Social Inclusion
2026 • Volume 14 • Article 12326
https://doi.org/10.17645/si.12326

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Open Access Journal

The Winding Road to Professionalisation: Care Work in Romanian Nursing Homes

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Submitted: 3 March 2026 **Accepted:** 29 June 2026 **Published:** 29 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Across Central and Eastern Europe, the expansion of formal long-term care provision has intensified questions regarding the organisation, recognition, and professionalisation of care work. Romania offers a particularly relevant case, as the rapid growth of residential care for older persons has created new institutional spaces where care is increasingly organised as paid work. Despite the legal regulation of occupations in this field, occupational roles overlap in practice, and employers recruit a substantial share of workers without prior qualifications, while skills are acquired through short courses, peer learning, and on-the-job experience. This article examines these processes of professionalisation in Romanian nursing homes, focusing on how overlapping roles, emotional labour, and tacit knowledge shape everyday care practice. Drawing on qualitative interviews with care workers and managers in private nursing homes, the findings reveal fluid professional boundaries, with medical, non-medical, and relational responsibilities frequently overlapping. Professionalisation emerges slowly and unevenly, not through institutional reform or credentialisation alone, but through workers' everyday adaptation, informal learning, and the practical negotiation of professional roles under conditions of labour shortages and limited institutional support.

Keywords

care work; nursing homes; professionalisation; Romania

1. Introduction

Care arrangements for older people in Romania have undergone gradual transformation over the last two decades. While family care continues to dominate and remains the socially preferred model, demographic ageing, migration, changing household structures, and increasing care intensity have expanded the role of formal care provision (Hărăguș & Földes, 2026; World Bank, 2022). Among formal services, private residential facilities have grown particularly rapidly and have become an increasingly important site for organising long-term care (LTC) through salaried labour (European Commission, 2022). This expansion introduced new occupational roles and intensified recruitment and retention pressures, while bringing care work into institutional settings marked by labour shortages and weak role differentiation. Residential care remains socially ambivalent and often treated as an exceptional arrangement, reflecting the continued dominance of familial care norms (Bó et al., 2020; Dohotariu & Băluță, 2021). Despite the centrality of the care workforce to the quality and sustainability of residential provision, little is known about how care work is organised and professionalised within Romanian nursing homes.

Care work has increasingly been analysed not simply as moral obligation but a form of socially necessary labour that remains systematically undervalued despite sustaining welfare systems and social reproduction (England, 2005; Folbre, 2001). At the same time, professionalisation scholarship has moved beyond classical models centred on occupational closure and credentialing to emphasise more uneven and organisationally embedded forms of competence formation (Bellini & Maestripieri, 2023; Evetts, 2011). This shift is particularly relevant for care work, where expertise often develops under conditions of fragmented institutional support and limited occupational autonomy and extends beyond formal qualifications to include relational, emotional, and practical forms of competence (Hochschild, 2015; Mol et al., 2010). Such dimensions of care work remain difficult to formalise, measure, and translate into recognised professional status and remuneration, making care an especially productive site for examining how professionalisation takes shape in practice and under which conditions it remains partial or constrained.

Against this background, our article asks: What forms of professionalisation can be identified in care work in Romanian nursing homes, and which institutional and organisational conditions shape and constrain this process? Drawing on the concepts of professionalisation, emotional labour, and tacit knowledge, we examine how professional competence is produced, recognised, and negotiated under conditions of labour shortages, weak institutional support, and fluid occupational boundaries. Empirically, the article draws on qualitative research conducted in private nursing homes in Cluj-Napoca and its peri-urban area, combining interviews with care workers and managers to connect formal definitions of professional roles with institutional organisation and everyday care practices.

While existing literature often frames professionalisation as an organised process, we show that under-resourced settings rely on informal bottom-up negotiation, on-the-job learning, and workers' everyday adjustments, while remaining only partially recognised and rewarded. Changes toward more defined job roles are slow and arise primarily from workers' own practice, whereas managers are chiefly preoccupied with labour shortages and staff retention rather than clarifying professional boundaries. Formalised qualifications are not a precondition for hiring, and care workers routinely assume a broad range of tasks while informally negotiating their roles. As a result, professional identities are shaped less by certification than by capacities such as patience, flexibility, and emotional resilience.

