups. For instance, significantly fewer registered nurses reported learning new things at work (57.9%, ASR −4.5), and fewer support staff felt that their work provided a sense of achievement (50.9%, ASR −4.6) or fully utilized their skills and capacities (47.4%, ASR −4.4). Also, significantly fewer support staff reported training opportunities compared to the other groups. In contrast, both skill use and training opportunities were overall perceived most among allied health professionals and team leaders.

TABLE 2 | Characteristics care worker groups.

	Care assistants ($n=664$)	Registered nurses ($n=312$)	Support staff ($n=234$)	Allied health professionals ($n=225$)	Team leaders ($n=86$)
Gender					
Women	92.9	89.4	91.8	88.8	84.9
Men	7.1	10.6	8.2	11.2	15.1
Age					
≤30 years	28.4	9.6	18.4	29.2	8.9
21-40 years	25.8	25.4	15.5	22.1	25.3
41–50 years	23.3	26.1	21.4	26.7	30.4
>50 years	22.5	39.0	44.7	22.1	35.4
Employment percentage					
≤50	14.9	17.4	31.8	22.2	1.2
51–90	49.0	46.8	49.5	41.3	16.5
>90	36.1	35.8	18.6	36.4	82.4
Usual work shift					
Day shifts	74.6	69.6	97.8	100.0	98.8
Night shifts	10.4	14.1	0.4	0.0	0.0
Regular change of day and night shifts	15.0	16.3	1.7	0.0	1.2
Work experience in the nursing home					
<1 year	15.1	11.5	18.8	19.1	4.7
1–4 years	26.7	20.5	30.3	26.7	19.8
5–10 years	23.1	16.0	23.1	16.9	17.4
11–20 years	16.3	19.9	18.8	23.6	31.4
≥21 years	18.9	32.1	9.0	13.8	26.7

Note: Numbers reported in percentages.

3.2.6 | Social Support

Social support of both colleagues and supervisor was perceived by the majority of all care worker groups. Overall, levels of perceived support were similar among groups and no significant differences were found for items such as being able to ask for help and feeling appreciated.

3.3 | Work-Related Well-Being

Table 4 shows the percentages of care workers in each group that reported the well-being outcomes, along with the results of the comparisons and post hoc analyses. Specific ASR values are provided in Table S1.

High job satisfaction was prevalent in all care worker groups, but post hoc analysis showed that this was reported significantly more among allied health professionals (88.8%, ASR 3.7) compared to the other groups. Regarding intention to leave, significantly more care assistants (24.1%, ASR 4.3) were thinking about quitting their job compared to registered nurses (16.9%, ASR −0.2), support staff (13.7%, ASR −1.6), allied health professionals (10.7%, ASR −2.9), and team leaders (17.6%, ASR 0.1). For intention to search and intention to quit, no significant differences were found among the care worker groups. The percentage of care workers at risk for burnout or likely suffering from burnout was significantly higher among care assistants (24.1%, ASR 4.3) and lower among allied health professionals (8.6%, ASR −4.3) compared to the other groups.

4 | Discussion

Our study revealed significant differences in the perceived work environment and in work-related well-being among care worker

TABLE 3 | Comparison of work environment items among care worker groups – percentages of care workers who (strongly) agree.

