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"You close the door, wipe your sadness and put on a smiling face": a qualitative study of the emotional labour of healthcare professionals providing palliative care in nursing homes in France

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Abstract

Background Palliative care provided to frail and dying older persons in nursing homes results in intense emotions for residents and their relatives as well as for healthcare professionals. In France, scant attention has been given to how nursing home professionals manage their emotions when providing palliative care. This study analysed the emotional demands of providing palliative care in the nursing home context, the emotional strategies used by healthcare professionals to navigate such demands, and how these demands affect their emotional wellbeing.

Methods This qualitative study used a multiple case study approach. We purposively selected nine nursing homes from three geographical provinces in France with diverse ownership statuses (public, private, associative). Individual interviews and focus group discussions were held with 93 healthcare professionals from various occupational groups employed in the participating nursing homes. Data was collected from April 2021 to September 2022 and was analysed using thematic content analysis.

Results Data revealed that providing palliative care to dying residents within the nursing home context results in intertwined rewarding and exhausting emotional experiences for healthcare professionals. Professionals have to utilize multifaceted emotional strategies to navigate these experiences, including suppressing and modifying emotions and distancing themselves emotionally from residents to protect themselves from emotional suffering. Participants noted a lack of formal space to express emotions. Unrecognized emotional labour undermines the wellbeing of healthcare professionals in nursing homes, whereas acknowledging emotions enhances satisfaction and gives enhanced meaning to their crucial role in resident care.

Conclusion Acknowledging emotional labour as an inevitable component of providing palliative care in nursing homes is critical to supporting healthcare professional wellbeing, resilience, and retention, which may ultimately improve the quality of care for dying residents. Ensuring quality care and supporting the emotional wellbeing of

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nursing home professionals requires an organisational culture that considers emotional expression a collective strength-building resource rather than an individual responsibility, in hopes of shaping a new culture that fully acknowledges their humanity alongside their professional skills.

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Keywords Nursing home, Emotional labour, Staff wellbeing, Palliative care, End-of-life care, Emotional labour strategies, Healthy environment, Healthcare professionals

Background

The steady increase in the number of older persons affected by multiple and complex health needs has led to a growing number of nursing home (NH) residents worldwide spending their final moments of life and dying within these settings [1]. In turn, this trend has generated heightened attention for the necessity of integrating palliative care within the NH, an approach that has not traditionally been an area of focus [2–4].

The core philosophy and values of the NH are to provide a home-like environment for residents. When residents require palliative and end-of-life care, the focus shifts from supporting quality living to facilitating quality dying [5]. Such a shift is accompanied by intense emotions for residents, their relatives, and NH professionals who have had intimate interactions with residents and built strong ties and long-lasting relationships with them during the extended caregiving process. The process becomes even more emotionally laden for professionals, as they often see themselves as holding a professional caring role while also taking on the emotional work of a family member role [6]. When confronted with providing quality living while simultaneously supporting quality dying [5], NH professionals have to perform significant emotional labour to provide quality care and preserve the professional-resident therapeutic relationship, all the while maintaining their own health and emotional wellbeing [7].

In France, as in many other countries, the provision of palliative care in NHs relies heavily on a multidisciplinary staff mainly composed of nursing assistants, personal support workers, registered nurses, and other regulated professionals, under the supervision of a medical coordinator. A medical coordinator in the French nursing home context is a physician, generally with geriatric competences, who has an overall coordination and medical advisory role for nursing home and external provider team for enhanced quality care. Moreover, as elsewhere, NHs in France suffer significant staff shortages due to professional fatigue, burnout, and professional turnover [8]. The recent COVID-19 pandemic has worsened the situation in NHs, with increased COVID-19-related deaths, augmented workloads, expanded isolation, and added psychological burden among care workers [9, 10]. There is a pressing need for NH organisations to acknowledge the emotional labour endured by healthcare professionals during the caregiving process, particularly when it involves providing palliative and end-of-life care to residents.

Current evidence has demonstrated a strong link between burnout, job satisfaction, performance, staff retention, and attrition and the emotional labour of caring [11, 12]. When healthcare professionals have to suppress or modify their emotions, they experience dissonance between feelings and performance, which in the long term can result in emotional distress, burnout, and intention to leave the profession [12, 13]. Other studies have noted that when emotions are freely expressed and supported, they may have a positive impact on professional-patient interpersonal relationships, staff member wellbeing, and the quality of patient care [14]. However, most studies that have explored the emotional labour involved in providing palliative care have focused on hospital, hospice, or palliative care unit settings. Rarely have these studies been conducted in NH contexts. In fact, the physical labor associated with caring in NHs and the economic aspects of the work, such as wages and scheduling, receive more attention than does emotional labour [15]. In addition, emotional intelligence is an expected competency of healthcare professionals, particularly an individual's ability to manage their own emotions to the point that failing to do so is viewed as an individual weakness and professional failure [16]. Yet, it has been documented that the effectiveness of emotional labour depends on various factors, including the nature of the service and the organisational culture [13]. This requires situated knowledge to better understand the emotional work performed by healthcare professionals in specific contexts, such as NHs.

Emotional labour in palliative care and in nursing homes

Emotional labour has been defined as the process through which healthcare professionals suppress or change their feelings to align with organisational rules and guidelines while still conveying to others a sense of being cared for [17]. Emotional labour involves three strategies: surface acting, deep acting, and displaying genuine emotions [18]. Surface acting entails suppressing or hiding felt emotions or faking unfelt emotions to alter outwards expression. Deep acting entails a conscious attempt to modify inner feelings and felt emotions to match expected emotions [18, 19]. Displaying genuine emotions entails the expression of natural emotions that are congruent with felt feelings without any adjustment [18]. In this study, we conceptualize emotional labour as the efforts deployed by healthcare professionals to manage their emotions when providing palliative care to NH residents.

Nurse scholars have expanded the concept of emotional labour to nursing, emphasizing the emotional component and the demand associated with caring in nursing [19]. Nurses perform emotional labour when they have to induce or suppress their feelings to align them with what is expected by their institutions to make patients feel cared for and safe, irrespective of their own actual feelings [20, 21]. For example, when nurses are confronted with death but feel unable to facilitate a 'good death', they may have complex feelings of guilt and anger but may have to suppress these feelings to continue attending to patients and their relatives [22, 23].

Emotions are inherently linked to caring, as they are essential to the development of effective and meaningful relationships with patients, their relatives, and other professionals [24]. Studies that have explored the emotional labour associated with providing palliative care highlight the complexities of the emotionally demanding experiences healthcare professionals encounter in their practice [6, 23]. The cumulative emotional effects of grief and sadness experienced by NH professionals attending to dying individuals require them to deploy significant effort to balance the demands of the healthcare organization, the emotional needs of others, and their own wellbeing [23].

