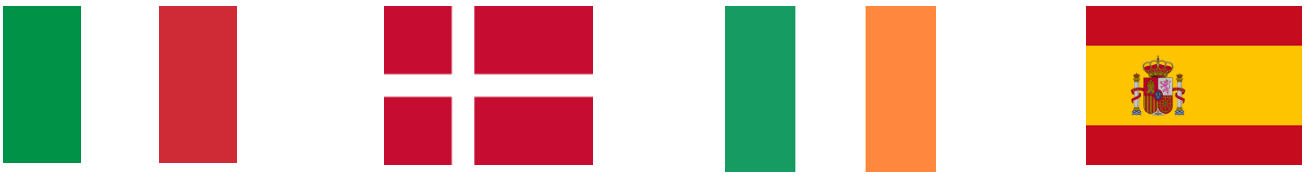
HOUSING CARE

Analysis of Care Worker Profiles



Objectives

The main objective of this paper is to provide an overview of the personal and global situation of domestic workers across Europe.

The population is ageing by leaps and bounds and there is no generational replacement that can support the elderly. The population pyramid in most countries is inverting, generating a change in the needs and demands of those who occupy it. One of the sectors that will be most affected is care for the elderly. As time goes on, changes in the way we act and think about care will be mandatory.

The pandemic situation has aggravated this situation, accelerating the whole process, leaving many vulnerable older people isolated in their homes. Therefore, the next actions to be taken should not only contemplate intervention in residences or day centres, but should also include personalised action for those people who cannot move from their own homes.

And it is in this area that home-based carers come in. They play a very important role in the intervention for the elderly, but they have generally been very neglected by all institutions: low salaries, excessive workloads, which ultimately affect their emotional and physical state. Therefore, a change of model is needed to improve their working life, in order to improve the care provided to users.

This requires an in-depth analysis of the overall situation of domestic care workers across Europe in order to steer the right measures in the right direction.

1. The definition of Care workers in each country

This section gives a brief overview of the general situation of Care Workers in each of the countries covered by the Housing Care project, Italy, Spain, Ireland and Denmark.

1.1 Italy.

In Italy, unlike other European countries, the professional figure of the **Care Worker** is **not legally regulated** and therefore there is no data and information available on this profession. However, other professional figures are recognised and regulated, whose activities can be compared to care workers. Specifically, they are the **socio-medical operators (OSS)** and the **socio-assistance operators (OSA)**.

Difference between OSS and OSA

To clarify the differences between OSS and OSA we refer to the classification of professions of ISTAT (National Institute of Statistics). These professions, although they are part of the same professional macrocategory of "**Qualified Professions in Business and Services**", are then grouped into two distinct subcategories.

The OSS are part of the "**Qualified professions in health and social services**" which are defined by ISTAT as professions that "*support health personnel in the administration of therapies and in the surveillance and protection of hygiene and public health safety; provide physical and manual assistance by carrying out, within the scope of their competences, prevention, treatment, rehabilitation and functional recovery through massage therapy, balneotherapy and hydrotherapy; carry out assistance interventions aimed at satisfying the primary needs of patients; deal with the psychological, motor, recreational and health development of children*". Other professions such as chairside **assistants**, **massage therapists** and **sports masseurs** belong to this category.

The OSA are part of the "***Qualified professions in cultural, security and personal services****" and, more specifically, of the "Personal assistance workers*", i.e. those who *"assist, in institutions or at home, elderly, convalescent, disabled, temporarily or permanently non-self-sufficient or with emotional problems, helping them to carry out normal daily activities, to care for themselves and to maintain an acceptable quality of life*".

This category also includes other figures such as **socio-sanitary assistant** with support functions in institutions, **carer of invalids**, **animator in residences** for the elderly, **assistant and carer for the disabled in institutions**, **social worker for home care**.

From these definitions, and from the differences in the training programmes, it is clear that the **OSS** figure **has more health characteristics** and **above all nursing characteristics** to support both patients suffering from pathologies and other more qualified health figures; the **OSA** figure instead concentrates **more on the assistance to people** in need in **their daily life activities** and **has less competences in the health field**, while those in the social field remain high.

1.2 Denmark.

In Denmark there are two types of workers:

a) **Skilled** Care Workers and b) **Unskilled** care workers

The Skilled Care Workers are either educated as a:

1.) **Social- and health care worker (SSH)**
2.) **Social- and health care assistant (SSA)**

But most **SSH** are working in the clients home due.

o more general tasks. The **Skilled Care Workers** there is the possibility of training in **two different ways** that vary depending on where and how you work, such as at **the client's home** or in a **care centre**

Although the overall policy is**, that municipalities will not employ unskilled care workers, they have to because of the increasing numbers of elderly** in need of care and the decrease of numbers of people wanting to work as a home care.

1.3 Ireland.

In Ireland Home Care is generally referred to as **Home Help or Carers**. Home Help/Carers provide *care services for people who are unable to look after themselves due to short/long-term health condition, disability, mental health conditions, old age, other identified care needs or for people leaving hospital who may need further support and children with serious long-term illness*. Ireland has an ageing population with an increasing number of people leaning towards remaining in their own home rather than going to a nursing home or relocating with family.

Home support provided by carers in Ireland is provided by staff drawn from the HSE, voluntary organisations and for-profit organisations in addition to significant unpaid care which is provided predominantly by family members

1.4 Spain

In Spain there are two types of care workers: a) **Skilled** and b) **unskilled** care workers, **Household or "domestic care worker"**

a) The skilled worker can work for a **private company** or for **a public institution**, taking place in the **user's home** or in a **care center**.

The Skilled Care Worker are either educated as a:

1.) **Home Help Service Assistant**
2.) **Home Help Service Coordinator**

The Home Help Service Assistant is the professional who can best access the home to take an interest in the real needs of the people, knowing their fears and concerns, getting to know the families, their concerns and the

environment in which the elderly live. **They are the people within the Home Help Service System who are in direct daily contact with the user**. Within this system we would also find social workers, family doctors, specialists, psychologists, nursing staff and occupational therapists, although the role of these is generally relegated mostly to the health system.

On the other hand, **The Home Help Coordinator** have overall responsibility for assisting in the coordination and planning of care cases with the team of professionals. Their main task is to manage the assistants and the administration of the users**.**

The **Unskilled Care Worker** are**:**

Household employee or **domestic employee** fulfil the same functions as the Home Help Service Assistance, with the only difference that the household employee is regulated by a different type of law that allows for an informal regime in the care of dependent persons.

2.5 Conclusions

1) It can be stated that the role of homeworkers in most of the countries analysed is fairly well established, with the **exception of Italy** where the homeworker is not legally regulated and has to resort to other similar professions in order to meet the needs of dependent elderly people living in their own homes.
2) In virtually all countries we observe a distribution of job responsibilities according to qualifications. However, in some countries such as **Denmark or Spain**, reference is made to the high percentage of **unskilled care workers** who are taken advantage of by the system, either because of a **lack of resources or staff** or to fill those jobs that would be much more expensive with qualified staff. **Unskilled care workers usually work in the home**.
3) It's noted that in most countries, care workers may have different names (Assistant, Care, Domestic worker...). This sometimes makes it difficult to reach a common consensus on the definition of their work or role. Therefore, language differences aside, would it be advisable to define care workers by a single name that can define all care workers in all countries?

2. The typical care worker and gender distribution.

In this section we will try to explain the general characteristics of care workers in each of the countries involved in this project. We present statistically objective data taken mainly from studies carried out by public institutional bodies.

