sustainability

MDPI

Article

Abuse and Wellbeing of Long-Term Care Workers in the COVID-19 Era: Evidence from the UK

Eirini-Christina Saloniki [1,2], Agnes Turnpenny [3], Grace Collins [4], Catherine Marchand [5], Ann-Marie Towers [5] and Shereen Hussein [6,*]

1 Department of Applied Health Research, University College London, London WC1E 7HB, UK
2 NIHR ARC North Thames, London WC1E 7HB, UK
3 Institute of Public Care, Oxford Brookes University, Oxford OX2 9AT, UK
4 Personal Social Services Research Unit, University of Kent, Canterbury CT2 7NF, UK
5 Centre for Health Services Studies, University of Kent, Canterbury CT2 7NF, UK
6 Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, London WC1H 9SH, UK
* Correspondence: shereen.hussein@lshtm.ac.uk

Abstract: The UK long-term care workforce has endured difficult working conditions for many years. During the pandemic, the sector faced unprecedented challenges, which further exacerbated these conditions and brought concerns about workplace abuse and violence. Such experiences can vary by personal and work characteristics, particularly affecting minority ethnic groups. They can subsequently impact workers' wellbeing and the sector overall. Drawing on the first wave of a UK longitudinal workforce survey, this article examined the impact of COVID-19 on social care workers' working conditions, general health and wellbeing, and intentions to leave the employer and sector altogether. The analysis is based on both quantitative and qualitative responses 1037 valid responses received between April and June 2021. The respondents were predominantly female, working in direct care roles and mainly serving older adults (including those with dementia). The findings highlighted worrying experiences of abuse in relation to COVID-19, which differed significantly by nationality, ethnicity and care settings. The analysis further showcased the negative impact of experienced abuse on work-life balance and intentions to leave the current employer or the care sector altogether. The findings emphasise the need for targeted measures that promote workers' physical, emotional and financial wellbeing.

Keywords: abuse; COVID-19; long-term care; wellbeing; workforce

Citation: Saloniki, E.-C.; Turnpenny, A.; Collins, G.; Marchand, C.; Towers, A.-M.; Hussein, S. Abuse and Wellbeing of Long-Term Care Workers in the COVID-19 Era: Evidence from the UK. *Sustainability* **2022**, *14*, 9620. https://doi.org/10.3390/su14159620

Academic Editors: Kerstin Nilsson, Tove Midtsundstad, Peter Lundqvist, Joanne Crawford, and Clas-Håkan Nygård

Received: 22 June 2022
Accepted: 2 August 2022
Published: 4 August 2022

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.

1. Introduction

The COVID-19 pandemic created significant challenges for the UK's long-term care (LTC) workforce. Government policy prioritised the protection of the National Health Service (NHS), while the risk for the LTC sector was largely unrecognised [1,2]. It is estimated that around 25,000 older people were discharged from hospitals to LTC settings to 'free up capacity' without testing or quarantine and the provision of adequate personal protective equipment (PPE) for staff in the first months of the pandemic [3] (p. 11). As a result, COVID-19 rapidly spread in care settings, leading to a significant rise in deaths and excess mortality, especially in care homes [4]. Meanwhile, the Government's response was perceived as slow and indecisive [5], managers had to keep up with continuously changing guidance [6], and care workers had to take on tasks usually undertaken by registered nurses [7,8]. The increased volume of tasks during the pandemic resulted in higher workloads among existing staff [9]. In addition, lack of adequate PPE, staff shortages exacerbated by sickness-related absences, and a workforce with a high proportion of low-paid and precarious workers [10] created a 'perfect storm' for adverse working conditions

[1,11]. The first wave of the pandemic saw an apparent decline in care workers' health and wellbeing [12] and brought to light concerns about mistreatment of the workforce in the form of workplace abuse and violence. Although media reports mainly focused on healthcare workers and the NHS, care workers were given less attention and were featured primarily on connections to negative experiences in care homes [13].

Workplace violence is defined as 'incidents where staff are abused, threatened or assaulted in the circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health' [14] (p. 3). This includes physical and psychological violence, the latter defined as the 'intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats' [14] (p. 4).

Many LTC staff experience some form of abuse, assault or threat during their working lives (see, for example, [15–17]). Experiences of different types of abuse have been found to differ by care setting and institutional practices. So far, most research has focused on residential settings and physical violence, suggesting that residential care workers are more at risk than those in domiciliary care [18–21]. However, more recent research highlights the prevalence and impact of verbal abuse towards domiciliary care workers by clients and their families [16], finding an increased risk of abuse when caring for someone with dementia and having insufficient space to work and a decreased risk when predictable work patterns are maintained enabling a relationship-centred care model [15].

A recent scoping review focusing on aggressive behaviour of people living with dementia towards home care workers found that care staff often minimised and normalised the aggression and violence directed towards them and considered it 'part of the job', rather than recognising the behaviour as an expression of unmet need or a reflection of stressful caregiving activity [22]. Instead of challenging the time and task model of care delivery where they are unable to meet their clients' needs in a person- and relationship-centred way, organisations and staff tend to minimise and normalise these behaviours by attributing them to the vulnerability—cognitive and physical decline—of the individuals they support, ultimately exacerbating burnout, depression, detachment, and exhaustion of the workforce [23,24].

Coping and cognitive emotion regulation strategies are also important in mediating the impact of work-related stress on burnout: dysfunctional coping strategies, such as disengagement or denial, are associated with greater emotional exhaustion and depersonalisation [25]. Meanwhile, those adopting problem- and/or emotion-focused strategies were less likely to experience these adverse outcomes (ibid). A study of hospital nurses exposed to workplace violence in China [26] highlighted the importance of considering the range of strategies that are available to the individual and how these are combined, also underlining the importance of interventions to support mental health among frontline workers exposed to violence.

To understand the context of workplace violence in LTC, it is helpful to consider the sector's dynamics and characteristics. With around 1.7 million jobs, it represents 5% of all jobs in the UK economy and has seen a significant expansion in the last ten years [9,27]. The workforce is predominantly female (over 80% in England and Scotland) and low-paid, with average pay close to the statutory minimum wage [9,28]. Furthermore, cultural norms and racism explain differentiated experiences among minority ethnic workers and non-UK nationals who are overrepresented in the LTC sector [9,29].

Marketisation and outsourcing have created a complex and fragmented landscape of services, particularly in England. Over 18 thousand organisations provide LTC services, varying in size and ownership—from self-employed 'micro-providers' to large corporate chains owned by private equity [30]. Most LTC services are publicly funded (i.e., commissioned by local authorities or the NHS), but there are also self-funders (i.e., those who pay for social care services), the latter estimated to be just under 40% in residential care [31]. Previous research has shown that disproportionately gendered and racialised occupations

are particularly at risk of workplace violence and abuse [24]. For minority workers, abuse incidents can also often be racially motivated [29,32]. Race and ethnicity can influence the nature and frequency of physical and verbal abuse against LTC workers, although further research on these groups is needed [33–35]. In the context of COVID-19, there have been concerns about mistreatment of LTC staff in the form of abuse by service users, their families, and the public, likely triggered by restrictions such as limited visitations in care homes, increased workload, perceived lack of safety measures with potential impact on care practices, and inability to travel [36]. Evidence from qualitative interviews with LTC stakeholders in the UK emphasised the growing concerns about the abuse of workers during the pandemic calling for further research on this topic [37].

While it is crucial to examine the prevalence and nature of abuse experienced in LTC in relation to COVID-19, it is equally important to consider the consequences of such experiences for workers' wellbeing and the sector more broadly to sustain a dynamic and resilient workforce. Abuse of care workers negatively impacts their physical and mental wellbeing, reduces job satisfaction, increases burnout, absenteeism and turnover, and reduces retention at the organisational level [19,38–43]. Such experiences ultimately impact care quality, safety and efficiency [18,44–47].

This study aims to examine the impact of the first wave of the COVID-19 pandemic on LTC workers' working conditions, general health and wellbeing. It investigates the differential experiences of workplace violence by nationality, ethnicity and care settings. The study further explores the association between the experience of abuse and mistreatment with workers' wellbeing, and their intention to quit their current employer or the care sector.