The limited available literature on emotional labour in NHs illuminates the critical influence that the physical and social environments of NHs have on shaping care providers' emotional experiences of caring for dying residents [7]. Caring for ill, disoriented residents with aggressive behaviours as well as dying residents in their last stages of life requires NH professionals to regulate their emotions, often masking their true feelings to prioritize the emotional needs of residents and their families above their own [6, 15]. Additionally, ethical and moral concerns that professionals face during end-of-life-care provision, such as preserving residents' dignity, engaging in end-of-life conversations, respecting end-of-life preferences, life-prolonging treatment or treatment withdrawal, likely play a role in emotional regulation and strategies undertaken by professionals [23, 25]. All these may affect healthcare professionals' capacity to interact effectively with residents and co-workers, nurture their sense of self, and provide optimal care [7, 22]. However, it is important to note that the regulation of emotions may also produce positive effects, such as facilitating caring and forming the bonds necessary to foster a home-like NH environment [5, 15].

Despite the crucial role that emotions play in providing care in NHs, the emotional labour undertaken by NH care professionals remains an invisible aspect of job requirements [15]. Notwithstanding the critical role that healthcare professionals play in supporting quality living and quality dying for residents in the French NH context, little is known about how they manage their emotions amidst the complex situations they encounter in their practice or how they continue to provide care without jeopardizing their own emotional wellbeing. This study aimed to help fill this gap in the research by (1) analysing the emotional dimensions of providing palliative care in the NH context as well as the strategies used by healthcare professionals to manage the emotional aspects of caring for dying residents and (2) exploring the effects of emotional labour on NH professionals' wellbeing. To this end, this study sought to answer the following research questions: (1) How do NH professionals manage the emotional demands of caring for residents requiring palliative care? (2) What effects do emotional demands have on professional-resident interactions and the emotional wellbeing of NH professionals? This study's findings will inform NH management on strategies and interventions to not only reduce the emotional exhaustion and burnout of healthcare professionals but also improve their resilience and wellbeing at work, ensuring that they are best equipped to provide optimal care to residents and their relatives.

Methods

Study overview and design

The findings presented in this manuscript originate from a broader implementation study that evaluated the effectiveness of a timely and integrated palliative care approach in 21 NH facilities in France. The initial study used a mixed-method [26] approach and was segmented into three phases: pre-implementation, implementation, and post-implementation. The current manuscript reports materials from the pre-implementation phase. A detailed methodological description of the broader study has been reported elsewhere [27]. The qualitative component of the study follows a multiple case study approach [28]. Among the aims of the qualitative study were to explore NH professionals' experiences and quality of life at work and to understand how they navigate the emotional demands associated with providing palliative care to residents.

Participants and settings

This manuscript presents qualitative findings from nine out of the 21 NHs that participated in the broader study.

The nine NHs were purposively selected to ensure a balanced sample of three NHs per geographical region (Iles de France, Nouvelle Aquitaine, Provence-Alpes-Côte d'Azur) as well as diversity in terms of ownership status (public, private, and private non-profit).

For this study, we purposively included healthcare professionals from various occupational groups employed on a fixed contract in the selected NHs. Participants had to have a minimum of five months of experience and had experience providing palliative care to residents in the same NH. Casual and non-fixed contractual professionals were excluded from the study.

Data collection

A combination of focus group discussions and individual in-depth interviews was used to collect data. This was to achieve an enhanced understanding of the phenomenon of emotional labour within a NH context by exploring views at individual and social contexts [29]. Nine focus group discussions were conducted with various healthcare professionals who provide direct care to residents. Each focus group was composed of seven to eleven professionals. Given the purpose of the study which was to explore how different professionals navigate the emotional demands of providing palliative care within a NH context, group composition brought together all professionals involved at varying degrees in providing such a type of care. However, to allow participants to share their experiences freely and to avoid any status distinction or hierarchical influence [30], professionals in the managerial roles were not included in the focus groups. They were involved in individual interviews.

Prior to data collection, a meeting was organized at each participating NH to introduce the broader interventional study to professionals and invite them to take part in the study. The focus group sessions were held at a predetermined location within the NH at a time convenient to the participants and facility and lasted between 90 and 120 min. Individual in-depth interviews were conducted with the supervisory teams, namely the nurse coordinators and medical coordinators. Each individual interview lasted approximately 45 min and was held at a time and place convenient to participants. We used the interview guide developed by the researchers for the purpose of this study (supplementary material 1). The same interview guide was used for individual and focus group discussions, with slights changes on the phrasing of questions for interviews with the management team. Focus group and individual interview questions inquired about experiences of providing palliative and end-of-life care to residents, the emotional dimensions associated with such a type of care, how professionals navigate those experiences and the perceived consequences on professional wellbeing. Examples of questions included the following: How would you describe your experience of caring for dying residents in NHs? What are the emotional aspects of providing palliative care to residents, and how do you navigate those experiences? The last author conducted most of the individual interviews and some focus group discussions, while a trained research assistant under the supervision of the last author moderated the remaining focus groups. Both hold PhD degrees and have experience in conducting qualitative interviews for health research. All interviews and focus group discussions were conducted from April 2021 to September 2022. The interviews were audio-recorded after the participants granted permission. Regular field notes were written immediately after interviews and focus groups. Data collection continued until we have gained adequate and in-depth understanding [31] of emotional experiences of providing palliative care in NH.

Data analysis

Thematic content analysis following the analytical approach of Paillé and Mucchielli [32] guided the analysis. The level of analysis was a NH, with each NH considered a case. After verbatim transcription of all the data from the nine cases, two authors (BU & DL) became acquainted with the data by rereading the transcribed interviews, examining participants' narratives from each case separately, and then developed a list of codes. From the code list, they created a thematization journal using code subdivision, integration, and hieararchization [32]. Next, the same two authors grouped related codes from all the cases, with a third team member (BE) resolving any discrepancies between the previous analysts. At the end of this stage, a thematic tree of three themes and eight subthemes was constructed. *NVivo 14* software assisted with data management and facilitated the coding process.

Rigor

To ensure methodological rigor, the authors used the recommended strategies for trustworthiness of qualitative data [33]. To ensure the reliability of the findings, two analysts completed the coding of transcripts, organized peer debriefing meetings throughout the analysis, and kept a reflexive journal recording all the steps taken and decisions made. A third analyst resolved any disagreements through consensus. To ensure credibility of findings, the authors triangulated methods (individual in-depth interviews and focus groups) and collected participant perspectives from various healthcare professions (nurses, nurse assistants, personal support workers, psychologists, occupational therapists, physiotherapists, medical doctors). The writing of the manuscript followed the "consolidated criteria for reporting qualitative research (COREQ)" [34] (Supplementary material 2).

Ethical considerations

The French Committee of Protection of Person (CPP) granted ethical approval for this study (Approval number: 2020.09.06 bis_20.07.31.64318). All focus groups and interviews respected the rights of participants to choose to participate in the study through informed consent. To ensure confidentiality and anonymity of the collected data, the reporting used codes instead of names.