2.1 Italy

Finding accurate data and statistics on OSS and OSA is not very easy as they are auxiliary professionals without a specific register**.** However, **the ISFOL - ISTAT survey on professions published on 24th May 2013** provides quite detailed information on the two professional categories to which OSS and OSA belong. In the

QUALIFIED PROFESSIONS IN HEALTH AND SOCIAL SERVICES
DATA (average 2016-2018)

Number of persons employed in the profession (thousands): **232**

Percentage composition by gender		
Qualified professions in health and social services	16%	83%
Total employed	58%	41%
	Males	Females
Percentage composition by age group		
Qualified professions in health and social services	28%	71%
Total employed	34%	65%
	< 40 y.o.	>= 40 y.o.
Percentage composition by professional position		
Qualified professions in health and social services	97%	2%
Total employed	76%	23%
	Employees	Self-employed

PERSONAL ASSISTANCE WORKERS
DATA (average 2016-2018)

Number of persons employed in the profession (thousands): **444**

Percentage composition by gender		
Personal assistance workers	9%	90%
Total employed	58%	41%
	Males	Females
Percentage composition by age group		
Personal assistance workers	23%	76%
Total employed	34%	65%
	< 40 y.o.	>= 40 y.o.
Percentage composition by professional position		
Personal assistance workers	97%	2%
Total employed	76%	23%
	Employees	Self-employed

health and social services" and "**Personal assistance workers**" in order to compare them with each other. The data reported are therefore from ISTAT, in collaboration with ISFOL (today **INAPP - National Institute for the Analysis of Public Policies**), they concern **sex, age and professional position** and they compare the statistics collected for these two professional categories with those of the total employed at national level in all sectors. Although this report is from 2013, these data have been updated by ISTAT in the three-year period 2016-2018

As we can see in the social and health care sector, as in personal assistance, are **female over 40 years of age** would be the worker profile that best represents both groups with a high occupancy rate in both groups**.**

2.2 Denmark

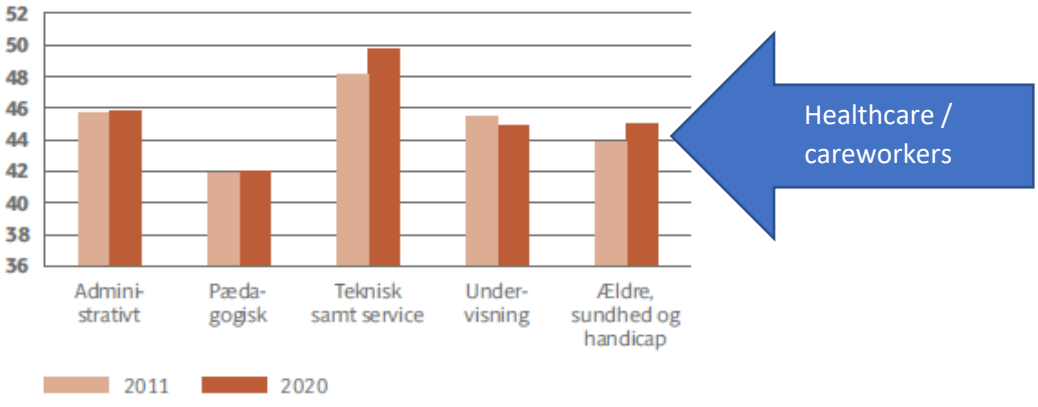
The typical care worker is female and the average **age is 44.5 years** and the age has increased by 1,4 years the last 10 years, and an **increasing number** of care workers are above **the age of 55**, and a decreasing number **under the age of 25**.

A fulltime care **worker is entitled to 6 weeks holiday with full pay**, and the employer contributes 10% to pension.

All care workers skilled or unskilled can participate in development of competences free of charge, with full salary (labour market training) and the employer get a salary refund. (wage loss compensation)

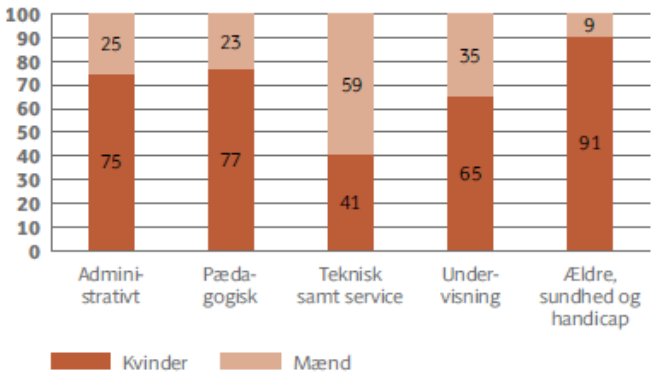
Most of the care workers live in **traditional families**, with spouse and children, or in patchwork families, after divorcing and getting remarried again.

The Ministry of Health wants all employees to be skilled and the Ministry of Education are branding social- and health care educations and most of the employees are skilled either SSH or SSA.



Kilde: KRL

77% of employees in municipalities are women, and **91% of employees in care centers/homecare are women.** The Danish labour market is thus characterized by gender segregation across sectors.



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2.3 Ireland

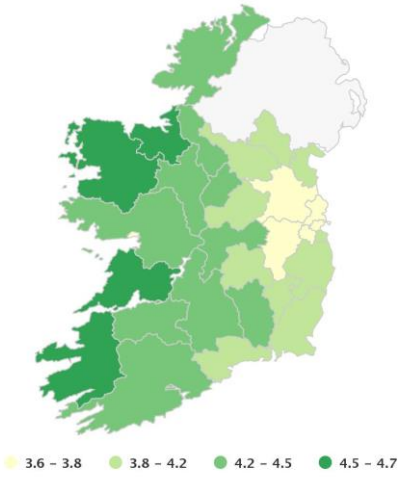
The census of 2016 showed a total of **195,263 persons** (4.1% of population) identified themselves as carers. The breakdown in gender of carers - **77,112 male and 118,151 female**. **Female carers represented under 61% of the total number of carers**. There were 1776 carers over the age of 85.
There were **3,800 children aged under 15 providing care**, accounting for 1.9% of all carers.
Carers provided 6,608,515 hours of care **per week**, an average of **38.7 hours per carer**. There were **also 16,926 carers (8.7%) who provided full time** 24 hour/7 day unpaid care which represented **43% of total care hours provided.**

Dublin city had the highest number of carers with 20,808, representing 10.7% of carers in the country. This was followed by Cork county with 18,269 (9.4%), South Dublin with 10,534 and Fingal with 10,515 (both 5.4%).

Although the **Fingal area of Dublin had over 10,000 carers**, they represented just 3.6 per cent of the population of the county, the lowest of any administrative county. Kildare (3.7%), Galway city (3.7%) and Dublin city, South Dublin, Meath (all 3.8%) also had relatively lower number of carers compared with other counties, as illustrated in Map 5.1.

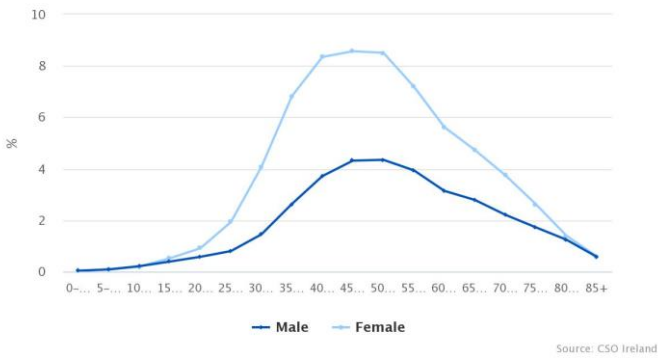
Sligo had the highest proportion of its population engaged care giving where 4.73 per cent of people identified themselves as carers. This was followed by counties Mayo (4.7%), Clare (4.62%) and Kerry (4.58%).