2. Methodology

2.1. Survey Design

The data used in this article stem from the first wave of a longitudinal LTC workforce survey conducted as part of the Retention and Sustainability of Social Care Workforce (RESSCW) project. The project team designed the survey in consultation with the steering group and the funder of the project (The Health Foundation). The longitudinal survey design was informed by the findings from an earlier 'pulse survey' conducted in the summer of 2020, followed by qualitative interviews with stakeholders as part of the same study [12,37]. The longitudinal survey was designed to be completed online. It included several questions taken from validated and widely used workforce surveys (e.g., Workplace Employment Relations Survey, World Health Organisation: Workplace in the Health Sector), adapted where appropriate to social care. It also included open-ended free-text questions. The survey was piloted with three LTC workers to ensure clarity in early April 2021 and was then revised with changes in wording, response options and order of some questions to address the feedback received.

2.2. Recruitment and Data Collection

The lack of a care workers' registry and the fact that many might be working in several settings reduced the effectiveness and feasibility of targeting worker groups within specific care settings. Instead, to maximise survey coverage, the project team opted for a more inclusive recruitment strategy. First, the survey details were shared with the project's steering group members (who represented large care workers and providers representatives), who distributed them to the relevant contacts. Additional recruitment channels involved formal and informal groups of care workers through social media and newsletters and individuals or organisations who had previously engaged in research, interested in the LTC workforce in the UK. Qualtrics was used to implement the survey optimised for mobile devices. Ethical approval was gained from the School of Social Policy, Sociology and Social Research SRC Ethics Committee (SRCEA ID 240) at the University of Kent. Participation in the survey was voluntary and anonymous, and participants could

withdraw at any time. Participants were asked to read a brief study information sheet about the benefits and potential risks of taking part, and the data protection and privacy notice before proceeding to the questions. A prize draw was offered (online retail vouchers) to incentivise uptake. Respondents could opt-in to the prize draw by leaving their contact details. All personally identifiable information was removed from the dataset before analysis. The survey was open from 13 April to 28 June 2021.

2.3. Measures

The survey included multiple-choice questions with pre-recorded and free text options to best capture the workers' views and characteristics. The questions covered basic demographic information, working conditions, support, general health, wellbeing, intention to leave employer or sector, experience during COVID-19, such as mistreatment and abuse, and COVID-19-specific topics (including vaccination, infection of staff and clients, and isolation). The nature and incidents of abuse and mistreatment in relation to COVID-19 were captured by responses to several questions, including (a) type of abuse (verbal abuse, bullying, threat, physical violence—for a definition of the different types as presented to the respondents, see Appendix A, Table A1); (b) perpetrator(s) (manager/supervisor, colleague/staff member, service user/client, service user's/client's family, general public) if indicated experiencing at least one type of abuse; and (c) subsequent action(s) taken by the respondent (took no action, reported it to a manager/supervisor, told a colleague/staff member, sought help from a union). A dummy indicator of any abuse incident was generated if responded positively to at least one type of abuse. A severity measure (for abuse) was created based on the number of positive responses to any abuse type (i.e., single or multiple). In addition, respondents were asked to indicate how much of the time in the past few weeks their job has made them feel (a) tense, uneasy or worried; (b) calm, contended or relaxed; (c) depressed, gloomy or miserable; and (d) cheerful, enthusiastic or optimistic, with five response options ('All of the time', 'Most of the time', 'Some of the time', 'Occasionally', 'Never'). A composite index based on responses to these feelings questions was created as a proxy wellbeing measure. The second wellbeing indicator used in this article reflected responses on a 5-point Likert-type work-life balance satisfaction scale ('Very satisfied', 'Satisfied', 'Neither satisfied nor dissatisfied', 'Dissatisfied', 'Very dissatisfied'). Intentions to leave the current employer or the sector altogether in the next 12 months were captured by responses on 4-point Likert type scales ('Very likely', 'Quite likely', 'Not very likely', Not at all likely'). Open-ended free text questions where participants could add more information or explain their answer choices (for example, about abuse and wellbeing support received) were also included.

2.4. Analysis

Data from the survey was downloaded (in Excel) and split into a qualitative and a quantitative dataset. Qualitative data—free text responses to open-ended questions—was transferred to NVivo version 12 and analysed thematically [48]. All quantitative data were analysed in Stata SE 15.1 [49]. Several steps, including identifying hard and soft red flags, were undertaken during the data cleaning process to ensure only valid responses were included in the analysis (for more details, see Appendix A). Missing data was minimal (up to 2%) and was imputed with the mean to retain the total sample [50]. We examined the demographic characteristics of the overall sample and identified differences among specific population groups. We focused on differences by nationality, ethnicity, and care setting, as these have been found to be important in previous research. Following [12], we combined responses to nationality and ethnicity questions and created three subgroups: White British, White Non-British, Black, Asian and Minority Ethnic (BAME). For care settings, we distinguished between residential care (with or without nursing) and domiciliary care or other to capture groups with very few respondents (including, for example, daycare centres and supported living/extra care housing). Independent t-tests were used to ascertain differences between the different subgroups. Finally, regression analyses (i.e.,

ordinary least squares and probit) were performed to identify how the experience of abuse (any; type; severity) impacted workers' wellbeing and intention to leave, using a set of controls (i.e., age, gender, ethnicity and nationality, employer type, care setting, client group, job role, tenure, contract type, union membership, regional COVID-19 cases and deaths, north-south dummies), most of which have been used in the literature to identify such relationships (see, for example, [19,51]). All descriptive statistics are reported as proportions or percentages, and the lower statistical significance level was set at 0.01.

3. Results

3.1. Survey Respondents

The survey received 1037 valid responses from staff working in the LTC sector across the UK. The demographic and work-related characteristics of survey respondents are summarised in Table 1. Like the overall profile of the LTC workforce in the UK, most respondents were female (82.2%), and almost a third (29.0%) were aged 45-54 years old, which is consistent with the national picture [9]. Over two-thirds (83.5%) were White British, and a tenth (11.1%) were from a BAME background. Nationally, BAME workers constitute 21% of the adult LTC workforce, suggesting that this group was under-represented in the survey. However, difficulties with engaging participants from this population group in research have been highlighted elsewhere [21]. Survey respondents had, on average, at least six years of experience in the LTC sector, which is broadly consistent with the national average [9]. Nearly three-quarters of all respondents were employed on permanent or temporary contracts with guaranteed hours (70.0%), and more than half worked in the private sector (53.7%) or were currently/had been in the past a member of a trade union or staff association (57.8%). Most workers were in direct care roles (e.g., care worker, support worker, care assistant), serving mainly older adults, including those with dementia (58.4%). In terms of care settings, there were slightly more respondents working in domiciliary than residential care (38.3% and 36.2%, respectively), which is similar to what is observed nationally [9]. At the time of the survey, less than a quarter (22.9%) reported fair or poor general health.

Table 1. Summary Statistics: Basic Characteristics.

Characteristic	*n*	%
Gender		
Male	167	16.1
Female	852	82.2
Other/Prefer not to say	18	1.7
Age		
Under 25 years	48	4.6
25–34 years	222	21.4
35–44 years	206	19.9
45–54 years	301	29.0
55–64 years	260	25.1
Nationality and Ethnicity		
White British	866	83.5
White Non-British	56	5.4
BAME	115	11.1
Time working in social care		
Less than 6 months	25	2.4
6–11 months	62	6.0
12–23 months	113	10.9
2–5 years	225	21.7
6–10 years	194	18.7

More than 10 years	418	40.3
Employment type		
Guaranteed hours (temporary/permanent)	726	70.0
Zero-hours	280	27.0
Self-employed	11	1.1
Other	20	1.9
Main employer		
Public sector	183	17.7
Private (i.e., for profit)	557	53.7
Temporary staffing agency	29	2.8
Charity	133	12.8
Individual employer	30	2.9
Self-employed	11	1.1
Other	94	9.1
Trade union or staff association		
Yes	464	44.7
No, but have been in the past	136	13.1
No, have never been a member	437	42.1
Main job role		
Direct care	763	73.6
Management	193	18.6
Regulated professional	49	4.7
Other (incl. ancillary)	32	3.1
Client groups		
Older adults (incl. those with dementia)	606	58.4
Adults with physical and/or sensory disability	170	16.4
Adults with mental health needs	144	13.9
Adults with learning disability or autism	82	7.9
Children and young people	27	2.6
Setting mainly carrying out work		
Residential care (with/without nursing)	375	36.2
Domiciliary care	397	38.3
Day centre/service or community	48	4.6
Supported living/extra care housing	202	19.5
Other	15	1.5
Main area of work		
North	292	28.2
Midlands	251	24.2
London	98	9.5
South	242	23.3
Scotland	92	8.9
Wales	38	3.7
Northern Ireland	24	2.3
General health		
Excellent/very good	454	43.8
Good	346	33.4
Fair/poor	237	22.9

3.2. Self-Isolation, Working Hours and Pay

Thinking back to the beginning of 2021, 330 respondents (31.8%) indicated increased workload without additional pay, while 212 (20.4%) had increased their paid working hours (for more information, see Appendix B, Table A2). This was also reflected in the free text responses, emphasising the lack of staff with suggestions for improvement.