Findings

Demographic characteristics of participants

All NH professionals who met the inclusion criteria and who were available on the day of the focus group were included in the study. In total, 93 professionals participated, including 79 participants in nine focus groups and 14 participants in individual interviews. Tables 1 and 2 provide the detailed characteristics of the settings and demographic characteristics of participants.

Quotes from individual interviews are followed by an acronym designating the profession of the participant (for example NC for Nurse Coordinator, MedCo for Medical Coordinator) as well as the code number of the NH. Quotes from focus groups are designated by the acronym FG, followed by an acronym for the location of the NH (IDF for Ile de France, NA for Nouvelle Aquitaine, PACA for Provence-Alpes-Côte d'Azur), and the code number of the NH.

Analysis of participants' narratives revealed three overarching themes related to the emotional dimensions of providing palliative care in NHs: (1) intertwined emotionally rewarding and challenging experiences; (2) multifaceted emotional strategies; and (3) switching between emotional engagement, detachment and exhaustion. Supplementary material 3 illustrates the generation of themes and subthemes with illustrative quotes.

Theme 1. Intertwined emotionally rewarding and challenging experiences

Participants' narratives revealed two intertwined and simultaneous emotional dimensions of providing palliative care to dying residents in NHs: (1) emotionally rewarding experiences and (2) emotionally challenging experiences. The emotionally rewarding dimension of the experiences was supported by the individual professionals' intrinsic commitment, devotion, and engagement with older persons under their care and a professional duty to provide them with the "best possible care" they deserve. On the other hand, the NH context as a place of living and of care, with its organisational constraints, rendered the experience of providing palliative care to residents emotionally challenging. Specifically, it hindered the care providers' ability to facilitate what they perceived to be a "dignified death," leaving them with feelings of distress, frustration, guilt, and uselessness.

Table 1 Characteristics of the nursing homes and participants

Nursing home characteristics					**FG Participants**					**Interview Participants**		
Code	**Location**	**Bed capacity**	**Area**	**Ownership**	**RN**	**NA**	**PSW**	**Other**	**Total**	**NC**	**MedCo**	**Total**
111	IDF	125	Urban	Private non-profit	2	3	3	1	**9**	1	1	**2**
116		106	Urban	Private non-profit	1	2	6	2	**11**	1	1	**2**
117		108	Urban	Public	2	4	3		**9**	1	1	**2**
751	NA	101	Rural	Private	3	5			**8**	1		**1**
753		204	Rural	Public	2	4		1	**7**	1	1	**2**
755		98	Rural	Private	2	2	3	2	**9**	1		**1**
931	PACA	80	Urban	Private non-profit	1	2	3	2	**8**	1		**1**
933		104	Rural	Public	2	4	2	2	**10**	1		**1**
935		90	Rural	Private non-profit	1	6		1	**8**	1	1	**2**
					16	**32**	**20**	**11**	**79**	**9**	**5**	**14**

RN Registered Nurse, *NA* Nursing Assistant, *NC* Nurse Coordinator, *MedCo* Medical Coordinator, *PSW* Personal Support Worker, *Other* Psychologist, Occupational therapist, *IDF* Iles de France, *NA* Nouvelle Aquitaine, *PACA* Provence-Alpes-Côte d'Azur

Table 2 Participant demographic characteristics

Interviews	Variables	Categories	Count
Individuals in-depth interviews (*N* = 14)	Age (Years)	18–25	2
		26–35	2
		36–45	4
		46–50	2
		> 50	4
	Gender	Female	12
		Male	2
	Professional experience (In Years)	< 3	2
		3–5	2
		6–10	4
		> 10	6
Focus group (*N* = 79)	Age (Years)	18–25	5
		26–35	15
		36–45	21
		46–50	11
		> 50	27
	Gender	Female	70
		Male	9
	Professional experience (In Years)	< 3	12
		3–5	22
		6–10	19
		> 10	26

Caring for dying residents: emotionally rewarding experiences

Numerous participants described working in NH as a deliberate professional choice and vocation, stemming from their sense of commitment and engagement to offer dependant older people the care they deserve. The relational dimension associated with caring for NH residents gives meaning to their work and becomes a source of pleasure, satisfaction, and self-worth, as illustrated by the following registered nurse:

> *"Helping older persons is my passion. I find that there is less invasive care in NHs, and there is a relationship that develops and that I enjoy" (NC, NA, 751).*

For the majority of healthcare professionals, this deliberate choice to work in NHs implies that confronting death on an ongoing basis is a professional responsibility. Despite the emotional challenges that come with multiple exposures to death, the participants affirmed their commitment to confront death as part of caring for residents. They held the belief that dying is part of living and that accompanying death is a normal process that comes with caring for the living. The devotion to accompanying residents until the end was perceived by NH professionals as a rewarding experience when they felt they had fulfilled their responsibility of facilitating a dignified death:

> *"It feels so rewarding to see a resident dying the way they should: with dignity, respect, free of pain and with the best possible comfort. That is what we are here for" (FG, PACA, 935).*

Although death is considered an expected life trajectory in NHs, participants recognized that dying older persons are often overlooked as a category of the population requiring adequate palliative care. Their perceived duty to accompany residents until the end demonstrates their commitment to ensuring that dying residents experience comfort and dignity equal to that experienced by individuals dying in settings outside the NH.

Similarly, for some residents, NH professionals are the sole individuals they can bond with at a human level and who can meet their diverse emotional needs. Participants believed their role goes beyond that of care providers. Their drive to go above and beyond and make a difference in the end-of-life trajectory of residents becomes a rewarding experience that provides a sense of pride and self-worth. The NH professionals expressed feeling honoured to be the ones to accompany residents in that ultimate moment, even if it means forgetting themselves:

> *"Aging comes with many losses and emotional needs: most of them do not want to be here [in the NH]; they feel abandoned by their families, they lose their autonomy over things they used to do, they need to feel cared for. Being there for them through the most important moments of their stay here is very rewarding to us. Basically, in the first place, if they are put here, it is so they do not die alone" (FG, PACA, 931).*
>
> *"It's truly a phase full of emotions where everything comes out: their past traumas, their anxiety, their worries. We try to hold it together, to forget ourselves a little so we can give them what they deserve…" (FG, NA, 755).*

Participants' accounts bring to the forefront that despite the emotionally laden experience of providing palliative care in an NH context, their commitment and determination to accompany residents in their last living moments make this experience emotionally rewarding.