Map 5.1 Percentage of carers by administrative county, 2016



The **mean age of carers in Ireland is 44.4 years**. Healthy Ireland Survey (HIS), Waves 1-4. And it's estimated that **about 60.5%** of the total of the care workers **are females**. Regarding about the marital status, the lates data show us that **62%** of the **care workers** are **married**, **24%** are **single**, **6% are separated** and **4% widowed**.

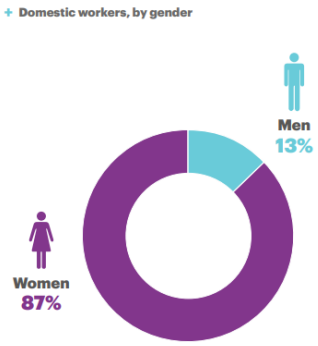
Figure 5.3 Proportion of care hours provided by males and females in each age group, 2016



Source: CSO Ireland

2.4 Spain

Data from the **Labour Force Survey** estimate that in the year **2020** there were around **of 92.000 people employed as home carers** (employed by public and private social services oriented to home care) and **456.000** domestic workers in Spain (the data represent the annual average for the year 2020)).



The typical care worker from Spain is **female** (is estimated that **86,4% of total care workers are female**), The places with the lowest percentage of women are Granada (70%) and Barcelona (87%), and the **average age is 37,5**. Working an average of **40 hours** per week. In some cases, these hours may be **exceeded.**

2.5 Conclusions

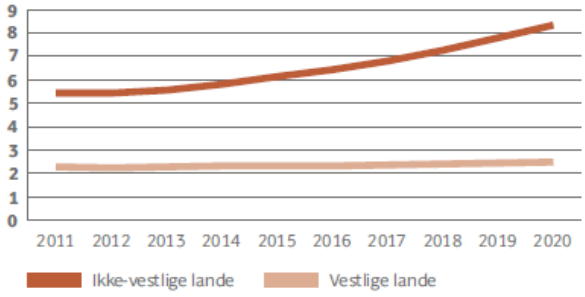
1) It can be said that in all countries, the vast majority of **care workers** are **women**, between **87%** and **90%. Except in Italy**, where men slightly outnumber women, with women accounting for **40%** of care workers in Italy.
2) The **average age** of Care workers is about **43 years**.
3) Working an average of **37.5 - 40 hours** per week.
4) A profession that generates a large amount of work. For example in Italy we observe an 80% employment rate, in **Ireland 195,263** people are employed in the care sector and in **Spain 456,000** people would be considered as domestic workers and another 90,000 as home care workers.

3. Immigrants as care worker.

In this section we will discuss the important role of migrant women in home care.

3.1 Denmark

The largest share of municipal employees with **Non-European background is working in the municipalities around Copenhagen**. Other major cities like **Aarhus are experiencing more Non – Western immigrants** attending health care colleges.



Kilde: KRL (særkørsel) samt Danmarks Statistik

3.2 Ireland

21.7% Home Carers in Ireland are born **outside of Ireland**

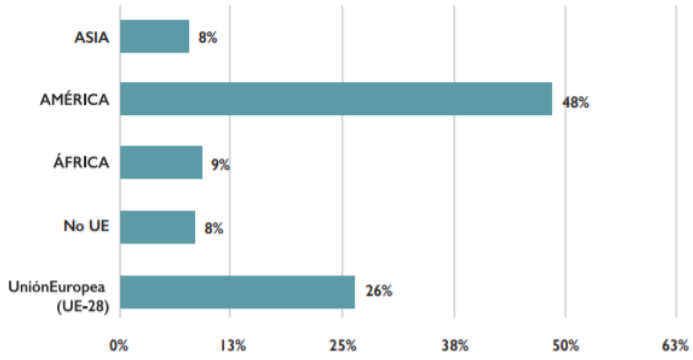
3.2 Spain

The presence of **migrants** is significant in all these occupations and constitutes **50% of this workforce**, but it is especially concentrated in those services where labour precariousness is greater. Thus, in **domestic employment** their incidence reaches **63.7%** of the total number of workers, while in the **home care sector** provided by social services the figure stands at **30.6%.**

Three-quarters of domestic workers are of foreign nationality. Most of them are women under 35 years of age and of South American origin, especially Ecuadorians, who represent 29 per cent of the total. Ninety percent of the people doing this work are women, three quarters of whom are migrants.

Most of the care workers live in traditional families, with spouse and children, or in patchwork families, after divorcing and getting remarried again.

Gráfico 4. Número de personas extranjeras afiliadas al Sistema Especial de Empleadas de Hogar según procedencia (2019)



Fuente: Elaboración propia a partir de las Estadísticas de Afiliación a la Seguridad Social del Ministerio de Inclusión, Seguridad Social y Migraciones

3.4 Conclusions.

1) <u>In this area, we find two totally different situations</u>. On the one hand, countries such as **Denmark** and Spain show that the vast majority of care workers are of foreign or immigrant origin. Although we must point out that this depends on the care sector in which it is found. In **Spain**, for example, the percentage of **immigrant domestic workers (63.7%)** is much higher than those in the **care sector**

(30.6%). On the other hand, we look at the case of **Ireland** where migrant domestic **care workers are a minority (21.7%)**.

4. Terms of employment.

In this section we will take an in-depth look at the most characteristic terms and conditions of employment for domestic carers in the European region.

4.1 Italy

The **working conditions** of **OSS** have **worsened considerably during the Covid-19 pandemic** due to the high increase in the workload of both healthcare facilities and individual workers, which has not been matched, at least in the OSS sector, by an increase in recruitment.

The main consequences have been an **increase in working hours**, with a **reduction in rest shifts and holidays**, an **increase in occupational diseases and stress**, the latter also due to the assignment of **tasks of greater responsibility** and the increase in cases of **verbal and physical violence** by patients or family members, without considering the obvious fears arising from the possibility of contagion (according to the MEGIP Federation, OSSs are the category most affected by Covid infections).

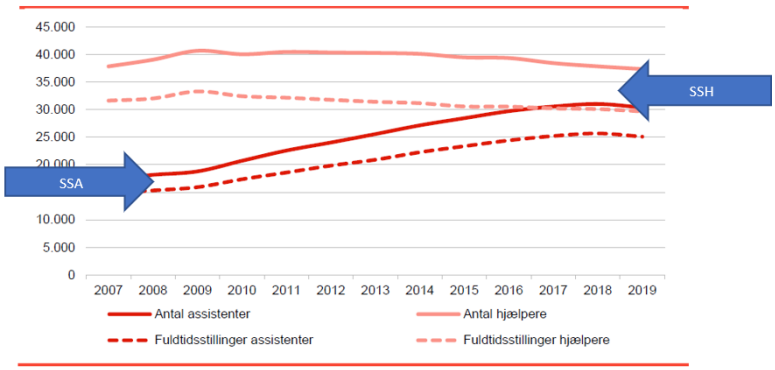
Below is the data on **Average Incoming Wage** recorded by INPS (National Institute of Social Security).

Average entry level salary				
	2017	2018	2019	2020
Qualified professions in health and social services	**23.522,00 €**	**22.946,00 €**	**23.520,00 €**	**23.560,00 €**
Personal assistance workers	**21.578,00 €**	**21.750,00 €**	**21.651,00 €**	**22.228,00 €**

The MIGEP Federation stresses above all the lack of new recruitment, the absence of sufficient protection for the psychophysical health of OSS, the excessive workload that leads them to carry out tasks that exceed their normal responsibilities, the poor professional recognition of these figures.