> '*We had to work longer hours with less staff…*' [Care worker, supported living/extra care housing]

> '*Employers should have more staff to avoid increased workload...*' [Care worker, older adults, domiciliary care]

During the same period, 283 respondents (27.3%) had to self-isolate, 182 (17.6%) took sick leave due to COVID-19, and 135 (13.0%) stopped/were stopped by employers from working in different places to reduce the spread of COVID-19. Notably, out of those who self-isolated, took sick leave or stopped working, 39 (10.5%) received no pay, which sometimes made it difficult to manage day-to-day expenses.

> '*I have found it such a struggle…to keep my head above water to pay bills and council tax as I only received about £93 for the 11 days I had off with COVID 19.*' [Care worker, older adults, care home]

3.3. Experiences of Abuse and Violence during the COVID-19 Pandemic

3.3.1. Prevalence, Types and Perpetrators of Abuse

Table 2 shows that a quarter of all respondents (25.6%) reported having experienced some form of abuse in relation to the pandemic. Among all abuse types, verbal abuse and bullying were most mentioned (19.8% and 11.4%, respectively), followed by threat (8.0%) and physical violence (5.1%). The free text responses expanded on some negative experiences, with social media portrayed as exacerbating these experiences.

> '*Being called names, being threatened, being followed.*' [Care worker, adults with physical and/or sensory disability, supported living/extra care housing]

> '*A huge amount of negative comments on social media, blaming carers for so many residents who died of COVID, and blaming care homes of keeping residents hostage, unwilling to allow visits.*' [Care worker, older adults, care home]

Table 2. Summary Statistics: Abuse.

		Abuse Type			
	All	**Verbal Abuse**	**Bullying**	**Threat**	**Physical Violence**
Abuse (any)					
Yes	265 (25.6%)	205 (19.8%)	118 (11.4%)	83 (8.0%)	53 (5.1%)
No	772 (74.5%)	832 (80.2%)	919 (88.6%)	954 (92.0%)	984 (94.9%)
Abuse (severity)					
Single	143 (13.8%)	-	-	-	-
Multiple	122 (11.8%)	-	-	-	-
Perpetrator (if Abuse Type = 'Yes')					
Manager/supervisor	-	38 (18.5%)	34 (28.8%)	21 (25.3%)	2 (3.8%)
Colleague/staff member	-	49 (23.9%)	37 (31.4%)	13 (15.7%)	6 (11.3%)
Service user/client	-	88 (42.9%)	28 (23.7%)	23 (27.7%)	27 (50.9%)
Service user's/client's family	-	65 (31.7%)	19 (16.1%)	18 (21.7%)	9 (17.0%)
General public	-	49 (23.9%)	12 (10.2%)	12 (14.5%)	7 (13.2%)
Action taken (if Abuse Type = 'Yes')					
Took no action	-	54 (26.3%)	13 (11.0%)	11 (13.3%)	8 (15.1%)
Reported it to a manager/supervisor	-	96 (46.8%)	35 (29.7%)	31 (37.4%)	19 (35.9%)
Told a colleague/staff member	-	39 (19.0%)	32 (27.1%)	14 (16.9%)	7 (13.2%)
Sought help from a union	-	20 (9.8%)	18 (15.3%)	14 (16.9%)	12 (22.6%)

Respondents indicated that the service user(s) (42.9%) or their families (31.7%) were mainly behind the verbal abuse they experienced, whereas for bullying, it was a colleague/staff member (31.4%) or manager/supervisor (28.8%). Respondents' free text responses confirm the most frequent perpetrators and point out several triggers of the experienced abuse.

'*Because we were on the front line and trying to implement guidelines we had been given, we got all the abuse thrown at us from residents and staff. No support given.*' [Management, supported living/extra care housing]

'*Family's don't seem to understand that the company I work for don't make the rules, or guidance given from PHA. They can be very frustrated and take that anger out on us.*' [Care worker, older adults, care home]

'*Management threatened that we would have to complete our isolation period in work and live there for the duration if there was an outbreak amongst residents. Management ordered us to not use the track and trace app on our phones.*' [Care worker, children and young people, care home]

'*I was threatened with a disciplinary from a regional manager due to me stating I was not going to let my team look after residents without full PPE despite having positive COVID results on my unit.*' [Regulated professional, older adults, care home]

While about half (46.8%) of those verbally abused reported it to a manager or supervisor, over a quarter (26.3%) took no action. For bullying, nearly a third (29.7%) said it to a manager or supervisor, less than a third (27.1%) told a colleague/staff member and, interestingly, over a tenth (15.3%) sought help from a union. Notably, it was not safe to report the incident in some settings, but there were also cases where it was said to management with no further action.

'*It's not safe to get help.*' [Care worker, adults with physical and/or sensory disability, supported living/extra care housing]

'*There was nothing I could do. It was reported to line management. I was trying to keep all within the government guidelines and to keep people safe and colleagues wanted and did work against the directives given placing all others at risk. When this was raised they bullied and used threating behaviour...*' [Management, care home]

'*… It was reported to police and management, but they did nothing because "can't do anything about it because of COVID restrictions and tenancy agreements". So we had to take the abuse for almost a year…*' [Care worker, adults with mental health needs, domiciliary care]

3.3.2. Abuse Differentials by Individual and Organisational Characteristics

White British were the least likely to have experienced any type of abuse about COVID-19 compared to White Non-British and those from a BAME background. Specifically, BAME respondents were twice as likely to have been abused than the White British (40.0% vs. 23.4%, respectively), and the difference is statistically significant. All remaining comparisons by race and ethnicity were not statistically significant (see Table 3 for more details). Regarding care settings, respondents working in residential care were significantly more likely (31.5%) to have reported at least one type of abuse than those working in domiciliary care or other settings (22.2%).

Table 3. Abuse Differences by Population Subgroups.

	Nationality and Ethnicity			Care Setting	
	White British	**White Non-British**	**BAME**	**Residential Care**	**Domiciliary Care and Other**
	(1)	**(2)**	**(3)**	**(4)**	**(5)**
Abuse (any)					
Mean (SD)	0.234 (0.424)	0.286 (0.456)	0.400 (0.492)	0.315 (0.465)	0.222 (0.416)
N	866	56	115	375	662
	(1)–(2)	(2)–(3)	(1)–(3)	(4)–(5)	
Diff. (SE)	−0.051 ^{ns} (0.059)	−0.114 ^{ns} (0.078)	−0.166 *** (0.043)	0.093 *** (0.028)	-

Note. SD, standard deviation. SE, standard error. *** $p < 0.01$, ^{ns} not significant.

Care staff also highlighted the structural stigma associated with this work compared to working in the NHS. For example, NHS workers received discounts and queue jumps at the beginning of the pandemic before social care workers were acknowledged. This was mentioned frequently by the respondents.

> '*Trying to keep staff motivated & committed was all the harder when they saw media reports of what NHS [National Health Services] staff were getting (freebies, discounts, etc).*' [Management, supported living/extra care housing]

Shame from social stigma was also reported by some participants when they felt the public blamed them for spreading COVID.