Below, we first present the context and institutional background of Romania's care landscape. We then ground our work with key concepts. We subsequently detail the methodological premises of our research. Finally, the analysis section is divided into two parts to reflect care workers' and managers' differing interpretations regarding key aspects of the process.

2. The Landscape of Care for Older Persons in Romania

Care for older persons emerged relatively late on the Romanian political agenda, largely in connection with preparations for EU accession, and it has been framed in political discourse as primarily a family responsibility (Dohotariu & Băluță, 2021). Historically, Romanian family policy has been geared towards demographic objectives rather than supporting carers or building comprehensive long-term care systems for dependent adults (Inglot et al., 2022). Care for dependent older adults has consequently remained marginal within the family-policy framework, reinforcing reliance on informal, family-based provision. Informal care delivered by family members thus dominates the Romanian care landscape (Hărăguș & Földes, 2026; World Bank, 2022, p. 70), placing the country within the implicit familialism category regarding the distribution of care responsibilities between family, state, and market (Leitner, 2003; Saraceno & Keck, 2010). This familialist arrangement is underpinned by cultural norms that organise care along gendered lines, typically carried out by female family members (Bó et al., 2020; Precupetu et al., 2019). As per an unpublished finding from the CareOrg project, there is a strong preference for ageing at home with familial support. Public trust in residential care has been further eroded by recurrent quality scandals, most visibly investigative reporting in early 2023 (Buletin de București, 2023) exposing severe neglect in several privately operated centres, and the social acceptability of institutional care remains correspondingly low.

The most recent LTC strategy adopts respect for autonomy and freedom of choice—including the choice of care setting—as a guiding principle and prioritises home and community-based care together with support for informal carers and the prevention of institutionalisation. Implementation, however, has remained partial with reliance predominantly on family-based care and limited use of formal services (Hărăguș & Földes, 2026; World Bank, 2022). Romania records lower rates of home-care use than most European countries, and the overall reach of formal services remains limited, particularly in rural areas and for low-income households.

Within the formal care sector, residential facilities dominate the Romanian LTC landscape in terms of accredited providers, budgets, staff, and infrastructure. These facilities are predominantly private and tend to be small or medium-sized. The sector has expanded rapidly, driven by demand outstripping public capacity (European Commission, 2021), with private residential facilities rising from 235 in 2017 to 674 in 2026 (Ministry of Labor, Family, Youth and Social Solidarity, 2026; World Bank, 2022, p. 70), though this expansion has remained territorially uneven. Provision is governed by a uniform accreditation regime, though quality monitoring remains weak and evaluation tends to be one-sided rather than participatory (Ghența & Matei, 2024). The cost of LTC is shared between central, regional, and local authorities and the beneficiaries themselves, who pay the highest share of the costs, far exceeding average pensions. This effectively restricts access to those with substantial private resources, leaving low-income older people especially vulnerable (Hărăguș & Földes, 2026).

The decentralised structure of the system further exacerbates these inequalities. Responsibility for social services rests with local authorities, allowing flexibility but also fragmenting provision because service

capacity depends more on local budgets than on care needs (World Bank, 2022). Indicators of demographic ageing are negatively correlated with the presence of nursing homes, suggesting that areas carrying the heaviest ageing burden often have the fewest formal care resources (as per unpublished findings from the same project). Economic capacity, therefore, shapes the distribution of formal care more strongly than demographic need.

This fragmented, privately dominated, and weakly monitored residential sector, where access reflects economic capacity more than care need, provides the institutional context in which questions of who provides care, how care work is organised, and whether and how it becomes professionalised become particularly salient.

3. Care Work as Professional Category and Moral Obligation

Care work has increasingly been analysed as a central component of contemporary welfare regimes and labour markets, rather than as a private or purely moral activity. Feminist political economy has shown that care constitutes a form of socially necessary labour supporting life and social reproduction, while remaining structurally undervalued because it is historically associated with women and the family (England, 2005; Folbre, 2001). Research on the feminisation of care labour demonstrates how care occupations are devalued through their association with women's presumed natural dispositions, which contributes to segmented labour markets and precarious working conditions (Palenga-Möllenbeck, 2013). Building on this perspective, Razavi (2007) conceptualises care as being located at the intersection of state, market, family, and community arrangements, demonstrating how care regimes shape the distribution of responsibilities, labour conditions, and professional recognition. Comparative research shows that reforms such as marketisation, cash-for-care schemes, and privatisation have often prioritised cost containment and service expansion while paying limited attention to job quality, contributing to precarious care labour markets (van Hooren, 2012; van Hooren et al., 2019). Care consequently occupies an ambiguous position simultaneously as paid work and as a moral relationship, creating tensions around which forms of competence become visible, valued, and recognised as professional labour. Understanding care as work, therefore, requires attention to its material conditions and the normative expectations that frame it.