4.2 Denmark

In Denmark the health care sector is dominated by **part time workers (63%)**. A **full-time job is 37 hours per week**, and **part time is mostly from 20 – 35 hours per week**. A minority is working **less than 12 hours** per week and some are paid by the hour. The largest group of part time employees in the municipalities is healthcare workers and **only 25% are working full time.** This figure shows number of **SSH and SSA working fulltime or part time** and there the number of **SSH are the highest**.



Anm.: Figuren viser udviklingen i antal fuldtidsstillinger på overenskomstområdet ' Social- og sundhedspersonale, KL' i december måned det givne år.
Kilde: KRL Sirka.

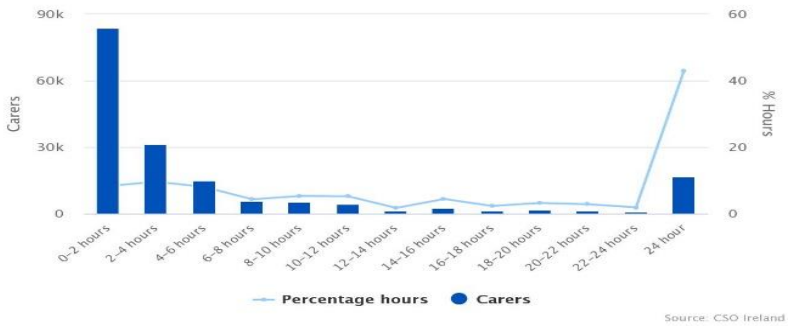
Regarding about the employment barriers faced by Denmark Care Workers, we can say that the most important skill is to **be able to talk to and with the citizen you care for**. That's why the ability to **speak and understand Danish is vital**. The care **worker must be able to write as well or at least be able to record tasks** so others can do the required written documentation.

It's also necessary to **be able to ride a bike or car**. Most care workers ride bikes in the cities and drive by car in the urban areas. The ability to balance their private life and professional life and being too familiar in the cooperation.

4.3. Ireland

The chart below shows that 83,754 **carers provided up to 2 hours of care** a day representing **80.3% of the all care** hours provided. At the other end of the scale just **16,926 carers** (8.7% of all carers) **providing 24 hours** care accounted for a total of 2,843,568 hours care representing 43% of all care hours provided.

Figure 5.2 Number of carers and percentage hours caring, 2016



The average **health care assistant** salary in Ireland is **€26,325** per year or **€13.50** per hour. Entry-level positions start at **€23,400** per year, while most experienced workers make up to **€35,193** per year.

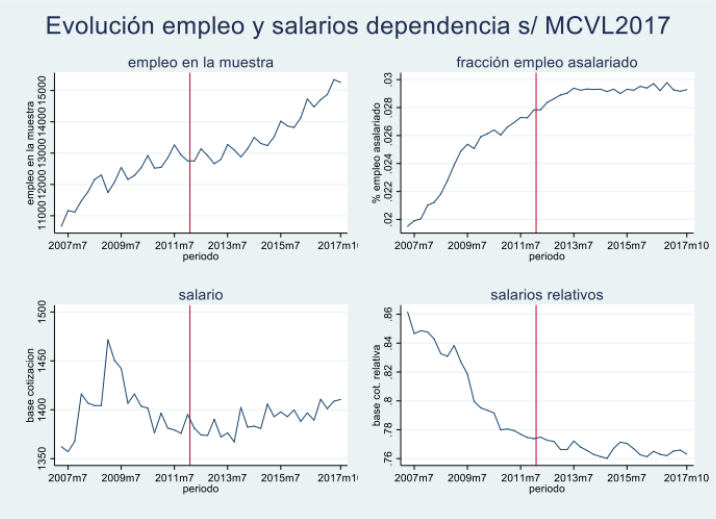
4.4 Spain

A full-time care worker must be paid at least the National Living Wage, which is about **€950,** until **€1,200** for **eight hours a day worked** with a maximum working week of **40 hours**. This establishes an annual salary of **€13,300 – 16,800 in 2020**, and a limit on the discount for payment in kind to 30% with the obligation to respect the NLW. If they work **20 hours they will be paid €500 gross in 14 payments**

From 2015 onwards, an upturn in employment began that has continued to the present day. The relative evolution of the **sector shows that it is not one of the most affected sectors of the Spanish economy**, since its weight in total employment grew from **2 to 3% in the period as a whole** (although it has been stagnating for some years at the aforementioned value).

This graphics shows the evolution related with the salary and employment of the care workers during the year 2017. Estimates suggest that this development has been progressive over the last few years

Gráfico 26: Empleo y salarios en el sector de dependencia según la MCVL.



Type of contract	Time	Definition
Interim job	Monday to Saturday afternoon	Almost permanent arrangement. They settle continuously including at night. **They usually face working hours of 14 to 16 hours a day**.
	Weekend	**Almost permanent arrangement**. They work on Saturday and spend the night at home and the day ends on Sunday evening.
Work from external	Day full	Total availability excluding nights. They usually have a working day that **exceeds 8 hours and can be up to 12 hours from Monday to Friday**
	Part-time	Willingness to work a specific and limited timetable when hiring. **Working hours of less than 12 hours.**
Per hours		Workers usually belonging to a **company or institution dedicated to the care of the elderly.**

4.5 Conclusions

In this area we can observe differences between the countries analyzed, although they are not significant at all:

1) On one hand, regarding to the hours worked by Care Workers, we observe that the **most common contracts are part-time hours** being 12 hours per week, two hours per day. For example, in the case of **Denmark** the care workers with a **part-time contract represent the 63%** of the total. The **full-time contracts** are less common in general, being 37h-40h per week, 8-10 hours per day. In other side, we will found the care workers who lives in the same house at the users providing 24h per day, being less common, but in the case of **Ireland, are more usual** than the workers with full-time contract. **Representing the 8.2% of the total**.
2) The average wage depends of each country, in this sense we found some differences. For example, in **Italy** their assistance workers in 2020 should have been paid at least with **€22,228.00,** being **€1,800** per month. In the other side, the home care workers from **Spain** have the minimum wage of all the countries analyses. The last year, their salary it was between **€950** and **€1,200.** In **Ireland** depends of the experience of the worker, but initially it would be about **€23,400** per year and with more experience it would be **€35,193.**
3) It should be noted that the working conditions of domestic workers have been affected by the pandemic situation caused by Covid-19. Longer hours, heavier workload, more responsibility, **reduction in rest shifts and holidays**, which particularly affect the increase in **occupational illnesses and stress**.

5. Employment barriers, Occupational hazards and Care Workers Health or Well-being

In this section we have tried to bring together all the data related to the difficulties and risks that home-based carers face on a daily basis, and the effects these can have on their health and well-being.

5.1 Italy.

The main reasons why the **OSS should be considered a demanding profession** are listed:

1) The operator carries out **7 - 8 - 12 - 18 hours of continuous work**, without ever detaching himself from contact with patients, who are in any case destabilising.
2) The operator is in **contact with the patient's suffering**, he is in contact with life and death, he is attentive to every word or gesture to avoid greater damage.

3) In the **psychological context**, as a helping profession, it is just as prone as the others to develop disorders specific to these professions such as the most acclaimed, **the 'burnout' syndrome**.
4) The profession is linked to the contexts of **exposure to contaminating and infectious agents**, in daily activities, within both public and private care facilities and the third sector.
5) The work performance and conditions of these operators, who have been **working continuously for 42 years, are over 60 years old**.
6) The operators work nights in complete solitude and **without nurses**.
7) The activities expose workers to **physical risks of injury** or the increased likelihood of developing musculoskeletal disorders over time.
8) In reception facilities, such as family homes, home services, drug addiction facilities, they are left to their own devices with heavy workloads in the absence of aids.