> '*A huge amount of negative comments on social media, blaming carers for so many residents who died of COVID, and blaming care homes of keeping residents hostage, unwilling to allow visits.*' [Care worker, older adults, care home]

3.4. Implications of Abuse/Mistreatment on Individual Workers and the Organisation

Over a third (39.0%) of respondents reported that their job in the past few weeks made them feel tense, uneasy, or worried, while almost half (44.1%) occasionally or never felt depressed, gloomy or miserable. Nevertheless, less than a third (27.6%) were dissatisfied or very dissatisfied with their work-life balance overall (for more information, see Appendix B, Table A3). The frequent negative feelings could be related to the nature of the role itself and the extra challenges created by the pandemic, as mentioned in some quotes.

> '*It has been a hard year and fear to the job working all the way through the COVID 19 pandemic. Stress and depression on staff not knowing the outcome.*' [Care worker, care home]

> '*Have found working during pandemic very stressful.*' [Care worker, older adults and adults with a learning disability, autism or mental health needs, domiciliary care]

> '*The pandemic was extremely stressful. The information changed daily and we were struggling to enforce what was needed...*' [Management, older adults, care home]

> '*Unreasonable workloads and lack of support for shielding household. The stress involved led me to step down from position in order to protect them.*' [Care worker, domiciliary care]

Looking at the relationship between experiencing abuse and wellbeing, the findings show that, irrespective of the measure used (i.e., proxy or work-life balance; different abuse indicators), abuse negatively impacts workers' wellbeing (see Table 4). More severe (i.e., multiple types) abuse has a more adverse negative effect on wellbeing. When focusing on the impact of each abuse type, while the relationship remains negative and strongly significant for all types except for threat, the adversity of the effect differs by the wellbeing measure used. Specifically, bullying impacts the most on the proxy wellbeing measure, whereas physical violence affects work-life balance (the full estimation results are included in Appendix B, Table A4).

Table 4. Impact of Abuse on Worker's Wellbeing.

	Wellbeing: Proxy (Feelings at Work)			**Wellbeing: Work-Life Balance**		
Characteristic	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
	β	β	β	β	β	β
Abuse (any)						
Yes	−0.185 *** (0.023)	-	-	−0.312 *** (0.064)	-	-
Abuse (severity)						
Single	-	−0.128 *** (0.028)	-	-	−0.143 * (0.081)	-
Multiple	-	−0.254 *** (0.030)	-	-	−0.519 *** (0.082)	-
Abuse (type)						
Verbal abuse	-	-	−0.093 *** (0.027)	-	-	−0.182 ** (0.077)
Bullying	-	-	−0.145 *** (0.035)	-	-	−0.222 ** (0.096)
Threat	-	-	−0.033 ^{ns} (0.046)	-	-	−0.015 ^{ns} (0.123)
Physical violence	-	-	−0.107 ** (0.050)	-	-	−0.381 *** (0.138)
N	1037	1037	1037	1037	1037	1037

Note. Robust standard error in parentheses. All models include controls for personal and work characteristics. The omitted group is no abuse in all cases. *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$, ^{ns} not significant.

A staggering 43.3% reported that they were likely to leave their current employer in the next 12 months (see Appendix B, Table A5 for more details), which could have been exacerbated by the experienced abuse. Indeed, according to the estimation findings reported in Table 5, the experience of at least one type of abuse increases the probability of wanting to leave, with multiple types of abuse having a more substantial negative effect than a single abuse type. Among the different abuse types, the picture is mixed; verbal abuse influences the intention to leave the sector, whereas bullying has the strongest influence on the intention to leave the current employer (the full estimation results are included in Appendix B, Table A6).

Table 5. Impact of Abuse on Worker's Intention to Leave.

	Intention to Leave in the Next 12 Months: Sector			**Intention to Leave in the Next 12 Months: Current Employer**		
Characteristic	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
	ME	**ME**	**ME**	**ME**	**ME**	**ME**
Abuse (any)						
Yes	0.233 *** (5.71)	-	-	0.260 *** (7.04)	-	-
Abuse (severity)						
Single	-	0.225 *** (4.48)	-	-	0.223 *** (4.72)	-
Multiple	-	0.243 *** (4.17)	-	-	0.200 *** (3.67)	-
Abuse (type)						

Verbal abuse	-	-	0.135 *** (2.86)	-	-	0.115 *** (2.92)
Bullying	-	-	0.103 *** (1.55)	-	-	0.057 ^{ns} (1.05)
Threat	-	-	0.128 * (1.61)	-	-	0.072 ^{ns} (1.06)
Physical violence	-	-	−0.067 ^{ns} (−0.64)	-	-	0.020 ^{ns} (0.24)
N	1037	1037	1037	1037	1037	1037

Note. Marginal effects at mean. Z-scores based on robust standard errors in parentheses. All models include controls for personal and work characteristics. The omitted group is no abuse in all cases. *** $p < 0.01$, * $p < 0.1$, ^{ns} not significant.

4. Discussion

The LTC sector in the UK is facing long-standing challenges centred around chronic underfunding, workforce shortages, poor pay and the low status of the care workforce. The ongoing challenges in the sector were exacerbated by the COVID-19 pandemic, with severe implications on the workforce. The wellbeing of care workers was put to the test, with minority ethnic workers more at risk of challenging experiences [29]. For many, the workload and responsibilities increased directly due to the pandemic. LTC workers, while usually short-staffed, were required to cover for significant increases in absenteeism while managing infection control measures to contain the pandemic. The latter measures were not always easy to implement. Examples include contradicting guidance in the first wave of the pandemic around safety measures, such as social distancing, isolation and limiting visitations by family members in care homes [52]. Since the onset of COVID-19, care workers were often perceived by family members as the ones not allowing visitations, further exposing staff to potential abuse and bullying incidents. The additional workload associated with limited guidance led to higher levels of stress and staff burnout. The uncertainty brought in by the pandemic could have only intensified the effects of abuse and mistreatment incidents. The lack of support mechanisms to mitigate these negative behaviours adversely impacted care workers' health and physical and mental wellbeing. This study confirmed that feelings of neglect, depression and stress combined with increased workload featured during the pandemic.

This study focused on the impact of the COVID-19 pandemic on LTC workers' working conditions, general health and wellbeing. Using data from the first wave of a UK longitudinal LTC workforce survey, it was found that the workload of staff increased substantially during the pandemic. In most cases without extra pay. While the increased workload could be, for example, due to a lack of staff and resources, or additional tasks created by the pandemic, it raises concerns about its sustainability and the long-term impact on workers' health and wellbeing. It is essential to highlight that despite organisational and governmental processes in place, some workers who took sick leave, self-isolated or were stopped from working as a measure to control the infection reported that they did not receive any pay, adding to the financial challenges already faced by low-paid staff. Crucially, receiving no pay while sick, in a sector characterised by very low wages, is likely to negatively impact all wellbeing aspects of the LTC workers, especially their financial wellbeing [29].

Furthermore, our study found that a quarter of respondents experienced some form of abuse in relation to the pandemic. While the overall abuse prevalence is lower than reported in other studies (see, for example, [15,16,35]), the context is different given the focus on the pandemic. Nevertheless, the dominance of verbal abuse observed in our study was also present in the pre-COVID era (see, for example, [19,53]). Our study findings showed a higher prevalence of abuse incidents among minority ethnic workers, perhaps explained by the lack of empowerment and deeply entrenched negative attitudes,

including structural racism, towards minority workers [29,54]. As in other studies [19,21], we found significant differences in abuse experiences between care settings, with such incidents more common in residential care. This could be explained by the nature and needs of clients served in each setting, the job demands and stressors, and specific restrictions pertinent to the pandemic. The structural stigma of social care work, particularly in the context of the COVID-19 pandemic, was also likely to exasperate these feelings [55].

The negative experiences of abuse identified in this study stress the importance of considering the broader implications for workers' health and wellbeing, the organisation and the sector. For instance, our results showed a negative association between abuse and work-life balance irrespective of abuse type. Consistent with similar studies, we found that many LTC workers frequently felt tense, uneasy, depressed and gloomy because of their job, with further implications on their general health and work-life balance [55,56]. In addition, workers' intention to quit the sector was found to be about half of that quitting the current employer voluntarily in the next year. The direction of these findings showcases the strong motivations of the care workforce for joining the sector and the hope that a change of employer will result in better working conditions. Despite all the challenging experiences faced before and during the pandemic, the workforce remains highly committed to the sector.