3.1. Care Work in the Process of Professionalisation

Professionalisation is commonly understood as the process through which occupations acquire recognised expertise, legitimacy, and authority over a defined domain of work. Classical sociological approaches conceptualise this process as involving the institutionalisation of specialised knowledge, the establishment of occupational boundaries, and the achievement of social recognition and professional autonomy (Abbott, 1988; Larson, 1977). Training and formal qualifications occupy a central place in this process, as they codify expertise, regulate entry, and distinguish one occupational group from another (Evetts, 2014; Tholen, 2017). Professional status, therefore, depends not only on the performance of tasks but also on the social recognition of particular forms of knowledge as legitimate, exclusive, and worthy of protection.

Early formulations conceptualise professionalisation as a professional project: a collective and strategic effort through which occupational groups translate expertise into labour market control, occupational closure, social recognition, and professional autonomy (Larson, 1977). Such approaches assume coherent pathways of

professional development supported through credentialing, boundary work, and institutional recognition. More recent scholarship has questioned whether contemporary forms of professional work follow such trajectories and distinguish between occupational professionalism—grounded in collective control over norms and practice—and organisational professionalism—shaped through managerial regulation and standardisation (Evetts, 2011). Bellini and Maestripieri (2023) emphasise heterogeneity, organisational embedding, and the diversification of pathways through which professional competence is produced and recognised, rather than assuming stable professional boundaries and coherent professional projects. From this perspective, professionalisation may unfold unevenly and remain incomplete, particularly in sectors that experience organisational instability, labour shortages, fragmented authority, and fluid occupational boundaries.

This distinction is relevant in care settings, where institutions often shape standards, role definitions, and expectations rather than occupational groups collectively negotiating them. Care occupations occupy an ambiguous position within professional hierarchies because they combine formal, relational, and practical forms of expertise that are difficult to stabilise within conventional professional categories (Wrede et al., 2008). The professionalisation of nursing home workers and home care workers is often characterised by fragmented training systems, low entry barriers, and fluid occupational boundaries (Daly & Lewis, 2000; Meagher & Szebehely, 2013). As a result, care work remains under-recognised professionally despite requiring complex competencies produced in practice.

3.2. The Value of Emotional Labour

The maintenance of low formal entry requirements and blurred occupational boundaries contributes to the classification of care work as "low-skilled" labour. Feminist sociology of work has shown that when emotional and affective labour is framed as a natural disposition, especially for women, it is excluded from what is considered professional expertise. Building on Hochschild's understanding of emotion management as central to producing "the sense of being cared for in a convivial and safe place" (Hochschild, 1983) and her later discussion of emotional surplus value, emotional engagement is not simply individual disposition but can be understood as productive labour that generates value while remaining difficult to formalise and remunerate (Hochschild, 2015). Research on emotional labour in healthcare and care settings shows that this dimension of work tends to remain secondary to technical forms of competence that are more easily standardised and measured (Bolton, 2005; Riley & Weiss, 2016; Theodosius, 2008). Emotional competence—central to producing good care—thus remains weakly recognised as a skill and poorly translated into professional status and remuneration.

In this framing, emotional labour is idealised as a freely given personal commitment, while its status as labour is obscured, becoming marginal in how professional competence is defined, reinforcing low pay and low status. The emotional labour of carers is naturalised as a "serving heart" that brings a "second pay cheque" in the form of gratitude and hugs rather than wages (Johnson, 2015). In what follows, we analyse how this misrecognition is reproduced in Romanian nursing homes by both managers and workers in the way they approach and talk about "working from the heart" as indispensable, while rarely describing it as a skill that might be trained, evaluated, or formally recognised as part of the care worker's professional profile.