A living and dying space: emotionally challenging experience

Narratives from healthcare professionals emphasized the context of the NH as being initially designed to serve as a living space. Such a home-like living environment that progressively becomes a place of care and ultimately a place of dying leads to the development of close bonds between NH professionals and residents for an extended period. The emotional and physical closeness formed with residents during their stay transcends the caregiver-resident therapeutic relationship. Healthcare professionals have to navigate these different aspects of the NH and remain professional caregivers, all the while providing a home-like environment. One participant explained:

> *"I'm here from 8am to 8 pm; we live with them [residents]. I do not call some of them by their names anymore. I call them grandpa, grandma. By living with and caring for them for an extended period, they end up becoming like family. When they die, it breaks our hearts" (FG, PACA, 931).*

Boundary-setting issues such as these make the relational dimension of care especially difficult, as NH professionals can become too close to residents, which naturally complicates the transition to end-of-life care. Accompanying death for older persons who they have accompanied for living represented a challenging transition for participants who considered residents like their own relatives, as expressed by the following medical coordinator:

> *"They're not just people we care for; we live with them. These are the people for whom we've fought for every minute to make life worth living. Professionals look after them almost as if they were their parents. Accompanying someone who is going to die, while you have accompanied them so they can live, is in itself emotionally hard" (MedCo, IDF, 116).*

Their strong emotional bond with residents became a challenge for NH professionals when discussing the residents' end-of-life preferences and the palliative decisions that needed to be made in preparation for the end-of-life care plan. Many shared avoiding these discussions, even when residents prompted them, as they did not feel ready to engage in such emotionally charged conversations.

> *"Palliative care supposes that we should help them think about their death, but we are unable to do that. We are primarily a place of life, and at the end, there is always death. That's the complexity of [providing] palliative care in NHs" (NC, NA, 753).*

The experience of providing palliative care in NHs was also challenged by structural and organisational constraints such as heavy workloads, a lack of time, and unmanaged pain. As a result, some participants reported that they were unable to provide dying residents with the required relief, which caused NH professionals lingering regret even after the death of the resident.

> *"That resident who died last week, I would have wished to have been able to stay with them a little longer, hold their hand, put on some music, so that there is a presence, like putting life into the end of life. Unfortunately, I was not able to free myself. And it is difficult to live with such a feeling" (FG, IDF, 116).*

Theme 2. Multifaceted emotional strategies

When asked how they cope with the emotional demands of providing palliative care to residents, participants highlighted a diversity of emotional strategies they deployed to protect themselves and to continue fulfilling their caring roles. These ranged from genuinely expressing their emotions to modifying and suppressing their emotions to fit the moment. Modification and suppression of emotions were cited as the most commonly used strategies as opposed to the authentic expression of emotions.

"We shed tears", "We've laughed with": genuine display of emotions

Participants used expressions such as *"We cry with"*, *"We've shed tears"*, *"We've laughed with"* to convey the authentic emotional strategies put in place. They genuinely expressed their emotions in situations when they felt a deep connection with residents. Most of these genuine emotional strategies occurred in the moments approaching death or following death.

> *"All the residents on the floor are like my family. Last time I went to see Mrs. B, when my colleague told me she was dead, I was shocked, truly shocked. It was quick. I cried all my tears. I was so sad. I was unable to continue work because I was crying" (FG, IDF, 111).*

In some situations, the NH professional's personal history prompted the authentic expression of feelings. For example, if a resident's death mirrored the death of their own loved ones, it made it difficult for them to conceal their true feelings as they usually do. Some referred to it as not being able to pretend to have no feelings.

> *"I accompanied my dying father in palliative care. Every time there is a death of a resident, it echoes my father's. We had a resident death not long ago. When I saw him, I completely broke down. I cannot pretend anymore" (FG, IDF, 117).*

The authenticity of emotions also manifested through allowing oneself time to grieve the death of a resident. A participant discussed requesting a day off to grieve, but some NHs also provided space for grieving the deceased residents.

> *"I was truly attached to Mr G. When he died, I took a day off. Everyone else [colleagues] continued liv-*

> *ing their life… laughing. For me, I could not come to work because I was grieving his death" (FG, IDF, 116).*

Other participants also recognized a need for the authentic expression of emotions and requested emotional management support for the team.

> *"For a resident we'd known for a long time to whom we were very attached, we felt helpless with her end-of-life care, and so we genuinely asked for help. We held a round table…, and we asked for help from an external person" (FG, NA, 751).*

While some participants expressed their genuine feelings, many participants across focus groups were in favour of emotions being unnoticed and noted a lack of formalized organisational strategies to deal with emotions. Many NH professionals admitted to frequently modifying their feelings to display emotions that are "acceptable."

"You wipe your sadness and put a smile on your face": modification of displayed emotions

Some NH professionals described their emotional work as involving frequent switching between sadness and joy to respond to the needs of the moment. Many shared trying to display emotions that were not what they truly felt because the situation at hand required them to convey different, often contradictory emotions; for the participants, this constituted difficult emotional labour.

> *"On one hand, you've got one person who is dying and next to them residents who are living. It is very difficult because you have to go into the room [and] take care of someone who is dying. You are sad because you know you will not see that person again. Nevertheless, the moment you see this person for a few minutes, you have to close the door, wipe your sadness, and put a smile on your face to accompany the next-door resident with a serene face. It is difficult to manage all these emotions at the same time. In one day, you have to give contradictory feelings. You are sad for one person, but at the same time, you have to bring joy to the other resident. You have to show them a different face, and that is not easy" (FG, IDF, 117).*

The modification of emotions was compounded in the NH environment for some participants who not only adopted an expression in accordance with what was expected but also tried to set limits and find the appropriate time and space for revealing their true feelings when out of the NH. Participants described this ability to emotionally detach as protective:

> *"The moment I remove my uniform, I immediately put a different face…. When I reach home, if I have situations that have been painful, I allow myself to be restless and sad; I vent my true feelings…" (FG, PACA, 933).*

"You become numb and move on": suppression of feelings

Participants discussed the organisational expectation to suppress emotions in order to continue providing effective care. In a quest to fit into institutional norms, many NH professionals who describe themselves as normally prone to showing their emotions had to learn to suppress them.

> *"By nature, I am a very sensitive person, but now I keep all my emotions inside of me, and at the end, it becomes difficult to unload. Here, it is not common to open up and show emotions or talk about them. We are expected to keep it to ourselves and move on" (FG, PACA, 933).*

Multiple exposures to death and a lack of time and a safe space to grieve deceased residents forced NH professionals to suppress their feelings in an attempt to cope with the distress and to continue providing care to residents.

> *"How can you display feelings when you have four successive deaths? You become numb and move on. Tomorrow you will have another one. You pretend as if everything is fine but there is a problem…" (FG, IDF, 117).*

Theme 3. Switching between emotional engagement, detachment and exhaustion

Participants reported that the emotional labour of providing palliative care in NHs results in both negative and positive consequences. The majority of NH professionals noted that the negative consequences of emotional labour resulted in an inability to provide effective care, and the lack of supportive space to express their feelings caused emotional distress, feelings of guilt, and a sense of failure and powerlessness. Some participants accepted emotions as essential to their caring role and mentioned that they give meaning to their work.