This study is not without limitations. First, the study sample was self-selective, focusing only on one survey mode (i.e., online). This potentially prevented some groups of workers from participating, including live-in carers and personal assistants, where we observed a handful of respondents. Furthermore, our findings—especially from the estimations—reflect associations and cannot be interpreted as causal relationships. Future analysis, using longitudinal data on abuse, wellbeing and working conditions, which attempts to establish causal relationships between these measures, could be a natural extension of this study. As too would be a further investigation into the nature of changes to working conditions, including a focus on the intention to quit, during the challenging, uncertain and multi-faceted COVID-19 era.

5. Conclusions

In an era of continued challenges, including austerity, a new post-Brexit immigration system and changes in practices to allow for a more flexible work model following the global COVID-19 pandemic, there is a call for targeted interventions to focus on more supportive jobs that will improve workers' wellbeing at work [29]. It is not just about maintaining adequate standards and building relationships with the care workforce but also emphasising all aspects of wellbeing—physical, mental and financial—that can pave the way forward.

This study highlights issues of considerable policy importance. The first is acknowledging the implications of COVID-19, including the increased levels of abuse and mistreatment, on the LTC workers' wellbeing and ensuring adequate interventions to mitigate them in place. This is of high policy relevance to ensure a sustainable workforce. However, a recent government inquiry report [57,58] assessed the government's response to the health and social care workforce wellbeing as inadequate. It highlighted the differentiated experiences across different groups of workers and between health and social care settings in England. This lack of recognition of the impact of COVID-19 on the LTC workforce in the UK was reflected in minimal support measures during the pandemic compared to other countries such as Australia and Canada [2]. The second policy implication is the linkage between the exposure to mistreatment and abuse and the intention to quit. With current workforce recruitment challenges and high turnover rates, it is crucial to implement interventions aimed at reducing incidences of bullying and abuse to minimise the haemorrhage of talents and wasted training and skills.

Author Contributions: Conceptualization, S.H., E.-C.S., A.T. and A.-M.T.; Data curation, E.-C.S., A.T., C.M. and G.C.; Formal analysis, E.-C.S., C.M. and G.C.; Investigation, S.H., E.-C.S., A.T.; Methodology, S.H., E.-C.S. and A.T.; Project administration, S.H.; Supervision, S.H.; Writing—original draft, E.-C.S., A.T., A.-M.T. and S.H.; Writing—review & editing, E.-C.S., A.T., A.-M.T., S.H., C.M. and G.C. All authors have read and agreed to the published version of the manuscript.

Funding: This study is part of the Retention and Sustainability of Social Care Workforce (RESSCW) project, funded by the Health Foundation's Efficiency Research Programme (ID: 1325587). The Health Foundation is an independent charity committed to improving health and health care for people in the UK.

Institutional Review Board Statement: Ethical approval was gained from the School of Social Policy, Sociology and Social Research SRC Ethics Committee (SRCEA ID 240) at the University of Kent

Informed Consent Statement: Informed consent to participate was collected from the participants in the longitudinal survey.

Data Availability Statement: The data used in this study are managed by the authors and cannot be accessed by others outside of the project research team.

Acknowledgments: We would like to thank all participants for taking the time to complete the online survey. We also thank the RESSCW research team for valuable feedback on the development of the survey. The views expressed as well as any errors are entirely of the authors.

Conflicts of interest: The authors declare no conflict of interest.

Appendix A. Data Quality Checks and Exclusions

The survey was completed by 1530 respondents. Several fields were used separately or in combination to identify if the responses were valid. These included: (a) IP address, (b) survey completion time, (c) phone number (provided for prize draw), (d) (first half of) work postcode, (e) longitude and latitude (where available), (f) email and name (provided for prize draw), (g) free text responses. The following exclusions were made: duplicate formatting of contact details and/or unrecognisable free text ($n = 19$), invalid email address or name ($n = 30$), non-UK longitude and latitude ($n = 16$), invalid work postcode and/or phone number ($n = 28$), completion time under five minutes and/or invalid name/phone number ($n = 339$), all aforementioned fields invalid ($n = 61$), the latter including $n = 17$ who did not consent. In total, 493 responses were deemed invalid and excluded from the analysis.

Table A1. Abuse Types.

	Definition
Verbal abuse	Behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.
Bullying	Repeated and over time offensive behaviour through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or groups of workers.
Threat	Promised use of physical force or power resulting in fear of harm or other negative consequences to the targeted individuals or groups.
Physical violence (attack/assault)	The use of physical force against another person or group, that results in harm.

Note. Adapted from World Health Organisation: Workplace Violence in the Health Sector.

Appendix B

Table A2. Experiences since the Beginning of 2021.

	n	**%**
Required to self-isolate	283	27.3
Were on sick leave due to COVID-19	182	17.6
Stopped working due to the fear of infection	40	3.9
Reduced working hours/stopped working for personal reasons or caring responsibilities outside work	126	12.2
Were furloughed	57	5.5
Had workload increased without additional pay	330	31.8
Increased paid working hours	212	20.4
Been redeployed to a different role or workplace other than usual role or workplace	137	13.2
Stopped or been stopped by employer from working in as many different places to reduce spread of COVID-19	135	13.0
Worked from home	116	11.2
Were on sick leave – not due to COVID-19	16	1.5
Made redundant/were suspended/resigned	7	0.7

Table A3. Summary Statistics: Wellbeing.

Thinking of the past few weeks how much of the time has your job made you feel	***n***	**%**
Tense, uneasy or worried		
All/most of the time	404	39.0
Some of the time	335	32.3
Occasionally/never	298	28.7
Calm, contended or relaxed		
All/most of the time	335	32.3
Some of the time	302	29.1
Occasionally/never	400	38.6
Depressed, gloomy or miserable		
All/most of the time	249	24.0
Some of the time	331	31.9
Occasionally/never	457	44.1
Cheerful, enthusiastic or optimistic		
All/most of the time	412	39.7
Some of the time	317	30.6
Occasionally/never	308	29.7
Overall, how satisfied or dissatisfied are you with	*n*	%
Work-life balance		
Very satisfied/satisfied	529	51.0
Neither satisfied nor dissatisfied	222	21.4
Dissatisfied/very dissatisfied	286	27.6

Note. The composite index was created by (a) reverse coding for calm, contended or relaxed and cheerful, enthusiastic or optimistic; (b) normalisation of all four feelings questions; and (c) taking the average of all four (normalised) feelings questions.

Table A4. Impact of Abuse on Worker's Wellbeing (full results).