3.3. Tacit Knowledge and the Practice of Care

In a setting where formal training remains partial and fragmented and occupational boundaries are unstable, knowledge is accumulated through experience, informal exchange, and practice. The concept of tacit knowledge becomes a useful lens for thinking about how care workers develop competencies in Romanian nursing homes. Following Polanyi (1966), tacit knowledge refers to forms of "knowing how" that cannot be fully articulated through explicit rules. In health and social care, this has been described as practical judgement or "clinical craftsmanship," built through experience of concrete situations and expressed in the capacity to act appropriately without formal guidance (Benner, 1984).

Mol's (2008) analysis of care emphasises that good care is not the mechanical implementation of standardised procedures but a process of ongoing adjustment and coordination within material conditions and relational dynamics. Care practices rely on "tinkering," a continuous process of adapting actions, technologies, and relationships to shifting needs rather than applying general rules (Mol et al., 2010). From this perspective, expertise in care work is not absent; it is embedded in practice and remains only partially visible within credential-based definitions of professionalism.

In long-term support for dependent people, a high-quality professional–client relationship is not an optional moral supplement but a precondition for professional judgement (Reinders, 2010). Insight into a person's needs develops through sustained engagement and the ability to interpret situations, moods, and everyday changes over time. When quality is reduced to measurable indicators and standardised interventions, the relational and interpretive work through which professionals gain insight into residents' needs becomes invisible.

Taken together, these perspectives suggest that we cannot understand professionalisation in care solely through formal indicators such as credentialing, occupational closure, or role differentiation. Emotional labour and tacit knowledge point to forms of expertise produced through practical engagement, relational work, and situated judgement but remain difficult to formalise, measure, and reward. Building on this perspective, we approach Romanian residential care not as a case of incomplete transition towards an already established professional model, but as a setting in which professionalism is actively negotiated in everyday practice. The care workers in our study do not appear to engage in a professional project in Larson's sense, nor do they aim to exercise strong occupational control over standards, training, or entry into the field. Rather, as the empirical material will demonstrate, professional competence is developed and sustained through everyday work, informal learning, practical adaptation, and collective processes of knowledge sharing among workers. Professionalisation, therefore, appears less as an organised project than as a dispersed and uneven process that emerges under conditions of limited institutional support and fluid occupational boundaries.

4. Methodology

Our study focuses on private nursing homes for older persons in Cluj-Napoca and its peri-urban area. Most accredited residential care centres in Romania are private providers operating as NGOs. Public and socio-medical facilities remain important but operate under different organisational and funding arrangements and were therefore excluded from the analysis. The choice of private facilities also reflects the symbolic terrain on which care decisions are made, where placing a dependent relative in a private facility

eases the dissonance between the norm of "good care" at home and institutional care, which continues to carry associations with poor nursing homes from the socialist period. Private nursing homes are thus the dominant form of provision and the setting where care unfolds as paid, organised, and professionalised work.

Cluj County was selected as the empirical setting because it represents an economically stronger region in which residential care provision has expanded rapidly, reflecting broader national patterns of care infrastructure concentrating in areas with greater institutional and economic capacity. Of the 795 licensed residential facilities for older persons in Romania, 51 are located in Cluj County.

The article draws on qualitative methodology. We conducted 19 semi-structured interviews with care workers and 6 with managers of private nursing homes in Cluj-Napoca and its peri-urban area between May 2024 and February 2025. Interviews with care workers explored pathways into care work, formal qualifications and skill acquisition, everyday tasks, emotional labour, and perceptions of professional recognition. Particular attention was paid to how workers interpret professional categories such as *infirmieră* (nurse assistant) and *îngrijitoare* (care assistant) and how these categories function in practice. Interviews with managers focused on staff recruitment and retention, compliance with regulatory standards, and financial constraints.

Since Cluj-Napoca and its surroundings are ethnically mixed (around 17% of the population in Cluj County identifies as Hungarian), the workforce in nursing homes included both Romanian- and Hungarian-speaking care workers. We conducted interviews with representatives from both ethnic groups. Ethnic and linguistic background were considered during the analysis. However, across the themes covered in the interview guide, no systematic differences emerged.

Participation in the study was voluntary and based on informed consent. Respondents were informed about the aims of the research and the use of interview material. To protect confidentiality, the institutions are anonymised, and quotations are not linked with concrete respondents. The interviews were conducted by members of the research team in Romanian and Hungarian, depending on participants' preference. The researchers were external to the institutions and did not hold managerial or regulatory roles within them.