5.2 Denmark.

Regarding about the employment barriers faced by Denmark Care Workers, we can say that the most important skill is to **be able to talk to and with the citizen you care for**. That's why the ability to **speak and understand Danish is vital**. The care **worker must be able to write as well or at least be able to record tasks** so others can do the required written documentation.

It's also necessary to **be able to ride a bike or car**. Most care workers ride bikes in the cities and drive by car in the urban areas. The ability to balance their private life and professional life and being too familiar in the cooperation.

5.3 Ireland

Population and Carers by General Health (%) 2011 and 2016

General Health	Pop11%	Carers11%	Pop16%	Carers16%
General Health – very good	60.3	47.7	59.4	47.5
General Health - good	28.0	37.1	27.6	37.0
General Health - fair	08.0	12.4	08.0	12.5
General Health - bad	01.2	01.7	01.3	1.8
General Health – very bad	00.3	00.3	00.3	0.3
Not Stated	02.2	00.8	03.3	0.9
Total	100.0	100.0	100.0	100.0

This Table shows clearly that **caring is correlated with poorer general health**. The percentage of carers with **'Very good' health is significantly lower than the general population**. It is the case, however, that when **'Very good' and 'Good' are combined**, the difference is not so stark. There is a **significantly higher percentage of carers who rate their health as 'Fair'**. Though a low number overall, **the incidence of 'Bad' health is higher among carers**; but, **'Very bad' is the same as the general population in both 2011 and 2016**. It is interesting that the data suggest that carers are much less likely than the general population not to respond to this question in the census.

General Health by High-intensity Caring (%) 2011 and 2016

General Health	Pop 29+ Hours	Carers 29+ Hours	Pop 43+ Hours	Carers 43+ Hours	Pop 168 Hours	Carers 168 Hours
	2011	2016	2011	2016	2011	2016
General Health – very good	41.0	41.5	39.3	40.2	36.0	37.1
General Health – good	40.3	40.0	40.9	40.2	41.4	41.4
General Health - fair	15.5	15.1	16.4	16.1	18.4	17.4
General Health - bad	02.1	02.2	02.3	02.4	02.8	02.8

General Health – very bad	00.4	00.4	00.5	00.4	00.7	00.6
Not Stated	00.7	00.8	00.7	00.7	00.8	00.7

For another part, this table shows **self-rated general health by higher-intensity carers**. Here the differences are much more significant. The percentage rating their health '**Very good' is much lower than the general population**, and, though the rating '**Good' is significantly higher**, when these two ratings are bracketed the figure is significantly lower than in the general population, and noticeably lower than the carer population. The percentage rating their health a s 'Fair' among higher-intensity carers is very much higher than the general population, and the difference in the **rating 'Bad' is also significant.** Given the low overall rating **of 'Very bad' across all populations**, the significant spike in this rating is among those caring for **168 hours weekly** (24/7).

In this regard, we can see that the main employment difficulties experienced by domestic carers in Ireland are as follows**:**

- Non standardised pay and steady hours
- Lack of provision of standardised, regular training and upskilling support.
- Lack of job promotion opportunities
- IT literacy issues to support record keeping etc.
- IT literacy issues to support and stimulate the service user e.g. use of app
- Language barrier

5.4 Spain

Physical risks.

1) **Carrying weights:** helping the dependent person or user to move and/or move around involves the carer carrying their weight at different times: getting up, changing position, pushing a wheelchair, etc.
2) **Forced postures:** the same tasks as above can cause the caregiver to perform forced postures in which the body or joints deviate from their natural position and can cause back problems (back pain, herniated discs...).
3) **Aggression:** sometimes, there are dependent people who may behave aggressively towards their carers.

Psychosocial risks

1) **Overwork:** it is common for the worker to have to carry out several tasks at the same time, whether at home (cleaning, cooking...) or in a centre (caring for other dependent persons...).
2) **Emotional wear and tear:** due to the involvement with the problems presented by the user or to the situation of pressure and fatigue involved in caring for a certain type of person.

Biological risks

1) Carers are at risk of contracting diseases due to their contact with the dependent person, whether by contact with biological fluids, via the air, via the skin, etc. For this reason it is important to work with protective equipment (gloves, gown, mask, etc.) and to be up to date with vaccinations.

Employment difficulties:

1) Low wage levels. In one third of the countries with wage regulation, Housing Care workers do not enjoy equal minimum wage rights (9.3 per cent) or do not enjoy minimum wage coverage at all (22.2 per cent), and some 41 million have no legal minimum wage at all.
2) Little legal coverage in most countries.
3) Lack of resources.

4) High workload.

5.5 Conclusions.

In this section we can observe that the care workers of all countries probably have the same barriers and difficulties for arrive and do efficiently their work, having a higher impact in their emotional and physical health. In short, we can summarize these difficulties in two big groups:

1) **Employment difficulties**:
   - **Excessive working hours**: In Italy can be work until 18h per day.
   - **Exposure** to contaminating and infectious agents. Carers are at risk of contracting diseases due to their contact with the dependent person
   - **Physical risks:** Carrying weights, Forced postures, Aggressions.
   - **A lot of responsibility** without help from a senior professional. In Itali can be pass al night without a help of a nurse.
   - **Language difficulties**. As we have seen, the majority of home care workers are migrants, so the main problem they face is language.
   - **Driving licence required**. In some countries it's necessary have a car and be able to drive for go to the houses of the usuaries.
   - **Continuous employment for 42 years**. Possibility of working beyond the age of 60. In Spain the retirement age is 67.
   - **Non standardised pay** and steady hours
   - **Lack of provision of standardised**, regular training and upskilling support.
   - **Lack of job promotion opportunities**
   - **Little legal coverage.**

2) **Emotional issues and well-being**
   - In general, the emotional, psychological and physical health of domestic workers is severely affected.
   - High percentage of **burnout syndrome**.
   - One study did it in Ireland shows that **caring is correlated with poorer general health.** The percentage of carers in Ireland with **'Very good' health is significantly lower than the general population.** But we can say that these results are not specifically of Ireland these sense are common in the rest of the care workers from Europe.
   - The percentage rating their health '**Very good' is much lower than the general population**, and, though the rating '**Good' is significantly higher**. The **rating 'Bad' is also significant.**
   - For another part, this study shows the **self-rated general health by higher-intensity carers.** Also we observe again that the percentage rating their health '**Very good' is much lower than the general population**, and, though the rating '**Good' is significantly higher**

6- Educational background

In this section will present the average education of care workers around Europe.

6.1 Italy

Concerning Italy, the next table show the minium education that the care workers of this country should have:

IMPORTANCE	KNOWLEDGE	COMPLEXITY
57	**SERVICES TO CLIENTS AND PEOPLE.** Knowledge of the principles and procedures for providing services to customers and people. It includes assessing customer needs, achieving quality standards and evaluating customer satisfaction.	48
53	**ITALIAN LANGUAGE.** Knowledge of the structure and content of the Italian language or the meaning and pronunciation of words, rules of composition and grammar.	40
41	**PSYCHOLOGY.** Knowledge of human behaviour and performance, individual differences in aptitude, personality and interests, mechanisms of learning and motivation, psychological research methods and the assessment and treatment of behavioural and affective disorders	38
28	**MEDICINE AND DENTAL TECHNIQUE.** Knowledge of information and techniques necessary to diagnose and treat injuries, diseases and deformities of the human body, including knowledge of symptoms, alternative treatments, drug properties and interactions, and preventive care	21
19	**EDUCATION AND TRAINING.** Knowledge of principles and methods for educational and curricular design, for collective and individual teaching and training, and for measuring the effects of training	19
17	**CHEMISTRY.**Knowledge of the composition, structure and properties of substances, their underlying chemical processes and transformations; this includes the use of chemicals, knowledge of their interactions, danger signs, chemical production techniques and methods of remediation	18
17	**FOREIGN LANGUAGE.** Knowledge of the structure and content of a foreign language or the meaning and pronunciation of words, rules of composition and grammar	18

The above-mentioned Agreement of 22 February 2001 states that "The training of the socio-sanitary operator is the responsibility of the regions and autonomous provinces, which are responsible for organising the courses and the relative teaching activities", thus entrusting the regions with the task of organising the training courses and issuing the OSS qualification, and requiring as a minimum requirement for participation in these courses "a compulsory school diploma and the completion of the seventeenth year of age".