"Everyone was satisfied": enhanced satisfaction and meaning of work

Only a few NHs involved in the study had formalized procedures in place to support the emotional wellbeing of their healthcare professionals. These procedures included formal debriefs, a consultation with a psychologist, and massage therapy. In the majority of the NHs, informal peer-to-peer support was mentioned. In settings where emotions are acknowledged and supported, both professionals and managers reported increased satisfaction when accompanying dying residents.

> *"We had a resident to whom the team was so emotionally involved. When the end was approaching, emotions were high for both professionals and the resident. We [the supervisory team] requested the intervention of the external palliative care team to introduce a third party in the relationship and gently distance the team without completely disengaging them. At the end, everyone was satisfied, and the resident was properly accompanied. It ended up being one of the memorable end-of-life care for the staff" (NC, NA, 751).*

When participants believed that they gave their best up to the end and that the outcome was a peaceful death, they gained a sense of pride and accomplishment. They felt they had attained their mission, which, for many, was one of the reasons they remained working in the NH despite the stressful environment.

> *"On his passing, the resident was so peaceful, so were relatives. It was a real sense of satisfaction. It is the kind of end-of-life care where you feel you have done the right care and that gives you motivation to stay" (FG, NA, 753).*

"It is heart-breaking": a sense of guilt and powerlessness

Suppression or modification of emotions affected the wellbeing of participants as well as the care they provided to residents. Different constraints such as time pressure and competing tasks added to their frustration. Their emotional distress manifested itself as constant feelings of guilt, powerlessness, and a sense of failure for not providing adequate care to residents. One of the most common sources of guilty feelings was when the NH professionals believed that they were unable to offer a peaceful, quality presence during end-of-life moments and that the resident died alone. Dying alone was considered inhumane by participants, as they believed that residents were placed in NHs mainly to ensure they do not die alone.

> *"Very often you tell yourself, 'Well, I could have been by her side, tell her a comforting word, play the music she loved, rub her forehands, make sure she had a presence…, but no, she is gone and all alone.' It is not human at all, and you carry this with you for long" (FG, PACA, 933).*

Participants also expressed feeling powerless when they saw residents in pain and discomfort, and their inability to provide the required comfort to the dying residents left them with an immense sense of failure and uselessness, which negatively affected their wellbeing and their satisfaction with the work done.

> *"It breaks your heart to see people suffering like this and little is done about it. It's heart-breaking to think, 'We are here to help them, but in fact we're not even doing that.' We are useless" (FG, NA, 755).*

"You finally give up": distancing and exhaustion

To protect themselves from the distress associated with multiple exposures to death and a lack of institutional support, some participants admitted that they banalized death to emotionally distance themselves from dying residents, a strategy that the NH professionals recognized as inadequate.

> *"We give, we give, one day we can't take it anymore and we banalize death. We don't see death anymore. It does not affect us any longer, it becomes a commonplace gesture, mundane. Someone dies today; you attend to the next person who will be gone tomorrow, and so forth and so on. You keep accumulating and one day you explode" (FG, IDF, 117).*

Other NH professionals adopted a superficial attitude in an attempt to distance themselves and detach themselves from their true feelings. They chose to involve themselves less in the therapeutic relationship by concentrating more on carrying out instrumental and technical care and less on offering a caring and relational presence.

> *"I go in [the room], I give the injection and I get out. Not because I do not want to stay, but because I am thinking of the others. I cannot stay with the one who is dying while I have 70 others who are still alive. I have to look after those who are not dying" (NC, PACA, 935).*

Some participants dealt with emotionally challenging situations by refusing to accept the palliative care plan of residents with whom they had strong ties. They would ignore the team's decisions when it involved withdrawing feeding and restricting movement and instead provide the usual care such as taking blood pressure, providing hydration, and mobilizing residents, irrespective of the futile outcome or the risk of causing more suffering. In this way, they felt more useful towards the residents.

> *"We had a staff meeting, and they said Mrs X was in end-of-life care…that we should avoid mobilizing her and emphasize comfort care. When I arrived in the room, I did not do anything they said. Rather, I got her up from bed, I washed her, I dressed her, I brought the wheelchair, and I was about to take her out. When the nurse coordinator arrived, she could not understand what I was doing. I was in denial. I could not believe she was dying" (FG, IDF, 116).*

Several participants reported feeling emotionally strained, exhausted, and lacking the energy to accomplish their mission. Some of them even resigned or verbalized their intentions to resign from their posts. Their emotional exhaustion reportedly stemmed from an accumulation of frustration, discouragement and a lack of accomplishment, feeling incompetent, and a lack of support, which prompted them to resign rather than form a negative view of the residents and fail to deliver effective care.

> *"You fight, you try your best to keep going, you get discouraged and finally you give up. That is why I want to do something else. Eventually, I want to take care of people and give them what they deserve. Here, I do not give them what they deserve, which frustrates me, and I accumulate. I resigned. I would rather leave the job to someone who wants to do it the way it is done. As for me, I am going to hold onto something else. I do not want to become a bitter caregiver…." (FG, PACA, 933).*

Discussion

The findings from this study illustrate that providing palliative care to dying residents within the NH context exposes healthcare professionals to intertwined rewarding and exhausting emotional experiences. This emotionally demanding work results in a constant switching between feelings of pride and accomplishment on the one hand and guilt, distress, and grief on the other, and it prompts healthcare professionals to identify and distance themselves from the residents to protect themselves from emotional suffering. These findings lead to greater insights into how NH professionals navigate these emotionally laden situations to meet the needs of the residents and the NH as well as their own needs. Drawing from these important findings, our discussion focuses on three key insights from the study: (1) Caring for dying residents results in both emotionally rewarding and emotionally exhausting experiences, (2) NH professionals have to perform emotional labour to navigate the experiences associated with providing palliative care, and (3) Unrecognized emotional labour undermines the wellbeing of NH professionals.

Caring for dying residents results in both emotionally rewarding and emotionally exhausting experiences

Genuine interest in caring for frail older persons is at the heart of the engagement and commitment demonstrated by the participants in our study. Participants described becoming emotionally attached to residents they care for as "unavoidable and the right thing to do," especially given the expected "home-like" environment of the NH. In that sense, the affective dimension of working in NH and the internal motivation of the healthcare professionals aligned and helped them navigate the emotional labour of caring for dying residents and added meaning to their work. In line with other studies, the unique characteristics of NH, where care providers and residents engage repeatedly in deep personal and intimate exchanges for an extended time, forged closer and more trusting reciprocal relationships than are typically found within acute care setting nurse-patient interactions [35, 36].