Interviewed care workers were women aged 37 to 57, in their late 40s and 50s. Several had previous migration experience in care work, and their educational backgrounds varied from shorter training programmes to formal nursing assistant qualifications. Across the sample, respondents combined mixed formal credentials with substantial reliance on practical experience and peer learning.

The interviews were transcribed and analysed using thematic analysis supported by MaxQDA. We reviewed the interview material and identified recurring themes, emerging patterns, and preliminary analytical observations. Coding focused on how care workers and managers described professional roles, everyday work practices, training, and institutional conditions. Additional themes emerged through repeated engagement with the material and comparison across interviews. Particular attention was paid to tensions between formal occupational definitions and everyday care practices and the respondents' understanding of competence, professional boundaries, and care work.

5. Care Workers and Everyday Professionalisation

5.1. Professional Categories

In Romanian residential care facilities, *infirmieră* (nurse assistant) and *îngrijitoare* (care worker) are formally classified as distinct occupational categories within the Romanian Classification of Occupations (COR). Nurse assistants (COR 532103) receive recognised hygiene training and are qualified to provide personal hygiene care, assist with food and mobility, monitor vital signs, prevent pressure sores, and support basic non-invasive medical procedures under a nurse's supervision. Care workers (COR 532104) belong to the social care sector and are expected to provide assistance with daily living activities, including washing, dressing, cleaning, emotional support, and social activities, but not medical support. In practice, this boundary is much less clear in nursing homes, where persistent staff shortages and non-standardised work norms make the two roles overlap and become functionally similar. Workers are often recruited without formal qualifications, with some being hired under cleaning contracts and later reclassified after completing basic training. Skills are often acquired through practice, peer learning, or online resources, while structured professional development remains limited. In what follows, we examine how these formal categories operate in everyday care practice and how their boundaries are negotiated.

5.2. Everyday Practices of Care Work

Care workers describe their professional role not through formal definitions, but through the accumulation of tasks that structure their daily shifts. Their accounts describe a fluid and mixed form of labour in which professional boundaries are continuously stretched. Instead of referring to distinct occupational categories, many speak about "doing everything." One worker explains: "I didn't just care for the sick. I also gave medication, cleaned….Here we help with food and feeding too." The overlap with nursing responsibilities appears routine: assisting with catheters for residents who cannot remain still or administering medication when nurses are unavailable.

Cleaning, formally outside nursing assistance, is frequently absorbed into care work when no separate staff is hired. A former employee recalls that nursing assistants handled cleaning tasks as well. Grooming tasks further illustrate this expansion of roles. One care worker describes trimming residents' nails and hair herself when families refuse to pay for a hairdresser, explaining that she "can't just look at them with their hair like that, when everything else is taken care of." Professional differentiation between medical, domestic, and relational tasks becomes secondary to the immediate needs of residents. Importantly, workers do not describe this versatility as an additional competence but as an ordinary expectation of the job.

The physical dimension of this work reinforces its improvisational character. "This is a profession where you need to be versatile [polyvalent]," said one of our respondents. Care workers describe situations in which formal task allocation gives way to practical necessity. One recounts the case of a resident weighing around 130 kilograms who had been immobilised for months: Mobilisation depended not on formal roles, but on who was physically able to assist at that moment: "If I lift her with him, I very easily…she walks…but the girls can't lift her." In such situations, cooperation becomes essential. The distribution of tasks is shaped by bodily strength, availability, and experience rather than regulatory demarcation or formal planning.

Working conditions are further marked by staff shortages and institutional fragility. Care workers report staying beyond paid hours, covering for absent colleagues, and struggling to organise breaks or holidays because no replacement personnel is available. Care work appears as an accumulation of responsibilities produced by structural gaps—like staffing shortages and limited financial resources—without corresponding recognition in status, pay, or formal authority. Professional practice, therefore, develops through necessity and adaptation to patients' needs, rather than through clearly defined occupational differentiation with other professional roles in the nursing homes. Professional position lines are further blurred by the process of becoming qualified for different aspects of the job.