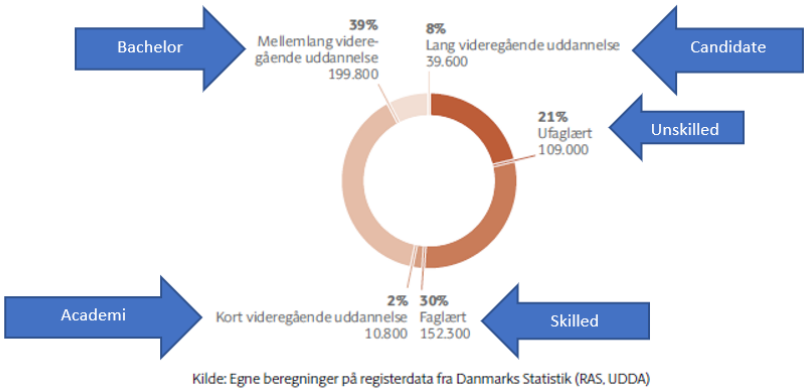
This agreement also establishes some minimum requirements that the regional training programmes for OSS must have:

- **Annual duration for a minimum of 1000 hours.**
- **Articulation of the course in basic module, vocational module and internship.**
- **Identification of the disciplinary areas.**
- **Final test for the OSS qualification.**

The Agreement, as anticipated, does not legislate on OSA, leaving to the Regions the task to prepare the training plans to obtain the qualification. In particular, observing the regional dispositions, it is possible to notice that the courses for OSA are shorter and less specialised than those for OSS, even if they foresee an apprenticeship and a final test. It also seems possible to acquire the OSS qualification after the OSA one. This difference in the training pathway derives from the professional differences between the two figures. The OSS is in fact a profession with a more sanitary and nursing character, with more functions of support to sanitary figures of higher qualification, while the OSA is dedicated to the pure social assistance to people in need.

6.2 Denmark

The education in Denmark is free and the students get salary from the municipalities (VET) or state education support, there is a group of mainly youngsters who are not in progress with an education. This group often works as care workers until they know what kind of education they are ready to attend.



Kilde: Egne beregninger på registerdata fra Danmarks Statistik (RAS, UDDA)

6.3 Ireland

In Ireland **31% of Carers** have a **third level education or higher**, with **6%** having a **primary level or lower.** This is **consistent with the national average**, where **29%** of the population whose **full time education** has ceased**,** have a **third level** or **higher education**.

○ No Formal Education	1.2%
○ Primary Education	8.5%
○ Lower Secondary Education	14.1%
○ Upper Secondary Education	17.6%
○ Technical/Vocational	9.2%
○ Advanced Certificate/completed apprenticeship	5.9%
○ Higher Certificate	6.0%
○ Ordinary Bachelors - Professional Qualification or both	8.2%
○ Honours bachelor degree/professional Qualification or both	8.6%
○ Postgraduate Diploma or Degree	8.5%
○ Doctoral or equivalent level (PH.D.)	0.8%
○ Not Stated	2.4%
○ Economic Status – Total at school, University etc.	3.8%
○ Economic Status - other	5.2%
Total	**100**

Also, it will be necessary get some kind of the next qualifications:

- At least **1-year relevant experience providing quality care** is essential
- Must hold at a minimum, **at least 2 QQI Healthcare modules – Care Skills & Care** of the Older Person, and be working towards achieving a full major award
- Up to date **Patient Moving & Handling certificate**;
- **Satisfactory Garda Vetting** (Anyone who works or volunteers with children and vulnerable adults must go through Garda vetting. This is a process to check whether you have a criminal record, or if there is any specified reason why you might pose a threat to vulnerable people
- Full, **clean drivers' licence**

Note: Education V Training

The Institute of Public Health study 2018 respondents indicated that there needs to be a programme of training and skills development to improve standards, health outcomes and to promote caring as a good pathway for workers and service providers. It was felt that formal and informal carers also need recognition, proper financial reward and support to deliver the best care possible for the people they look after.

6.4 Spain

The majority of Spanish women care workers, **54%, just have the upper secondary education**. **Immigrant women have a high level of education**, more than half of them have secondary or higher education, although there are also differences between groups

The **Certificate of Professionalism in Housing care Employment** or **The Certificate of Professionalism in Social and Health Care for Dependent Persons in Social Institutions** is the official document that accredits the official document that accredits the ability to carry out this professional activity and allows better access to job offers in the domestic sector. The Certificate of Professionalism is an official document issued by the public employment services and is valid throughout the national territory.

Also they would need:

- **High school diploma** (college degree preferred) is required.
- **Current and valid caregiver certification**
- **Current and valid first aid and CPR certification**

6.5 Conclusions

The majority of the care workers have the same level of studies, it's mean **secondary level or bachelors level**. But there are few differences in some of them:

- **Italy**: For work like a care worker, they need a minimum of training programs:
    - Training program **of Annual duration** for a minimum **of 1000 hours.**
    - Articulation of the course in basic module**, vocational module and internship.**
    - **Identification of the disciplinary areas.**
    - **Final test for the OSS qualification.**

Should be noted that the Agreement, as anticipated, does not legislate on OSA. And the courses for OSA are shorter and less specialised than those for OSS.

- **Ireland**:
    - At least **1-year relevant experience providing quality care** is essential
    - Must hold at a minimum, **at least 2 QQI Healthcare modules** – **Care Skills & Care** of the Older Person, and be working towards achieving a full major award
    - Up to date **Patient Moving & Handling certificate**;
    - **Satisfactory Garda Vetting**
- **Spain**:
    - The Certificate of Professionalism in Social and Health Care for Dependent Persons in Social Institutions
    - **Bachelor's level** (college degree preferred) is required.
    - **Current and valid caregiver certification**
    - **Current and valid first aid and CPR certification**

7. Legislation and Regulations

In this part we will try to explain the specific legislation and their respective regulations in relation to carers in each country.

7.1 Italy

In Italy, the **reference legislation** for these professional figures is the '***Agreement between the Ministry of Health, the Ministry for Social Solidarity, the Regions and the Autonomous Provinces of Trento and Bolzano***'

of *22 February 2001*. Subsequently, additions were made to this legislation, **but they have never been implemented in the system**. Instead, the regions were given the task of further detailing the characteristics that these operators must meet and, above all, of defining the training required to become OSS/OSA. It should also be pointed out that the aforementioned legislation **only identifies the professional profile of the OSS**; the **OSA is a figure that has evolved from the OSS,** whose differences can be seen in the various regional repertoires on the professions and which are substantiated not only in the different activities carried out, but also in the training required to obtain these qualification

7.2 Denmark

The tasks are formed by the formal rules and structures in the legislation and the management tools, used in the municipality, like quality standards and competency schemes. ***The employee works under both the Service and Health Act***.