A majority of participants recalled the emotionally rewarding experiences associated with caring for frail and dying residents. The NH professionals described accompanying residents as their professional duty and took pride in making their last days as dignified, comfortable, home-like, and respectful as possible. Moreover, accompanying residents in their final moments was considered a moral responsibility by participants. The positive experiences and feelings stemming from close and trusting relationships with residents have been recognized by previous studies as central to the emotional wellbeing of NH professionals [15]. Direct caregivers for dying residents characterize those particular moments as the rare moments they feel appreciated, noticed, and like they are making a difference in settings where they generally feel unseen [36]. In particular, our participants expressed positive emotions such as engagement, pride, accomplishment, and self-worth in situations where they felt they had achieved dignity in caring for the dying residents. This is relevant because dignity represents an essential part of caring in NHs and in palliative care [37, 38]. These personal characteristics and intrinsic motives constitute the internal resources and resilience attributes that allow healthcare professionals to cope with distressing situations surrounding accompanying death in NHs [10]. Future interventions and training should aim to reinforce the internal resources of NH professionals with a strong focus on building resilience.

Although participants perceived caring for dying residents as a rewarding experience, when the challenging working conditions within NH hindered them from achieving their moral and professional responsibility, it turned the experience into difficult emotional labour. The current NH working environment fails to provide necessary organisational resources and subsequently creates discrepancies between the ideals held by NH professionals on what constitutes the right comfort care to provide and the current practices. Under severe labour shortages, NHs prioritize technical and task-oriented activities over relational moments [39]. However, for participants in this study, not being present to hold the hands of the dying resident left them feeling guilty of failing their moral responsibility and their professional duty. Consistent with previous studies, the NH culture was found to prioritize tasks and expect healthcare professionals to be consistently "doing something" for residents versus "being" with residents [13, 40]. This dissonance creates the most difficult emotional challenges, moral concerns, and distress for NH professionals [25]. That perceived inability to facilitate a "good death" due to organisational constraints results in moral distress for NH professionals and complicates their grieving process [23, 41]. Echoing this, participants in our study shared how emotionally burdensome it was to constantly feel guilty of devoting less time to the "dying resident" because they were required to attend to the "living residents" instead. NH managers and policymakers should take measures to build a culture that enables healthcare professionals to prioritize the emotional needs of residents alongside their physical care needs, as both are equally important to end-of-life care.

Professionals have to perform emotional labour to navigate the experiences associated with providing palliative care

Participants in the current study used different emotional labour strategies to navigate the rewarding and challenging aspects of caring for dying residents in the NH context. Some adopted distancing strategies, such as focusing on task-based care and mechanical actions as well as avoiding feelings and emotional involvement, while others trivialized death or denied the impending death of residents. This process of strategy switching between engagement and detachment is prevalent among palliative care professionals as a way of coping with emotional demands and preventing grief [13, 23].

Numerous participants reported that they tended to modify their feelings by displaying emotions that were different from those they felt. For example, some noted "wiping [their] face and showing a smiley face," while others suppressed their feelings to "become numb and move on" in an attempt to display composure in the moment and comply with institutional rules. Attempting to modify one's felt emotions to match displayed emotions is known as deep acting, whereas displaying fake, unfelt emotions and suppressing one's felt emotions indicates a surface acting strategy [18]. The emotional strategies used by the participants in our study are similar to those commonly used by healthcare professionals in different care contexts [12]. Particularly in the NH context, emotional labour is intensified by the long-term therapeutic relationship, as the longer the therapeutic relationship the more complicated the emotional labour [7, 15]. Participants in our study shared that the stronger and the closer the bond with the resident, the harder it was to navigate the emotional labour associated with witnessing their suffering and providing them with end-of-life care. Debates persist on the appropriate emotional distance to take when accompanying a resident with whom the healthcare professional has formed a close bond. It is noteworthy, however, that healthcare professionals who try to convey caring while remaining emotionally detached may experience increased emotional dissonance and potentially negative effects [23]. This phenomenon resonates particularly within the NH care context, where professional boundaries are blurred and difficult to respect [6].

Some participants in this study identified the importance of safe spaces where they can freely express their emotions without faking and without feeling judged, such as spending time informally with colleagues during breaks or with relatives at home. Researchers classify this as the backstage area of emotional expression, owing to the lack of formal recognition and poor appreciation of emotional labour in practice [42, 43]. Given the complexity of emotional labour associated with providing palliative and end-of-life care in NHs, scholars recommend more strengthened, explicit, and structured backstage areas to recognize the emotional needs of healthcare professionals and support their emotional growth and resilience [43]. Unfortunately, findings from our study reiterate the inadequate support available in the NH context for their mental and emotional wellbeing.

In a few instances, some participants in our study allowed themselves to express naturally felt emotions. The close bond they had formed with residents prompted those who adopted the genuine manifestation of feelings to view the resident's death as a parallel of their own loved one's death; hence, they allowed themselves to react accordingly. Some took a leave of absence to process the grief, while others requested formal support as they struggled to come to terms with the death of the resident. Studies have shown that adopting naturally felt emotions as an emotional labour strategy can protect healthcare professionals from burnout, as it allows for authenticity and empathy expressions in care [12]. Genuine emotions have also been found to support nurses in the provision of compassionate care and to inspire cooperation from less-cooperative residents [6]. In our study, however, the absence of a formal supportive space within the NH to vent emotions discouraged the genuine expression of feelings. Even in the few NHs where opportunities for emotional sharing existed through support groups and psychologist interventions, the participants were reluctant to take advantage of these opportunities. One possible explanation could be that openly expressing emotions might be seen as a sign of weakness, incompetency, and inability to respect professional boundaries. Yet, organisational studies have shown that when grief and emotional suffering are acknowledged and collectively shared as a team, emotional distress is no longer perceived as an individual weakness but rather a collective suffering that requires collective measures to address. However, this cultural shift is only possible when it is supported by the institution through the provision of time, space, and opportunity to debrief and grieve [44].

Unrecognized emotional labour undermines the wellbeing of nursing home professionals

This study revealed that the emotions experienced by professionals receive relatively little attention within the NH context. This finding supports other studies that have highlighted the invisible nature of the emotional labour endured by healthcare professionals in end-of-life and palliative care within NHs [7, 15]. Current institutional rules reinforced by professional norms such as the self-imposed emotional strategies used by healthcare professionals implicitly discourage the open expression of emotions and position genuine displays of emotion as incompetence [6]. Considering the expression of emotions as weak and a sign of a problem to be addressed leads to emotional labour being unrecognized, professionally undervalued, and even discriminated against [24]. This is deeply problematic, as unrecognized emotional labour can lead to personal, professional, and organisational negative outcomes.

The effect of emotional labour on a healthcare professional varies depending on the frequency, intensity, diversity, and length of the needed emotional displays as well as the degree of emotional dissonance between the emotions experienced and those anticipated [14]. Evidence demonstrates that a constant mismatch between felt feelings and displayed emotions leads to emotional dissonance, an internal state of conflict that can cause healthcare professionals to experience difficulty in patient interactions, high levels of stress and burnout [12], emotional “estrangement” (p.443) [13], and increased intention to leave [45]. Consistent with these studies, participants in our study felt drained and worn out by the emotional efforts associated with caring for the dying residents. They experienced guilt and feelings of powerlessness and failure, and a significant number expressed their intention to leave the NH.