	Care assistants ($n = 664$)	Registered nurses ($n = 312$)	Support staff ($n = 234$)	Allied health professionals ($n = 225$)	Team leaders ($n = 86$)	Chi-square (p value)
Staffing adequacy						
There is enough staff to get the work done	**16.7**	22.8	29.1	30.2	46.5	52.04 (< 0.001*)
There is enough qualified staff to provide quality resident care	35.6	30.8	39.8	36.4	50.0	12.48 (0.014*)
There is enough time to discuss care problems with other care workers	36.3	**30.8**	44.8	44.0	46.5	18.27 (0.001*)
High workload						
I often have to work extra hard in order to complete a task	59.0	66.7	**48.3**	**40.0**	76.7	60.43 (< 0.001*)
I often work under time constraints	66.4	70.5	**48.1**	**45.8**	76.7	67.18 (< 0.001*)
I often have to hurry at work	59.7	68.4	50.6	**45.3**	65.1	36.32 (< 0.001*)
Emotional burden						
My work is heavy from an emotional viewpoint	48.1	52.9	**27.9**	**32.9**	55.8	55.15 (< 0.001*)
I am confronted in my work with elements which affect me personally	**48.4**	62.5	**43.3**	61.2	72.1	43.93 (< 0.001*)
My work puts me in emotional situations	51.4	62.5	**39.8**	65.3	74.4	54.97 (< 0.001*)
Work-life interference						
My work obligations make it difficult for me to feel relaxed at home	24.4	29.2	**16.4**	**16.1**	44.7	39.33 (< 0.001*)
I am irritable at home because my work is demanding	30.5	28.5	18.2	**12.1**	36.5	42.41 (< 0.001*)
My work schedule interferes with my personal life	31.2	35.6	**15.6**	**17.0**	43.5	52.09 (< 0.001*)
Involvement						
In this nursing home, staff are involved in decisions that affect them	39.8	**34.3**	44.5	44.4	65.9	29.82 (< 0.001*)
I feel that decisions in this nursing home are frequently made over my head	33.0	36.9	**23.3**	36.4	**17.6**	21.61 (< 0.001*)
Information is widely shared in this nursing home	54.6	53.4	54.0	55.6	71.8	10.08 (0.039*)
Person-centered vision						
We often discuss how to give person-centered care and support	64.8	56.6	**48.0**	65.2	81.2	38.45 (< 0.001*)

(Continues)

TABLE 3 | (Continued)

	Care assistants ($n = 664$)	Registered nurses ($n = 312$)	Support staff ($n = 234$)	Allied health professionals ($n = 225$)	Team leaders ($n = 86$)	Chi-square (p value)
We are free to alter work routines based on residents' preferences	**46.5**	57.9	46.6	70.5	76.5	62.96 (< 0.001*)
Residents can make choices about their care and support	53.2	56.3	**42.3**	61.6	80.0	40.84 (< 0.001*)
Residents are involved in important decisions about themselves	58.0	64.6	**48.4**	65.2	81.2	34.51 (< 0.001*)
The caregivers of a resident are involved in decisions when the resident is unable to participate	76.0	82.5	**55.7**	84.8	90.6	76.70 (< 0.001*)
Autonomy						
I can choose which tasks I perform	**14.9**	**12.9**	28.3	60.4	38.8	220.91 (< 0.001*)
I can decide when to take my break	**19.3**	20.8	**18.3**	43.6	69.4	146.06 (< 0.001*)
I can plan my own work	**30.0**	**37.9**	45.9	84.9	88.2	273.14 (< 0.001*)
I can carry out my work in the way I think is best	**54.1**	55.7	65.1	84.0	75.3	75.67 (< 0.001*)
I have a say in the development of my work schedule	**43.6**	**44.7**	52.8	83.6	88.2	158.34 (< 0.001*)
Salary satisfaction						
I feel I am paid adequately for the work I do	**16.7**	24.3	35.8	51.1	56.5	141.03 (< 0.001*)
Skill use						
I learn new things in my work	70.2	**57.9**	62.4	77.2	89.4	45.61 (< 0.001*)
My work gives me the impression that I can achieve something with it	63.5	60.3	**50.9**	76.8	87.1	54.58 (< 0.001*)
My work makes sufficient demands on my skills and capacities	64.3	53.6	**47.4**	65.6	80.0	42.19 (< 0.001*)
Training opportunities						
I am encouraged to attend training courses	69.4	65.9	**48.7**	64.7	71.8	33.99 (< 0.001*)
I can attend training courses within my working hours	67.7	63.2	**51.8**	83.0	87.1	67.71 (< 0.001*)
Training courses are paid for by the nursing home	78.6	78.5	**61.2**	80.8	89.4	42.17 (< 0.001*)
Social support of colleagues						
If necessary, I can ask my colleagues for help	89.2	87.6	88.5	89.7	96.5	5.67 (0.225)