- **The Service Act** deals with the municipal quality standards and the statutory requirement for free choice to choose. **It's called ordering – performing model**.
- **The Health Act** deals with decentralized competence assessments and the framework that constitutes the distribution af work tasks among different employee groups in practice.
- **The Health Act** is also about key concepts as delegation and sub-delegation, along with standards for registration of data called Common language III (Fælles Sprog III) and this is used as documentation of the various services under the 2 laws.

Home care 3 primary areas as the municipal councils offers:

- **Personal help and care**, help and support for practical tasks in the home and food service
- **Rehabilitation**. A short-term and time-limited course for persons with disabilities.
- **Relief of either** the weakened person or his relatives.

The elderly are examined for the level of services based on **"selfmanagement"** and **rehabilitation**.

7.3 Spain

On 16 June 2011, workers, employers and governments came together to adopt the **Domestic Workers Convention** (No. 189 and the recomendation 201). Since this adoption, some countries around the world have taken action to bring decent work to domestic workers. These measures represent the first steps on a long road to redressing a history of exclusion: making decent work a reality for domestic workers will require continued attention to ensure that real progress is made.

Currently, the **Special System for domestic employees is regulated in Section 1** of Chapter XVIII of Title II of the LGSS, approved by Legislative Royal Decree 8/2015, of 30 October 15, called "**Special System for domestic employees**".

- **The Home Help Service** (Servicio de Asistencia a Domicilio; SAD) was regulated in Spain in 2006 by Law 39/2006, of 14 December. **This law is known as the Dependency Law**. *This law established the generic framework for the functioning of public bodies in relation to dependency, although subsequent royal decrees have supplemented it*. Workers who are covered by this law are called "carers".
- **The Special Scheme for Domestic Workers (REEH):** The Special Scheme for Domestic Workers (REEH) is the one that applies to workers known as "**domestic workers" or "housekeepers**".

The legislative framework was reformed with **Law 27/2011, of 1 August**, on Updating, Adapting and Modernising the Social Security System. Subsequently, decrees were passed to supplement the text, including **Royal Decree 1620/2011, which regulates domestic work.**

7.4 Conclusions

Obviously, we observe some differences between the countries regarding about the law which regulates and try to protect the rights of the care workers. In brief we can say that:

- **Italy**:
  - Reference legislation: '***Agreement between the Ministry of Health, the Ministry for Social Solidarity, the Regions and the Autonomous Provinces of Trento and Bolzano***'
  - Additions were made to this legislation, **but they have never been implemented in the system**
  - Legislation **only identifies the professional profile of the OSS**; the **OSA is a figure that has evolved from the OSS.**

- **Denmark:**
  - Reference legislation: "***The employee works under both the Service and Health Act"***.
  - **The Service Act** deals with the municipal quality standards and the statutory requirement for free choice to choose. **It's called ordering – performing model**.
  - **The Health Act** deals with decentralized competence assessments and the framework that constitutes the distribution af work tasks among different employee groups in practice.
  - **The Health Act** is also about key concepts as delegation and sub-delegation, along with standards for registration of data called Common language III (Fælles Sprog III) and this is used as documentation of the various services under the 2 laws.
  - **Offering:** Personal help and care, Rehabilitation, Relief of either the weakened person

- **Spain:** In Spain there are two laws that covered of two type care workers on home
  - **Care Worker Assistant**:
    - Reference legislation: **The Home Help Service** (Servicio de Asistencia a Domicilio; SAD) was regulated in Spain in 2006 by Law 39/2006, of 14 December. **This law is known as the Dependency Law.**
    - Workers who are covered by this law are called "carers".

  - **Domestic Care Worker**:
    - Reference legislation: The legislative framework was reformed with **Law 27/2011, of 1 August**, on Updating, Adapting and Modernising the Social Security System.
    - The Special Scheme for Domestic Workers (REEH) is the one that applies to workers known as "**domestic workers" or "housekeepers**".

8. Required professional skills

8.1 Italy

Skills are sets of general cognitive procedures and processes that determine the ability to perform occupationally-related tasks well. they are, in particular, processes that are learned over time and that allow the acquired knowledge to be transferred effectively to the job. The next table show the **importance** and the **complexity** that the care workers must have for carry out efficiently their work.

IMPORTANCE	SKILLS	COMPLEXITY
69	**SPEAKING.** Talking to others to communicate information effectively	55
65	**ADAPTABILITY.** Coordinate one's own actions with those of others.	55
65	**LISTEN ACTIVELY.** Pay full attention to what others are saying, pausing to understand the main points, asking questions at the right time and avoiding inappropriate interruptions.	55
60	**UNDERSTAND WRITTEN TEXTS.** Understand sentences and paragraphs in work-related documents.	46
60	**UNDERSTANDING OTHERS.** Understanding the reactions of others and why they react in certain ways.	51
55	**SERVICE ORIENTATION.** Actively seek solutions to meet the needs of others.	49
54	**WRITING.** Communicate effectively in writing and in a manner appropriate to the needs of the recipient.	45
53	**TIME MANAGEMENT.** Managing one's own and others' time.	40
52	**CRITICAL SENSE.** Use logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.	48
46	**ACTIVE LEARNING.** Understand the implications of new information for current and future problem solving and decision making.	44
44	**LEARNING STRATEGIES.** Select and use appropriate training methods and procedures to learn or teach learning.	37
44	**SOLVING COMPLEX PROBLEMS.** Identify complex problems and gather information to evaluate possible options and find solutions.	39
42	**SELECTING TOOLS.** Identify the tools needed to carry out a task.	38
41	**TEACH.** Teach others how to do certain things.	42
40	**MONITORING.** Monitor and evaluate personal, other people's or organisations' work performance in order to improve or correct it.	36

WORK STYLES	IMPORTANCE
SELF-CONTROL. The job requires maintaining composure, controlling emotions, anger and avoiding aggressive behaviour even in difficult situations	78
GROUP WORK. Work requires preferring to work with others rather than alone and feeling personally part of a team at work.	77
STRESS TOLERANCE. The job requires accepting criticism of one's own work and handling high-stress situations calmly and actively.	76
ATTENTION TO OTHERS. The job requires being sensitive to the needs and feelings of others and being sympathetic and helpful to others at work.	75
RELIABILITY. The job requires being trustworthy, responsible and reliable and fulfilling one's duties.	73
COOPERATION The job requires being helpful to others at work and showing a cooperative spirit	72
INTEGRITY. The job requires you to be honest and have good morals	72
ATTENTION TO DETAIL. The job requires you to pay attention to detail and be thorough in completing tasks	70
CONCRETITION AND COMMITMENT. Work requires you to set and achieve goals yourself and to make efforts to accomplish important tasks	67
ADAPTABILITY AND FLEXIBILITY. The job requires adapting to positive or negative changes	63
INITIATIVE. The job requires a willingness to take on responsibilities and challenges	58
PERSISTENCE. Work requires persistence in the face of obstacles	54

8.2 Denmark

In the rapport "**Care workers in municipalities**" from 2020 researchers have investigated key competences and tasks in home care. Management and care works have been interviewed, and a very different skills appeared.