	Wellbeing: Proxy (Feelings at Work)			**Wellbeing: Work-Life Balance**		
	β	*β*	*β*	*β*	*β*	*β*
Characteristic	(1)	(2)	(3)	(4)	(5)	(6)
Gender						
Male	0.017 (0.028)	0.022 (0.028)	0.021 (0.028)	−0.042 (0.074)	−0.029 (0.074)	−0.026 (0.074)
Ethnicity and nationality						
White Non-British	−0.072 * (0.042)	−0.064 (0.042)	−0.058 (0.043)	−0.092 (0.119)	−0.069 (0.119)	−0.060 (0.119)
BAME	0.028 (0.032)	0.025 (0.032)	0.029 (0.031)	0.033 (0.080)	0.027 (0.078)	0.044 (0.078)
Age						
Under 25	−0.070 (0.052)	−0.067 (0.051)	−0.068 (0.051)	−0.177 (0.139)	−0.170 (0.138)	−0.170 (0.140)
25–34	−0.012 (0.030)	−0.008 (0.030)	−0.016 (0.030)	0.016 (0.081)	0.028 (0.080)	0.019 (0.081)
35–44	−0.023 (0.028)	−0.021 (0.028)	−0.019 (0.028)	0.031 (0.074)	0.037 (0.073)	0.043 (0.074)
55+	−0.019 (0.026)	−0.019 (0.026)	−0.018 (0.026)	0.006 (0.071)	0.008 (0.071)	0.008 (0.071)
Regional COVID						
Cases	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)
Deaths	−0.008 (0.012)	−0.009 (0.012)	−0.009 (0.012)	0.004 (0.033)	−0.001 (0.033)	0.003 (0.033)
Sector						
Public sector	0.051 * (0.027)	0.050 * (0.027)	0.050 * (0.026)	0.178 ** (0.069)	0.174 ** (0.068)	0.173 ** (0.068)
Charity	−0.020 (0.033)	−0.019 (0.033)	−0.018 (0.033)	−0.065 (0.090)	−0.060 (0.089)	−0.062 (0.089)
Other	−0.011 (0.027)	−0.012 (0.027)	−0.013 (0.028)	0.086 (0.073)	0.084 (0.072)	0.082 (0.072)
Setting						
Care home w/wo nursing	−0.067 *** (0.022)	−0.063 *** (0.022)	−0.062 *** (0.022)	−0.029 (0.060)	−0.018 (0.059)	−0.021 (0.060)
Service user						
Older adults	−0.005 (0.022)	−0.012 (0.022)	−0.014 (0.022)	0.111* (0.060)	0.093 (0.060)	0.091 (0.060)
Adults with physical/sensory disability	0.073 *** (0.028)	0.073 *** (0.028)	0.069** (0.028)	−0.015 (0.079)	−0.016 (0.078)	−0.018 (0.079)
Adults with mental health needs	−0.009 (0.033)	−0.011 (0.033)	−0.011 (0.033)	0.105 (0.086)	0.099 (0.085)	0.101 (0.084)
Other	0.004 (0.036)	0.006 (0.036)	0.009 (0.036)	−0.076 (0.096)	−0.068 (0.095)	−0.067 (0.096)
Role						
Non- direct care	−0.044 * (0.025)	−0.045 * (0.025)	−0.047 * (0.025)	−0.283 *** (0.068)	−0.284 *** (0.067)	−0.287 *** (0.067)
Tenure						
<2 years	0.043 (0.033)	0.043 (0.033)	0.045 (0.033)	0.015 (0.084)	0.016 (0.083)	0.024 (0.083)
2–5 years	0.021 (0.028)	0.020 (0.028)	0.021 (0.028)	−0.147 ** (0.074)	−0.148 ** (0.073)	−0.148 ** (0.074)
6–10 years	0.008 (0.027)	0.007 (0.027)	0.008 (0.027)	−0.094 (0.076)	−0.097 (0.076)	−0.094 (0.076)
Contract type						
Non-permanent	0.055 ** (0.024)	0.059 ** (0.024)	0.062 ** (0.024)	0.133 ** (0.064)	0.145 ** (0.063)	0.151 ** (0.063)
Union member						
Yes	−0.083 *** (0.022)	−0.083 *** (0.022)	−0.082 *** (0.022)	−0.082 (0.059)	−0.080 (0.058)	−0.073 (0.058)
Abuse (any)						
Yes	−0.185 *** (0.023)	-	-	−0.312 *** (0.064)	-	-
Abuse (severity)						

Single	-	−0.128 *** (0.028)	-	-	−0.143 * (0.081)	-
Multiple	-	−0.254 *** (0.030)	-	-	−0.519 *** (0.082)	-
Abuse (type)						
Verbal abuse	-	-	−0.093 *** (0.027)	-	-	−0.182 ** (0.077)
Bullying	-	-	−0.145 *** (0.035)	-	-	−0.222 ** (0.096)
Threat	-	-	−0.033 ns (0.046)	-	-	−0.015 ns (0.123)
Physical violence	-	-	−0.107 ** (0.050)	-	-	−0.381 *** (0.138)
N	1037	1037	1037	1037	1037	1037
R-squared	0.168	0.177	0.176	0.099	0.111	0.112

Note. Robust standard error in parentheses. Base categories: Gender: female; Ethnicity and Nationality: White British; Age: 45–54 years; Sector: private; Setting: domiciliary care/other; Role: direct care; Tenure: >10 years; Contract type: permanent; Union member: no. *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$, ns not significant.

Table A5. Summary Statistics: Intention to Leave in the Next 12 Months.

Characteristic	***n***	**%**
Current employer voluntarily		
Very/quite likely	449	43.3
Not very/at all likely	588	56.7
Social care altogether		
Very/quite likely	300	28.9
Not very/at all likely	737	71.1

Table A6. Impact of Abuse on Worker's Intention to Leave (full results).

	Intention to Leave in the Next 12 Months: Sector			**Intention to Leave in the Next 12 Months: Current Employer**		
	ME	**ME**	**ME**	**ME**	**ME**	**ME**
Characteristic	(1)	(2)	(3)	(4)	(5)	(6)
Gender						
Male	0.076 * (1.75)	0.076 * (1.76)	0.082 * (1.86)	0.082 * (1.69)	0.082 * (1.68)	0.090 * (1.83)
Ethnicity and nationality						
White Non-British	0.120 (1.60)	0.122 (1.62)	0.115 (1.55)	0.174 ** (2.30)	0.173 ** (2.29)	0.169 ** (2.23)
BAME	0.101 * (1.94)	0.101 * (1.94)	0.113 ** (2.14)	0.169 *** (3.03)	0.169 *** (3.03)	0.178 *** (3.17)
Age						
Under 25	0.032 (0.37)	0.033 (0.38)	0.028 (0.32)	0.077 (0.86)	0.076 (0.85)	0.070 (0.79)
25–34	−0.115 *** (−2.81)	−0.114 *** (−2.78)	−0.108 *** (−2.62)	−0.103 ** (−2.03)	−0.103 ** (−2.04)	−0.095 * (−1.89)
35–44	−0.047 (−1.11)	−0.046 (−1.10)	−0.046 (−1.10)	−0.053 (−1.08)	−0.054 (−1.09)	−0.053 (−1.08)
55+	0.036 (0.86)	0.036 (0.87)	0.032 (0.78)	−0.066 (−1.40)	−0.066 (−1.41)	−0.068 (−1.46)
Regional COVID						
Cases	0.000 (0.02)	0.000 (0.04)	−0.000 (−0.08)	0.000 (0.94)	0.000 (0.93)	0.000 (0.80)
Deaths	−0.004 (−0.20)	−0.004 (−0.22)	−0.002 (−0.08)	−0.015 (−0.68)	−0.014 (−0.67)	−0.012 (−0.55)
Sector						
Public sector	−0.029 (−0.71)	−0.028 (−0.71)	−0.033 (−0.82)	−0.073 (−1.58)	−0.073 (−1.59)	−0.074 (−1.62)