(Continues)

TABLE 3 | (Continued)

	Care assistants ($n = 664$)	Registered nurses ($n = 312$)	Support staff ($n = 234$)	Allied health professionals ($n = 225$)	Team leaders ($n = 86$)	Chi-square (p value)
I feel appreciated by my colleagues	77.1	77.2	78.2	79.9	87.1	4.91 (0.296)
My colleagues give me advice on how to handle things	63.6	**52.0**	66.1	53.1	63.5	19.73 (< 0.001*)
My colleagues pay attention to my feelings and problems	66.8	61.7	68.0	69.2	70.6	4.65 (0.325)
Social support of supervisor						
If necessary, I can ask my supervisor for help	79.7	79.2	81.9	79.5	84.7	1.87 (0.760)
I feel appreciated by my supervisor	71.5	73.7	77.7	70.5	76.5	4.48 (0.345)
My supervisor gives me advice on how to handle things	65.9	66.8	67.1	**54.5**	64.7	11.74 (0.019*)
My supervisor pays attention to my feelings and problems	66.3	61.4	68.9	60.7	77.6	11.35 (0.023*)

Note: Bold values indicate a significantly lower percentage compared to the other groups (Adjusted standardized residual < −2.8). Underlined values indicate a significantly higher percentage compared to the other groups (Adjusted standardized residual > 2.8).
*Indicates a significant difference among care worker groups (p value < 0.05).

TABLE 4 | Comparison of well-being outcomes among care worker groups.

	Care assistants ($n = 664$)	Registered nurses ($n = 312$)	Support staff ($n = 234$)	Allied health professionals ($n = 225$)	Team leaders ($n = 86$)	Chi-square (p value)
High job satisfaction (score ≥ 7)	78.3	75.7	78.9	<u>88.8</u>	82.4	15.78 (0.003*)
Intention to leave (agree or strongly agree)						
I often think about quitting my job	<u>21.2</u>	16.9	13.7	**10.7**	17.6	15.53 (0.004*)
I intent to search for a new job in the next year	9.1	8.8	7.1	4.0	7.1	6.52 (0.164)
I intent to leave my current job	7.0	6.8	4.9	3.1	4.7	5.56 (0.235)
At risk for or likely burnout (mean score ≥ 2.54)	<u>24.1</u>	19.9	16.0	**8.6**	14.1	28.63 (< 0.001*)

Note: Bold values indicate a significantly lower percentage compared to the other groups (Adjusted standardized residual < −2.8) Underlined values indicate a significantly higher percentage compared to the other groups (Adjusted standardized residual > 2.8).
*Indicates a significant difference among care worker groups (p value < 0.05).

groups in Flemish nursing homes, highlighting critical areas of concern and opportunities for improvement.

Our results show that more allied health professionals experienced work-related well-being compared to the other care worker groups, which suggests that their roles may support a more positive work experience. A key factor potentially contributing to this is the greater autonomy perceived by allied health professionals. The link between work autonomy and job satisfaction has been well-established in the literature for all care worker groups, including allied health professionals (Aloisio et al. 2018), team leaders (Penconek et al. 2021), care