At the organisational level, studies have demonstrated that poor patient outcomes and poor quality of care, including missing care opportunities and mistreating residents, are potential negative outcomes of emotional exhaustion and unrecognized emotional labour, as well as lower levels of staff recruitment and retention [46]. In contrast, emerging evidence suggests that when institutional expectations allow and support authentic emotional expression, positive effects can result for healthcare professionals, care recipients, and the healthcare system [12, 14].

Implications for policy, practice, and research

The findings from this study expand our understanding of the complex emotional demands associated with caring for dying residents in NHs. Caring for frail older persons requires extensive time, effort, and mental and physical energy, and it involves the interplay of physical and emotional tasks and skills [13]. These findings represent a valuable contribution to the NH care system, a system that has been predominated by instrumental-focused care. The data highlights the need for a paradigm shift toward valuing the emotional labour involved in accompanying life and death in contexts that are not palliative-care specialised. Upholding quality care alongside the wellbeing of healthcare professionals requires an organisational culture that does not separate instrumental acts from the emotional labour at the very heart of the caring profession. Instead, it requires organisational changes that result in emotional support seen as a collective routine practice that strengthens the team rather than as an individual responsibility and weakness. This will allow NH professionals to regularly share their feelings and emotions, leading to emotional openness and acceptance [40].

Regular in-service training initiatives should be put in place in NHs to equip healthcare professionals with effective emotional management skills. In particular, the nursing assistants and personal support workers in our study appeared to be most affected by the negative impact of emotional labour. These categories of professional groups require tailored training to help bridge their skill gap. Capacity building approaches such as critical companionship have been proven to equip healthcare professionals with skills on the effective use of emotions in therapeutic relationships and to allow them to reflect on the use of self in caring [19]. As a lack of institutional support and peer support discourages emotional expression, NH settings should reinforce work environments in which leadership, supervisor, and co-worker support are an integral part of routine practices.

Structural deficiencies such as inadequate staffing, heavy workloads, and competing tasks leave NH healthcare professionals with inadequate time to provide optimal care. This underpins most of the challenges healthcare professionals experience in the NH context and is a primary factor in the emotional burden they experience when they fail to provide quality palliative care to dying residents. There is a need to adapt resource allocation to the complexity of providing palliative care within NHs. Further studies are needed to design interventions that support emotional regulation while increasing the resilience and emotional intelligence of healthcare professionals in NHs.

A strength of our study was the use of individual and focus groups interviews, which enabled a comprehensive exploration of individual and group views on emotional labour of NH professionals. Including professionals involved in direct care and leaders, i.e. nurse and medical coordinators, enabled to capture a diverse set of experiences and perspectives across professional categories and roles. This study did not intend to establish the levels of influence of factors such as professional category, years of work experience, level of interaction with residents or settings characteristics on emotional labour and strategies used. This may constitute the focus of future research.

Conclusion

This study brought to the forefront the complex emotional labour performed by NH professionals while caring for residents requiring palliative care. The results demonstrated that emotions are an undeniable part of caring for frail and dying older persons in the context of a home-like environment; however, current NH culture discourages genuine emotional sharing and emphasizes emotional suppression. Unrecognized emotions undermine the wellbeing of healthcare professionals, leading to negative individual and organisational outcomes. Understanding and acknowledging the emotional labour of NH professionals is critical to supporting their wellbeing, resilience, and retention, and it ultimately may improve the quality of care for dying residents. The stigma surrounding the emotional labour of caring can be broken by decision makers who design healthy workplace environments that celebrate emotional transparency as a strength as well as by each and every healthcare worker who bravely displays their genuine emotions in hopes to shape a new culture that fully acknowledges their humanity alongside their professional skills.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

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Author contributions

EB conceptualized and designed the study, collected and analysed the data, and revised the manuscript. BU analysed the data and drafted and revised the manuscript. DL analysed the data and revised the manuscript. All authors have reviewed and approved the final manuscript.

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Data availability

The datasets used in this study are available on a reasonable request from the corresponding author.

Declarations

Ethics approval and consent to participate

Research ethics approval for this study was granted by the French Committee of Protection of Person, approval number 2020.09.06 bis 20.07.31.64318. The study is registered in the National Study Database as ID-RCB 2020-A01832-37. The use of databases and data processing were implemented in accordance with French law ("Informatique et Libertés" dated January 6, 1978 and amended June 20, 2018) and European regulations (General Data Protection Regulation - GDPR dated April 27, 2016). All participants provided their informed consent in writing before their inclusion in the study. Confidentiality was ensured using codes and pseudonyms.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. Honinx E, Van den Block L, Piers R, Onwuteaka-Philipsen B, Payne S, Szczerbińska K, et al. Large differences in the organization of palliative care in nursing homes in six European countries: findings from the PACE cross-sectional study. BMC Palliat care. 2021;20:1–12.
2. Carpenter JG, Lam K, Ritter AZ, Ersek M. A systematic review of nursing home palliative care interventions: characteristics and outcomes. J Am Med Dir Assoc. 2020;21(5):583–96. e2.
3. Reitinger E, Froggatt K, Brazil K, Heimerl K, Hockley J, Kunz R, et al. Palliative care in long-term care settings for older people: findings from an EAPC taskforce. Eur J Palliat Care. 2013;20(5):251–3.
4. Froggatt K, Payne S, Morbey H, Edwards M, Finne-Soveri H, Gambassi G, et al. Palliative care development in European care homes and nursing homes: application of a typology of implementation. J Am Med Dir Assoc. 2017;18(6):550. e7-. e14.