Charity	−0.071 (−1.60)	−0.071 (−1.60)	−0.073 * (−1.66)	−0.024 (−0.43)	−0.025 (−0.44)	−0.028 (−0.49)
Other	−0.028 (−0.66)	−0.028 (−0.66)	−0.028 (−0.66)	−0.009 (−0.18)	−0.009 (−0.18)	−0.009 (−0.17)
Setting						
Care home w/wo nursing	−0.008 (−0.24)	−0.008 (−0.23)	−0.008 (−0.23)	−0.024 (−0.61)	−0.024 (−0.62)	−0.026 (−0.64)
Service user						
Older adults	−0.065 * (−1.96)	−0.066 ** (−1.98)	−0.058 * (−1.74)	−0.009 (−0.22)	−0.008 (−0.20)	−0.001 (−0.04)
Adults with physical/sensory disability	0.025 (0.59)	0.025 (0.59)	0.034 (0.81)	0.021 (0.42)	0.021 (0.42)	0.032 (0.64)
Adults with mental health needs	−0.025 (−0.52)	−0.025 (−0.53)	−0.022 (−0.47)	0.040 (0.74)	0.041 (0.75)	0.041 (0.75)
Other	−0.038 (−0.72)	−0.037 (−0.72)	−0.047 (−0.89)	−0.038 (−0.60)	−0.038 (−0.60)	−0.046 (−0.72)
Role						
Non-direct care	−0.028 (−0.75)	−0.028 (−0.75)	−0.027 (−0.72)	−0.113 ** (−2.54)	−0.113 ** (−2.55)	−0.113 ** (−2.56)
Tenure						
<2 years	−0.030 (−0.65)	−0.030 (−0.58)	−0.024 (−0.51)	−0.011 (−0.21)	−0.011 (−0.21)	−0.005 (−0.10)
2–5 years	−0.024 (−0.57)	−0.024 (−0.58)	−0.025 (−0.60)	0.026 (0.53)	0.026 (0.53)	0.026 (0.54)
6–10 years	−0.012 (−0.29)	−0.012 (−0.29)	−0.016 (−0.39)	−0.057 (−1.18)	−0.056 (−1.18)	−0.057 (−1.20)
Contract type						
Non-permanent	0.062 * (1.67)	0.063 * (1.69)	0.061 (1.61)	0.073 * (1.68)	0.073 * (1.67)	0.071 (1.62)
Union member						
Yes	0.078 ** (2.29)	0.077 ** (2.29)	0.086 ** (2.52)	0.108 *** (2.77)	0.108 *** (2.77)	0.114 *** (2.93)
Satisfaction with workload						
Neither satisfied nor dissatisfied	0.043 (1.29)	0.044 (1.30)	0.043 (1.28)	0.137 *** (3.44)	0.136 *** (3.42)	0.132 *** (3.33)
Dissatisfied/very dissatisfied	0.241 *** (6.20)	0.242 *** (6.21)	0.243 *** (6.17)	0.429 *** (10.99)	0.428 *** (10.92)	0.432 *** (11.04)
Satisfaction with pay						
Very satisfied/satisfied	−0.101 *** (−2.72)	−0.102 *** (−2.73)	−0.100 *** (−2.70)	−0.131 *** (−3.07)	−0.131 *** (−3.05)	−0.127 *** (−2.98)
Neither satisfied nor dissatisfied	−0.057 (−1.41)	−0.057 (−1.42)	−0.063 (−1.57)	−0.078 * (−1.70)	−0.078 * (−1.70)	−0.080 * (−1.75)
Abuse (any)						
Yes	0.233 *** (5.71)	-	-	0.260 *** (7.04)	-	-
Abuse (severity)						
Single	-	0.225 *** (4.48)	-	-	0.223 *** (4.72)	-
Multiple	-	0.243 *** (4.17)	-	-	0.200 *** (3.67)	-
Abuse (type)						
Verbal abuse	-	-	0.135 *** (2.86)	-	-	0.115 *** (2.92)
Bullying	-	-	0.103 *** (1.55)	-	-	0.057 ^{ns} (1.05)
Threat	-	-	0.128 * (1.61)	-	-	0.072 ^{ns} (1.06)
Physical violence	-	-	−0.067 ^{ns} (−0.64)	-	-	0.020 ^{ns} (0.24)
N	1037	1037	1037	1037	1037	1037

Note. Marginal effects at mean. Z-scores based on robust standard error in parentheses. Base categories: Gender: female; Ethnicity and Nationality: White British; Age: 45–54 years; Sector: private; Setting: domiciliary care/other; Role: direct care; Tenure: >10 years; Contract type: permanent; Union member: no; Satisfaction with workload: very satisfied/satisfied; Satisfaction with pay: dissatisfied/very dissatisfied. *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$, ^{ns} not significant.

References

1. Beresford, P. What are we clapping for? Sending people to die in social care: Why the NHS did this and what needs to happen next? In *COVID-19 and Co-Production in Health and Social Care Research, Policy, and Practice*; Bristol University Press: Bristol, UK, 2021; pp. 89–99.
2. Reed, A.C.; Murmann, M.; Hsu, A.; Turnpenny, A.; Van Houtven, C.; Laberge, M.; Low, L.-F.; Hussein, S.; Allin, S. Risk recognition policies for the long-term care workforce during the first year of the COVID-19 pandemic: A multi-country study. *J. Long-Term Care* **2022**, *2022*, 22–39.
3. House of Commons Public Accounts Committee. Readying the NHS and Social Care for the COVID-19 Peak. HC 405. House of Commons, London. Available online: https://committees.parliament.uk/publications/2179/documents/20139/default/ (accessed on 14 March 2022).
4. Office for National Statistics Deaths Involving COVID-19 in the Care Sector, England and Wales: Deaths Registered between Week Ending 20 March 2020 and Week Ending 2 April 2021. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsregisteredbetweenweekending20march2020andweekending2april2021 (accessed on 4 April 2022).
5. Daly, M. COVID-19 and care homes in England: What happened and why? *Soc. Policy Adm.* **2020**, *54*, 985–998.
6. Towers, A.-M.; Killett, A.; Handley, M.; Almack, K.; Backhouse, T.; Bunn, D.; Bunn, F.; Dickinson, A.; Mathie, E.; Mayrhofer, A.; et al. Producing 'Top Tips' for Care Home Staff During the COVID-19 Pandemic in England: Rapid Reviews Inform Evidence-Based Practice but Reveal Major Gaps. *J. Long-Term Care* **2020**, 151–166 Available online: http://doi.org/10.31389/jltc.43. (accessed on 14 March 2022)
7. Care Quality Commission. Delegating Medicines Administration. Available online: https://www.cqc.org.uk/guidance-providers/adult-social-care/delegating-medicines-administration (accessed on 14 March 2022).
8. Shore, C.; Maben, J.; Mold, F.; Winkley, K.; Cook, A.; Stenner, K. Delegation of medication administration from registered nurses to non-registered support workers in community care settings: A systematic review with critical interpretive synthesis. *Int. J. Nurs. Stud.* **2022**, *126*, 104121.
9. Skills for Care. The State of the Adult Social Care Sector and Workforce in England; Skills for Care: Leeds, UK, 2021.
10. National Audit Office. The Adult Social Care Workforce in England. HC 714. National Audit Office, London. Available online: https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England.pdf (accessed on 7 April 2022).
11. The Care Workers' Charity. 'Just Part of the Job'—Violence, Aggression and Burnout in the Care Industry. Available online: https://www.thecareworkerscharity.org.uk/social-care-voices/just-part-of-the-job/ (accessed on 14 March 2022).
12. Hussein, S.; Saloniki, E.; Turnpenny, A.; Collins, G.; Vadean, F.; Bryson, A.; Forth, J.; Allan, S.; Towers, A.; Gou, K.; et al. *COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK*; Personal Social Services Research Unit: Kent, UK, 2020.
13. Edmunds, C. Carer finds note on car branding her a 'killer' after treating patient and NHS worker is abused for confronting joggers flouting lockdown rules in more attacks on frontline staff during coronavirus pandemic. *Mail Online*, 6 April 2020. Available online: https://www.dailymail.co.uk/news/article-8191863/Carer-treating-vulnerable-patient-coronavirus-crisis-finds-killer-note-car.html (accessed on 6 April 2022).
14. International Labor Organization. Framework Guidelines for Addressing Workplace Violence in the Health Sector; ILO: Geneva, Switzerland, 2002.
15. Gerberich, S. Verbal abuse against home care aides: Another shot across the bow in violence against health care and other workers. *Occup. Environ. Med.* **2019**, *76*, 593–594.
16. Karlsson, N.D.; Markkanen, P.K.; Kriebel, D.; Gore, R.J.; Galligan, C.J.; Sama, S.R.; Quinn, M.M. Home care aides' experiences of verbal abuse: A survey of characteristics and risk factors. *Occup. Environ. Med.* **2019**, *76*, 448–454.
17. House of Commons Health and Social Care Committee. Workforce Burnout and Resilience in the NHS and Social Care. Second Report of Session 2021-22. HC 22. House of Commons, London. Available online: https://committees.parliament.uk/publications/6158/documents/68766/default/ (accessed on 14 March 2022).
18. Colton, M.; Roberts, S. Factors that contribute to high turnover among residential child care staff. *Child Fam. Soc. Work* **2007**, *12*, 133–142.
19. Harris, B.; Leather, P. Levels and consequences of exposure to service user violence: Evidence from a sample of UK social care staff. *Br. J. Soc. Work* **2012**, *42*, 851–869.
20. Lovell, A.; Skellern, J. Tolerating violence: A qualitative study into the experience of professionals working with one UK learning disability service. *J. Clin. Nurs.* **2013**, *22*, 2264–2272.
21. Skills for Care. Supporting Social Care Employers to Prevent and Manage Abuse and Violence Toward Staff; Skills for Care: Leeds, UK, 2014.
22. Schnelli, A.; Karrer, M.; Mayer, H.; Zeller, A. Aggressive behaviour of persons with dementia towards professional caregivers in the home care setting—A scoping review. *J. Clin. Nurs.* **2020**, 1–18. https://doi.org/10.1111/jocn.15363
23. Braedley, S.; Owusu, P.; Przednowek, A.; Armstrong, P. We're told, 'Suck it up': Long-term care workers' psychological health and safety. *Ageing Int.* **2018**, *43*, 91–109.