assistants (Squires et al. 2015), and nurses (Aloisio et al. 2021). Allied health professionals more often reported having control over their schedule and the manner in which they provided care, which may potentially explain why fewer of them perceived a high workload compared to care assistants and registered nurses, who generally reported autonomy less often. In fact, research indicates that job control can have a moderating effect on the relationship between perceived workload and burnout (Burgess et al. 2024; Leiter and Maslach 2003; Portoghese et al. 2014). Thus, while reducing the workload among care assistants and nurses remains a major challenge for nursing home managers—particularly in the context of staffing shortages, high turnover rates, and limited resources—fostering an environment that empowers care workers to shape their own work experience through increased autonomy can help mitigate the negative impacts of high workload (Leiter and Maslach 2003; Portoghese et al. 2014). Such flexibility not only fosters a sense of ownership over one's practice but is also essential for implementing person-centered care practices. Being able to provide care based on residents' preferences allows care workers to build deeper connections, making their work feel more meaningful (Edvardsson et al. 2011; van den Pol-Grevelink et al. 2012). It is therefore not surprising that a person-centered vision in a nursing home not only benefits residents but also positively influences care workers' job satisfaction (Edvardsson et al. 2011; Rajamohan et al. 2019; van den Pol-Grevelink et al. 2012). These perspectives align with the Nursing Home Culture Change movement, which shifts from a task-oriented to a relationship-centered approach, emphasizing staff empowerment and collaborative decision-making as guiding principles (Barry et al. 2019; Berridge et al. 2018; Deprez et al. 2024). Evidence shows that Culture Change initiatives not only enhance residents' quality of life, but also improve job satisfaction and reduce staff turnover (Deprez et al. 2024). Implementing this culture change is complex, involving multiple stakeholders and interrelated factors across individual, team, organizational, and policy levels (Deuling et al. 2025; Sterns et al. 2010). Research highlights the crucial role of nursing home leadership in this process (Backman et al. 2022; Deuling et al. 2025). Leaders should first establish a clear vision of person-centered care, effectively communicate its goals, and actively support staff in integrating it into practice (Backman et al. 2020, 2022; Deuling et al. 2025). This requires ongoing commitment to ensure culture change moves beyond aspiration to a sustainable transformation in daily care.

Another important finding of our study is that among care assistants, who provide most of the daily care to residents and make up the largest workforce in nursing homes, work-related well-being was experienced the least. Given their pivotal role, literature underscores the need to empower care assistants rather than viewing them merely as passive helpers for the nursing staff (Afzal et al. 2018; Barry et al. 2019; Berridge et al. 2018; Cranley et al. 2023). We believe that this recommendation should be extrapolated to support staff, as they spend a considerable amount of their time in residents' rooms, making them well-positioned to build relationships with residents. Yet, their contributions often go unrecognized, as their work is not formally considered care (Müller et al. 2018; Vance et al. 2022). By actively involving care assistants and support staff in team meetings and decision-making processes to ensure their insights are integrated into care planning and by providing them with ongoing training opportunities tailored to their roles, nursing home leaders can cultivate a more inclusive environment where all staff members feel valued (Barry et al. 2019; Cranley et al. 2023; Müller et al. 2018; Vance et al. 2022).

A final finding we want to highlight is the notable discrepancy in work environment perceptions between team leaders and direct care workers. For instance, only 16.7% of care assistants agreed that there was enough staff to get the work done versus 46.5% of team leaders. Also, significantly more team leaders reported a person-centered vision and sense of involvement in the nursing home compared to the other care worker groups. Given their coordinating and supervisory role, team leaders may evaluate staffing and work conditions from a broader managerial perspective, whereas frontline staff experience its direct impact in daily practice (Zhang et al. 2011). These differences in perceptions underscore the importance of two-way dialogue. Banerjee et al. (2021) found that facilitated reflection meetings, where leadership and direct care workers engage in structured discussions, can bridge communication gaps by creating a safe space for all care workers to voice concerns, ultimately fostering collaborative problem-solving. Hence, team leaders, as well as upper management, should implement similar structured discussions to enhance mutual understanding, ensuring that workforce planning and workplace policies better reflect the realities of those providing direct resident care.

Nonetheless, the challenges faced by care workers also extend beyond the boundaries of nursing homes. They reflect broader societal issues related to healthcare funding, workforce development, and public perception of care worker roles (Devi et al. 2021). Acknowledging these external factors is crucial for understanding the system barriers affecting the work environment in nursing homes. To facilitate sustainable change, stakeholders—including nursing homes, policymakers, and researchers—must collaborate to create a supportive framework for nursing home care workers. This includes promoting public awareness of the critical role that all care workers play in delivering quality of care and support, advocating for fair pay and benefits equal to other healthcare settings, and investing in continuing education programs to allow care workers to advance within their profession (Afzal et al. 2018; Deprez et al. 2024; Fitzpatrick et al. 2023; OECD 2020).