5. Sussman T, Kaasalainen S, Mintzberg S, Sinclair S, Young L, Ploeg J, et al. Broadening end-of-life comfort to improve palliative care practices in long term care. Can J Aging/La Revue Canadienne Du Vieillissement. 2017;36(3):306–17.
6. Yan Z. I tried to control my emotions: nursing home care workers' experiences of emotional labor in China. J Cross-Cult Gerontol. 2022;37(1):1–22.
7. Giesbrecht M, Stajduhar KI, Cloutier D, Dujela C. We are to be like machines… fill the bed before it gets cold: exploring the emotional geographies of healthcare providers caring for dying residents in long-term care facilities. Soc Sci Med. 2021;272:113749.
8. Beyrie A, Douguet F, Mino J-C. Accompagner la fin de vie en maison de retraite: spécificités et limites d'un travail inestimable. ethnographiques org. 2017. (35-Vieillir en institution, vieillesses institutionnalisées. Nouvelles populations, nouveaux lieux, nouvelles pratiques).
9. Curtin M, Richards HL, Fortune DG. Resilience among health care workers while working during a pandemic: a systematic review and meta synthesis of qualitative studies. Clin Psychol Rev. 2022;95:102173.
10. Chang SO, Kim EY. The resilience of nursing staffs in nursing homes: concept development applying a hybrid model. BMC Nurs. 2022;21(1):129.
11. Yeh S-CJ, Chen S-HS, Yuan K-S, Chou W, Wan TT. Emotional labor in health care: the moderating roles of personality and the mediating role of sleep on job performance and satisfaction. Front Psychol. 2020;11:574898.
12. Kim JS. Emotional labor strategies, stress, and burnout among hospital nurses: a path analysis. J Nurs Scholarsh. 2020;52(1):105–12.
13. Hanlon N. Professional caring in affective services: the ambivalence of emotional nurture in practice. Eur J Social Work. 2023;26(3):441–53.
14. Xu Y-w. Emotional labor and job satisfaction among nurses: the mediating effect of nurse–patient relationship. Front Psychol. 2023;14:1094358.
15. Franzosa E, Tsui EK, Baron S. Who's caring for us? Understanding and addressing the effects of emotional labor on home health aides' well-being. Gerontologist. 2019;59(6):1055–64.
16. Wen J, Huang SS, Hou P. Emotional intelligence, emotional labor, perceived organizational support, and job satisfaction: a moderated mediation model. Int J Hospitality Manage. 2019;81:120–30.
17. Hochschild AR. Travail émotionnel, règles de sentiments et structure sociale 1. Travailler. 2003;1:019–49.
18. Diefendorff JM, Croyle MH, Gosserand RH. The dimensionality and antecedents of emotional labor strategies. J Vocat Behav. 2005;66(2):339–57.
19. Smith P, Gray B. Emotional labour of nursing revisited: caring and learning 2000. Nurse Educ Pract. 2001;1(1):42–9.
20. Badolamenti S, Sili A, Caruso R, FidaFida R. What do we know about emotional labour in nursing? A narrative review. Br J Nurs. 2017;26(1):48–55.
21. Gray B, Smith P. Emotional labour and the clinical settings of nursing care: the perspectives of nurses in East London. Nurse Educ Pract. 2009;9(4):253–61.
22. Ingebretsen LP, Sagbakken M. Hospice nurses' emotional challenges in their encounters with the dying. Int J Qualitative Stud Health well-being. 2016;11(1):31170.
23. Funk LM, Peters S, Roger KS. The emotional labor of personal grief in palliative care: balancing caring and professional identities. Qual Health Res. 2017;27(14):2211–21.
24. Fernández-Basanta S, Lois-Sandá L, Movilla-Fernández MJ. The link between task-focused care and care beyond technique: a meta-ethnography about the emotional labour in nursing care. J Clin Nurs. 2023;32(13–14):3130–43.
25. Wiersma E, Marcella J, McAnulty J, Kelley ML. That just breaks my heart': moral concerns of direct care workers providing palliative care in LTC homes. Can J Aging/La Revue Canadienne Du Vieillissement. 2019;38(3):268–80.
26. Guével M-R, Pommier J. Recherche par les méthodes mixtes en santé publique: Enjeux Et illustration. Santé Publique. 2012;24(1):23–38.
27. Bagaragaza E, Colombet I, Perineau M, Aegerter P, Guirimand F. Assessing the implementation and effectiveness of early integrated palliative care in long-term care facilities in France: an interventional mixed-methods study protocol. BMC Palliat care. 2023;22(1):35.
28. Yin RK. Case study research and applications. Sage Thousand Oaks, CA; 2018.
29. Lambert SD, Loiselle CG. Combining individual interviews and focus groups to enhance data richness. J Adv Nurs. 2008;62(2):228–37.
30. Patton MQ. Qualitative research & evaluation methods. 3rd ed. Thousand Oaks, CA: Sage; 2002.
31. Braun V, Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. Qualitative Res Sport Exerc Health. 2021;13(2):201–16.
32. Paillé P, Mucchielli A. L'analyse qualitative en sciences humaines et sociales-5e éd. Armand Colin; 2021.
33. Maher C, Hadfield M, Hutchings M, De Eyto A. Ensuring rigor in qualitative data analysis: a design research approach to coding combining NVivo with traditional material methods. Int J Qualitative Methods. 2018;17(1):1609406918786362.
34. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57.
35. Rodriquez J, editor. Editor it'sa dignity thing: nursing Home Care Workers' Use of emotions 1. Sociological forum. Wiley Online Library; 2011.
36. Cagle JG, Unroe KT, Bunting M, Bernard BL, Miller SC. Caring for dying patients in the nursing home: voices from frontline nursing home staff. J Pain Symptom Manag. 2017;53(2):198–207.
37. Holmberg B, Godskesen T. Dignity in Care at the End of Life in a Nursing Home: an Ethnographic Study. 2022.
38. Östlund U, Blomberg K, Söderman A, Werkander Harstäde C. How to conserve dignity in palliative care: suggestions from older patients, significant others, and healthcare professionals in Swedish municipal care. BMC Palliat care. 2019;18:1–12.
39. Herr M, Raharimanana S, Bagaragaza E, Aegerter P, Sipos I, Fabre C, et al. Evaluation de la culture de sécurité en etablissement d'Hébergement pour Personnes Agées Dépendantes (EHPAD): adaptation française du questionnaire nursing Home Survey on Patient Safety Culture. Can J Aging/La Revue Canadienne Du Vieillissement. 2017;36(4):453–62.
40. Funk LM, Peters S, Roger KS. Caring about dying persons and their families: interpretation, practice and emotional labour. Health Soc Care Commun. 2018;26(4):519–26.
41. Young A, Froggatt K, Brearley SG. Powerlessness' or 'doing the right thing'–Moral distress among nursing home staff caring for residents at the end of life: an interpretive descriptive study. Palliat Med. 2017;31(9):853–60.
42. Bolton S. Changing faces: nurses as emotional jugglers. Sociol Health Illn. 2001;23(1):85–100.
43. Slootman M, Mudde AL, The AM. Frontstage nursing and backstage growth: the emotional labour of student nurses in Dutch nursing homes. Nurs Inq. 2023;30(4):e12570.
44. Simard J. Autour de la souffrance soignante en soins palliatifs: entre idéal de Soin et juste distance 1. Frontières. 2014;26(1).
45. Bartram T, Casimir G, Djurkovic N, Leggat SG, Stanton P. Do perceived high performance work systems influence the relationship between emotional labour, burnout and intention to leave? A study of Australian nurses. J Adv Nurs. 2012;68(7):1567–78.
46. Eltaybani S, Yamamoto-Mitani N, Ninomiya A, Igarashi A. The association between nurses' burnout and objective care quality indicators: a cross-sectional survey in long-term care wards. BMC Nurs. 2021;20:1–10.

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