5.3. Professional Competence Between Formal Qualification and Tacit Knowledge

While qualification and formal training have traditionally been understood as central mechanisms through which professional groups distinguish themselves from other occupations, establish recognised expertise, and formalise professional boundaries, professional competence in care work cannot be reduced to formal qualifications alone but often develops through situated, embodied, and relational forms of learning. The experiences of care workers in Romanian nursing homes suggest that the relationship between certification and competence is neither linear nor stable. Professional competence often develops through multiple and uneven pathways, including informal, embodied, and practice-based learning processes that only partially overlap with formal training systems.

Many care workers describe entering the profession without formal qualifications and acquiring skills gradually, through colleagues, digital resources, and learning by doing. One former employee who entered the sector without certification explained that she was initially hired under a cleaning contract: "At first, they hired me based on the idea that experience wasn't mandatory….Initially, they hired me for cleaning services. Until I managed to complete the courses and obtain my nursing assistant diploma." Hiring people without certificates in positions that do not require formal qualifications—while expecting them to perform the work of a medical assistant or care worker—was a common strategy mentioned by both care workers and managers. Formal qualifications were frequently acquired later, through sporadic courses alongside employment.

While formal training opportunities do exist, they are partial and uneven. Some care workers completed medical assistant courses, sometimes while already employed. Others describe more intensive experiences, such as a two-year palliative care course that included several 3- or 4-day intensive workshops. Despite these occasional training courses and certifications, workers tend to emphasise experience as their main learning route. As one care worker with over seven years of experience in a nursing home said: "Here I took a qualification course to become a nursing assistant, but no…believe me, the best course is life." Training, therefore, is not the starting point of competence but an added layer of knowledge alongside continuous practice.

Informal learning emerges as a key mechanism through which tacit knowledge is formed and circulated. Techniques are transmitted horizontally, through peer guidance and demonstration, combined with YouTube videos and learning by doing. "Honestly, at first, I learnt from my colleagues over there—they showed me how to do things. Then I also took the course, read a bit, and watched things here too. So, I can say I learnt by working," noted one of the care workers, emphasising self-learning and peer skill transmission. One of the more experienced care workers recounted passing on skills to junior colleagues on a regular basis: "I also

watched some videos on YouTube…and she explained some lifting techniques to us….I teach the girls. Don't pull, don't strain yourself….You count '1–2-3' and then start." In this sense, learning happens bottom-up and in an unstructured fashion, based on needs, rather than established curricula.

Mutual assistance and informal task coordination fill the gaps left by formal training and qualifications. Heavy lifting, one of the most frequently mentioned examples across interviews, often becomes a collective task that care workers coordinate among themselves or require the assistance of other employees on the premises: "I always have to ask the cleaning lady or the physiotherapist or the nurse to help me put him in the chair and take him to the shower," explained one of our interviewees, reflecting a recurring pattern across respondents. These statements show that formal job categories dissolve under physical pressure. Cooperation across different categories of employees is considered indispensable, compensating for institutional gaps and creating collective forms of practical knowledge-sharing.

The availability and use of equipment is another point that care workers mention in the context of training. "There's no lifting system…or there is, but no one uses it or knows how," says one, adding: "No training is provided. No one wants to work with it. It's not mandatory…everyone's gotten used to their way." Learning how and using the equipment is an individual act. It is not introduced by the nursing home as a qualification and a required skill, despite its potential to improve working conditions. Thus, even where equipment is available, its effective use depends less on formal instruction than on embodied familiarity and confidence developed through repeated use. As studies of practical expertise suggest, the capacity to "know how" to act in concrete situations often exceeds what can be specified in manuals or procedural guidelines, which is at the core of tacit knowledge.

Taken together, these forms of learning correspond to what we conceptualised above as tacit knowledge: Skills are developed through observation, repetition, peer guidance, and gradual attunement to concrete situations rather than through formal instruction alone. Competence accumulates relationally. Because such competence is only partially visible within credential-based systems, professional boundaries remain blurred and differentiation between care roles remains weak.

5.4. Emotional Labour as Professional Competence

Emotional labour appears as the defining core of the job, not as an additional layer. Care workers consistently frame their work in relational and moral terms, describing attachment, patience, and empathy as more important than formal qualifications. As discussed in the literature section, emotional labour is not an individual disposition; rather, it becomes visible as part of how professional competence itself is understood and evaluated, yet is still not fully recognised as a professional category or as part of the formal job description.