The most important skill is;

- To be able to speak, read and write the language
- The ability to create relations and build trust. Next a lot of other important tasks as well.
- Hygienic principles
- Observations (change in conditions and know what to rapport and to whom)
- Handling of medication

- Ergonomi
- Welfare technology
- Assistive devices
- Empathy
- Communication
- Duty of confidentiality
- Documentation
- Interdiciplinary dialog
- Ability to reflect

A vital model in the professional work is PDSA cirkel

8.3 Ireland

In Ireland carers need a **compassionate and empathic personality,** have **patience**, an **outgoing** and **friendly personality** and good listening skills. To maintain the dignity of the **"patient" discretion** and **professionalism** are crucial qualities. **Reliability, honesty and punctuality** are also important traits. We can add:

- Be available to work at various times throughout the week
- Excellent communication & interpersonal skills
- Be calm, polite and professional while maintaining the highest level of confidentiality
- Be well presented and have a kind and caring nature
- Be a reliable and trustworthy individual who is committed to providing quality person centred care in a home environment

8.4 Spain

Regarding about the skills of care workers from Spain, it's considered that they must be:

- Discretion
- Responsibility
- Proactivity
- Punctuality
- Honesty
- Respect
- Positive attitude
- Consistency
- Flexibility
- Overcoming
- Organisation

8.5 Conclusions.

In this section we can observe the skills that the care worker has to have for do their work. It's significant that all the countries analysed are agree on the vast majority of the skills, it is therefore impossible to highlight the differences, but rather to indicate what qualities should be possessed. This is the list with the most important skills:

- Ability to speak with the other.
- Flexibility.
- Adaptability
- Active learning
- Selecting tools
- Self-control
- Cooperation
- Integrity
- Attention to detail
- Emphatic
- Ongoing
- Patience
- Honestly
- Be calm, polite and professional
- Be well presented and have a kind and caring nature
- Responsibility
- Proactivity
- Punctuality
- Ergonomi
- Welfare technology
- Assistive devices

9. Main Task

Now, let us detail the main tasks that home care workers have to perform on a day-to-day basis.

9.1 Italy

The next table shows the principal activities of care workers from Italy and the importance and complexity of each other.

- **SPECIFIC DUTIES AND ACTIVITIES**

	SPECIFIC TASKS AND ACTIVITIES	IMPORTANCE	FREQUENCY
✅	providing assistance in nursing care and therapeutic activities	4,1	4,4
✅	identifying the problems and needs of the clients	4,1	4,4
✅	preparing meals for the resident	3,9	4,2
✅	maintaining relations with the families of the patients	3,7	4,2
✅	carrying out hygiene checks	3,6	3,4
✅	assisting with cleaning and personal hygiene	3,5	3,7
✅	accompanying and supporting the person assisted in carrying out errands or paperwork	3,4	3,4
✅	provide companionship and support in daily entertainment activities, entertain and converse with the person assisted	3,3	3,2
✅	assist with meals	3,2	2,8
✅	check the physical condition of the person assisted	3	2,6
✅	provide psychological assistance	3	3,1
✅	administer medication, carry out minor dressings or bandages	3	2,9
✅	collaborating with colleagues, medical staff, physiotherapists, social workers, etc.	2	1,2
✅	welcoming the patients	1,7	0,7

9.2 Denmark

The majority up to 90% of the face to face contact is spent on personal care; Their main professional responsibilities would be:

- Bath.
- Clothing.
- Relocation from bed to chair.
- Preparing meals.
- Doing the laundry.
- Check aids as hearing aids.
- Help with medication.
- Documentation.
- Cleaning.

They don't do any shopping but can help calling the supermarket for home delivery or others shopping for them.

9.3 Ireland

In Ireland, the main duties of the Home Care Workers may include the following tasks**:**

- Assisting with caring duties at home, including both personal and practical care tasks e.g. **dressing, washing, toileting, light household work**
- Ensuring the dignity, privacy and independence of the Carer and Cared for Person are maintained and respected at all times
- Providing companionship to the Cared for Person
- Completing accurate and weekly activity sheets and other mandatory records as assigned
- Adhering to the ethics and culture of the organisation and the role played in supporting family carers
- The Home Care Worker will be flexible in his/her approach to performing the duties of the role and may be assigned additional duties from time to time in agreement with their line manager

9.4 Spain

You must have the ability to perform the following activities

- **General cleaning and maintenance of the home**.
- **Washing, ironing,** basic manual **sewing of clothes** and household linen.
- **Preparation of beds**.
- Basic food preparation:
    - **Food shopping**, stocking and restocking the pantry.
    - **Food handling and preparation**.
    - **Cleaning of utensils, crockery**, appliances and kitchen surfaces used
    - **Table service**
- **Care or attention** of family members.

To take care elderly (dependent) people in all their facets

9.5 Conclusion

As with the skills, we again observe that the tasks Care workers have to carry out are more or less similar: This is the list with the most important:

- Providing assitance in nursing care (Italy)
- Prepating meals for the resident (Italy)
- Carrying out
- Assisting with cleaning and personal higiene
- Provide companionship and support the persons assisted
- Assist with meals
- Check the physical condition of the person assisted.
- Bath.
- Clothing.
- Relocation from bed to chair.
- Preparing meals.
- Doing the laundry.
- Check aids as hearing aids.
- Help with medication.
- Documentation.
- Cleaning.
- Ensuring the dignity, privacy and independence of the Carer
- General cleaning and maintenance of the home
- Washing, ironing
- Food shopping
- Care or attention of family members.

10.How we can improve this situation? Proposal for a better future.

As we can seen, the working conditions of domestic workers are not good. Low pay with a high level of responsibility and a workload that can often be excessive. This ultimately affects the health and well-being of the workers. Therefore, in this project, we believe it is necessary to put forward some ideas with the intention of improving the quality of work of domestic workers. That is why each partner puts forward a series of proposals.

10.1 Proposals from Denmark.

- Recruitment strategy.
- Information materials / videos / online
- Plan for onboarding new employees in the organization, what's essential to know and be able to do.
- Offer language courses before entering the job.
- Courses and training / simulation
- Job shadowing with experienced colleges
- Mentoring

- Focus on progression in the job
- Match between the care worker and the citizen.

10.2 Proposal from Ireland

To support and develop Housing Care workers the following recommendations should be considered;

- Regulatory system developed with registration of all home care providers and home care workers
- Minimum quality standards of service clearly set out
- Program of training and skills development (in-service-training) to support home care workers updated and renewed on an agreed timeframe
- IT literacy skills including a focus on digital skills information transfer to service user in order to use innovative technologies slowly entering the care giving arena
- A focus by the employer on continuing personal and professional development with opportunities for educational advancement and promotion
- Adequate wages and mileage rates, steady hours of employment and enhanced benefits for home care workers
- Clear compliance and implementation processes put in place to protect care workers and support service delivery
- Policy developed to enable wraparound supports integrating care with health and wellbeing, disability, older people, housing and transport policies
- Autonomy of the service user to decide the supports they need and development of individual person centred plan in order for Home care workers to be clear on the service expected by the person being cared for and family
- Forum for home care workers to inform and play a part in the future development of the home care policies
- New technologies can help housing care workers improve their productivity see below extract from OECD 2020 report on new technologies in care arena

The OECD Health Policy Studies 2020 report

The range of innovative new tools "varies from simple and easy to access technologies, such as smartphones, alarm systems, sensors and GPS monitors, up to more complex devices such as surveillance and companionship robots or comprehensive technologies such as self- sufficient smart homes. There is increased evidence that technological services and devices are improving the independence of older people at home and increasing carers' productivity (Carretero, 2015). Wearable devices with advanced algorithms can also support remote monitoring in home care, and may reduce time spent by workers in promoting self-care practices. Home devices (like intelligent fridges) and medication dispensers can promote self-care and allow better management of elderly people's basic need. Silent alarm systemsthat replace noisy ones, intelligent systems filtering information to identify truly urgent needs and home devices (like intelligent fridges) can allow better management of elderly people's needs and professionals' time".

10.3 Proposal from Spain

Promote the introduction of ICTs and digitalisation tools to optimise the working time of care staff and improve the quality of life and independence of the people receiving services.

Implement a training plan that allows for:

- Provide training that is deemed appropriate at any given time to improve the activity to be carried out.

- Training activities are scheduled as far as possible during working hours in order to reconcile family life.