24. Funk, L.; Spencer, D.; Herron, R. Making sense of violence and victimization in health care work: The emotional labour of 'not taking it personally'. *Int. Rev. Vict.* **2021**, *27*, 94–110.
25. Bamonti, P.; Conti, E.; Cavanagh, C.; Gerolimatos, L.; Gregg, J.; Goulet, C.; Pifer, M.; Edelstein, B. Coping, cognitive emotion regulation, and burnout in long-term care nursing staff: A preliminary study. *J. Appl. Gerontol.* **2019**, *38*, 92–111.
26. Shi, C.R.; Ma, H.Q.; Huang, C.; Zhang, M.H.; Ren, Z.H. Cognitive emotion regulation strategies and depressive symptoms among nurses exposed to workplace violence: A person-centered approach. *J. Ment. Health* **2021**, *30*, 541–548.
27. Office for National Statistics. Vacancies and Jobs in the UK: March 2021. Available online: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/march2021 (accessed on 8 April 2022).
28. Hussein, S. "We don't do it for the money" The scale and reasons of poverty-pay among frontline long-term care workers in England. *Health Soc. Care Community* **2017**, *25*, 1817–1826.
29. Hussein, S. Employment inequalities among British minority ethnic workers in health and social care at the time of COVID-19: A rapid review of the literature. *Soc. Policy Soc.* **2022**, *21*, 316–330.
30. National Audit Office. The Adult social care Market in England. HC 1244. National Audit Office, London. Available online: https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf (accessed on 8 April 2022).
31. Office for National Statistics. Care Homes and Estimating the Self-Funding Population, England: 2019 to 2020. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/carehomesandestimatingtheselffundingpopulationengland/2019to2020#self-funding-population-of-care-home-residents (accessed on 14 March 2022).
32. Brockmann, M.; Butt, J.; Fisher, M. The experiences of racism: Black staff in social services. *Res. Policy Plan.* **2001**, *19*, 1–10.
33. Brockmann, M. New perspectives on violence in social care. *J. Soc. Work* **2022**, *2*, 29–44.
34. Denney, D. Violence and social care staff: Positive and negative approaches to risk. *Br. J. Soc. Work* **2010**, *40*, 1297–1313.
35. Skills for Care. Violence Against Social Care and Support Staff: Summary of Research; Skills for Care: Leeds, UK, 2013.
36. Giebel, C.; Hanna, K.; Marlow, P.; Cannon, J.; Tetlow, H.; Shenton, J.; Faulkner, T.; Rajagopal, M.; Mason, S.; Gabbay, M. Guilt, tears, and burnout—Impact of UK care home restrictions on the mental well-being of staff, families, and residents. *J. Adv. Nurs.* **2022**, *78*, 2191–2202.
37. Towers, A.-M.; Collins, G. The Impact of COVID-19 on the Social Care Workforce: Interviews with Stakeholders. PSSRU Blog. Available online: https://www.pssru.ac.uk/blog/the-impact-of-covid-19-on-the-social-care-workforce-interviews-with-stakeholders/ (accessed on 15 December 2021).
38. Koritsas, S.; Coles, J.; Boyle, M. Workplace violence towards social workers: The Australian experience. *Br. J. Soc. Work* **2010**, *40*, 257–271.
39. Littlechild, B. The nature and effects of violence against child-protection social workers: Providing effective support. *Br. J. Soc. Work* **2005**, *35*, 387–401.
40. Newhill, C.; Wexler, S. Client violence toward children and youth services social workers. *Child. Youth Serv. Rev.* **1997**, *19*, 195–212.
41. Norris, D.; Kedward, C. *Violence Against Social Workers*; Jessica Kingsley: London, UK, 1990.
42. Schat, A.; Kelloway, E. Workplace aggression. In *Handbook of Work Stress*; Barling, J., Kelloway, K., Frone, M., Eds.; Sage Publications: Thousand Oaks, CA, USA, 2005; pp. 189–218.
43. Small, T. Verbal abuse in home care. *Home Healthc. Now* **2021**, *39*, 53.
44. Keogh, P.; Byrne, C. Crisis, Concern and Complacency: A Study on the Extent, Impact and Management of Workplace Violence and Assault on Social Care Workers; Social Care Ireland: Dublin, Ireland, 2016.
45. Leather, P.; Beale, D.; Lawrence, C.; Dickson, R. Effects of exposure to occupational violence and the mediating impact of fear. *Work Stress* **1997**, *11*, 329–340.
46. Maffett, A.J.; Paull, D.N.; Skeel, R.L.; Kraysovic, J.N.; Hatch, B.; O'Mahony, S.; Gerhart, J.I. Emotion Dysregulation and Workplace Satisfaction in Direct Care Worker Burnout and Abuse Risk. *J. Am. Med. Dir. Assoc.* **2022**, *23*, 1257–1261.
47. Maleki, M.; Mardani, A.; Vaismoradi, M. Insecure Employment Contracts during the COVID-19 Pandemic and the Need for Participation in Policy Making. *Int. J. Environ. Res. Public Health* **2021**, *18*, 12548. https://doi.org/10.3390/ijerph182312548.
48. QSR International Pty Ltd. NVivo (Version 12). Available online: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home (accessed on 22 January 2022).
49. StataCorp. *Stata Statistical Software: Release 15*; StataCorp LLC: College Station, TX, USA, 2017.
50. Tabachnick, B.; Fidell, L. *Using Multivariate Statistics*, 6th ed.; Pearson Education, Inc: Boston, MA, USA.
51. Shields, M.; Price, S. The determinants of racial harassment at the workplace: Evidence from the British nursing profession. *Br. J. Ind. Relat.* **2002**, *40*, 1–21.
52. Sims, S.; Harris, R.; Hussein, S.; Rafferty, A.M.; Desai, A.; Palmer, S.; Brearley, S.; Adams, R.; Rees, L.; Fitzpatrick, J.M. Social distancing and isolation strategies to prevent and control the transmission of COVID-19 and other infectious diseases in care homes for older people: An international review. *Int. J. Environ. Res. Public Health* **2022**, *19*, 3450.
53. Skills for Care. Research on Abuse and Violence against the Social Care Workforce: Focus on Personal Assistants; Skills for Care: Leeds, UK, 2014.
54. Simmons, C.; Rodrigues, R.; Szebehely, M. Working conditions in the long-term care sector: A comparative study of migrant and native workers in Austria and Sweden. *Health Soc. Care Community* **2021**, 1–12. https://doi.org/10.1111/hsc.13657.

55. Schubert, M.; Ludwig, J.; Freiberg, A.; Hahne, T.M.; Romero Starke, K.; Girbig, M.; Faller, G.; Apfelbacher, C.; von dem Knesebeck, O.; Seidler, A. Stigmatization from Work-Related COVID-19 Exposure: A Systematic Review with Meta-Analysis. *Int. J. Environ. Res. Public Health* **2021**, *18*, 6183. https://doi.org/10.3390/ijerph18126183.
56. Hussein, S. Job demand, control and unresolved stress within the emotional work of long-term care in England. *Int. J. Care Caring* **2018**, *2*, 89–107.
57. Samuel, M. *Most Social Workers Happy in Role Despite Unpaid Overtime, Cuts and COVID Mental Health Toll*; Community Care: London, UK. Available online: https://www.communitycare.co.uk/2022/03/09/most-social-workers-happy-in-role-despite-unpaid-overtime-cuts-and-covid-mental-health-toll/ (accessed on 1 April 2022).
58. House of Commons, Health and Social Care Committee. Expert Panel: Evaluation of Government's Commitments in the Area of the Health and Social Care Workforce in England. Parliamentary Copyright House of Commons 2022. Available online: https://committees.parliament.uk/publications/23245/documents/169703/default/ (accessed on 29 July 2022).