4.1 | Implications for Research

Future research should explore the complex relationships between work environment factors and well-being outcomes among care workers, with a focus on the mechanisms driving these associations. Longitudinal studies are needed to shed light on how these dynamics evolve over time and impact job satisfaction, well-being, and retention. However, in order to gain a comprehensive understanding of the nursing home context, future research must consider all relevant care workers and their interprofessional collaboration, as focusing solely on nurses may overlook critical perspectives. Also, organizational characteristics such as ownership type and size should be taken into account, as they may shape the work environment and contribute to differences in resource allocation, staffing levels, and workplace culture (Lindmark et al. 2023; Vermeerbergen et al. 2017).

Finally, bridging the gap between research and practice is crucial. Findings should not remain confined to the scientific community, but be actively disseminated to policymakers, nursing home managers, and the public through accessible reports, presentations, and policy briefs. Only by ensuring that evidence reaches decision-makers can we drive real change in staff well-being.

4.2 | Strengths and Limitations

A key strength of this multicenter study is its broad scope, providing insights about the perceived work environment and well-being of five essential care worker groups in nursing homes. A notable limitation, however, was the use of a convenience sample, resulting in an underrepresentation of private for-profit and small-sized facilities, which limits the generalizability of our findings to the entire nursing home population in Flanders. Nevertheless, the relatively high response rate of 64.4% among care workers strengthens the reliability of our findings within the participating nursing homes. Additionally, results were reported at the single-item level, which some may view as less valid or reliable compared to composite scores. Nonetheless, item-level reporting offers detailed and transparent insights into the nuanced perceptions of respondents that composite scores might conceal, making it well suited for highlighting specific differences in this descriptive study.

5 | Linking Evidence to Action

- This study provides a comprehensive view of the current state of well-being of different care worker groups in nursing homes, while also shedding light on significant differences in how these groups perceive their work environment. These findings offer relevant insights for tailored initiatives to improve the work environment and support the well-being of all types of care workers.
- Nursing home leaders should prioritize strategies that enhance autonomy for care workers, particularly among care assistants and registered nurses. Providing more control over scheduling, task prioritization, and care delivery can potentially reduce perceived workload and mitigate burnout (Portoghese et al. 2014), also support the implementation of person-centered care, thereby enhancing job satisfaction (van den Pol-Grevelink et al. 2012).
- We encourage adopting the principles of the Nursing Home Culture Change movement. Transitioning to relationship-centered care models, empowering care workers at all levels to actively participate in decision-making, and fostering collaborative team dynamics have been shown to improve both resident quality of life and staff well-being (Deprez et al. 2024).
- Implementing reflection meetings, where team leaders, management, and direct care workers regularly discuss staffing challenges, workload concerns, and workplace improvements, can enhance mutual understanding, foster collaborative decision-making, and ensure that workforce planning and policies align with frontline experiences (Banerjee et al. 2021).
- Addressing system workforce issues in nursing homes is crucial. Efforts should for instance focus on advocating for equitable pay and benefits, investing in continuous training opportunities, and raising public awareness of the critical contributions made by all care workers. Such measures could elevate their roles, attract and retain skilled professionals, and ensure a healthy and stable workforce (Afzal et al. 2018; Deprez et al. 2024; Fitzpatrick et al. 2023; OECD 2020).

6 | Conclusion

Work-related well-being appeared to be experienced most among allied health professionals, while care assistants, who play a pivotal role in the nursing home workforce, faced more challenges. These disparities warrant targeted attention to address the unique needs of each group. The observed differences in perceived work environment between the care worker groups provide relevant insight for designing tailored initiatives to foster a supportive and inclusive workplace that benefits the well-being of all care workers and ultimately enhances resident care.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.