Care workers describe their way of working as "from the heart" or "putting your soul into it," without being specifically asked or prompted to talk about this during the interviews. "If you don't do it from the heart, you can't be here. You need to have a heart and dedication," one points out, while another talks of the soul: "If you don't also put a bit of your soul into it, you're not meant to be here." Dedication comes up in other interviews too: "This work means sacrifice, first of all. And it means dedication." And in some cases, the language becomes explicitly familial: "Simply, they are our children." Caring is framed as a moral and, to some

extent, even familial obligation, rather than simply a job. Care workers build strong bonds with the residents over time. The capacity to connect, to reassure, and to demonstrate empathy is part of doing the job well, according to our respondents. This relational orientation echoes the discussion above on tacit knowledge: Understanding residents' needs is described as developing through proximity, accumulated familiarity, and everyday interaction rather than through formal instruction alone. Across interviews, emotional engagement repeatedly appeared as a requirement for doing care work properly rather than as an optional personal quality.

At the same time, this moral framing coexists with the material and structural pressures described earlier. The emotional commitment that respondents include as a job characteristic does not replace the physical demands of lifting, cleaning, assisting with medical procedures, or administering medication. It is layered onto them. The same workers who "work from the heart" are those who cut hair when families refuse to pay for a hairdresser, who step in when nurses are not available, and who work beyond their shifts because no replacement is available. Emotional labour thus operates both as a professional ideal and as a coping mechanism in under-resourced environments. It sustains meaning in conditions of overload and blurred boundaries, but it also risks normalising the expectation that care should exceed formal obligation. Emotional attachment is not formally recognised or remunerated, yet it becomes central to how workers understand their own professional value. As outlined in the literature section, emotional labour remains difficult to formalise, measure, and reward. The accounts above suggest that emotional engagement functions simultaneously as a source of professional meaning and as a mechanism through which additional responsibilities become absorbed into everyday care work without corresponding recognition.

Importantly, care workers themselves differentiate between what is formally expected of them and what they provide beyond these expectations. The expected tasks are clear: feeding, washing, mobilising, administering medication, and cleaning. Emotional support, by contrast, is described as something additional, something that depends on the individual. One woman explains that, if her own mother required more assistance, she would never consider a nursing home: "Who knows how they will treat her?" The fear she expressed was not about incorrect procedures, but about the indifference that can come from a care worker who is not emotionally involved with their patients. The implication is that affection is not guaranteed by the institution. Workers, therefore, frame their own emotional involvement as an exceptional contribution. In doing so, they implicitly construct a distinction between professional duty and moral surplus. Respondents consider emotional labour both central and a special skill that some of them bring to the job, rather than a requirement. As the next section demonstrates, this understanding is in direct tension with managerial discourses, in which emotional disposition is treated less as an additional contribution and more as a condition for employability itself.

6. Managers' Perspectives: Professionalisation Under Constraint

In the interviews with managers, the professional role of care workers appears as something shaped by institutional constraints and external conditions like labour shortage, and not by formal definitions required by the authorities. While legislation defines categories such as nurse, carer, or social worker, managers describe everyday practice as organised around availability, financial viability, and the ability to respond to residents' needs. Their accounts reveal how the role of the carer is negotiated between regulation, labour shortages, and the expectation that care must be both technically adequate and emotionally meaningful. In contrast to care workers, who described competence through everyday practice and accumulated

responsibilities, managers frame professionalisation primarily as an organisational challenge. Across all themes discussed below, categories, practices, qualifications, and emotional engagement are interpreted through the constraints of staffing, budgets, and institutional sustainability.

6.1. Categories and Professional Boundaries

The main aspects that keep recurring in the managers' accounts are financial limitations, which managers describe as the main reason for labour shortages, limited differentiation between professional categories, fast turnover, and restricted training opportunities. Differentiation between professional categories is only partially achieved due to resource constraints. One manager notes that the state subsidy of around RON 2,000 (approximately EUR 400) per beneficiary "doesn't even cover meals, let alone all necessary conditions." At the same time, the rates that families pay cannot be increased endlessly, because services would become unaffordable. Under these conditions, the expectation that each professional category is represented by a distinct staff member is seen as difficult to implement. "If we were to hire a person for every single position, we would end up having more staff than beneficiaries," notes one manager. Another explained: "We try to hire enough staff to cover, right? Right now, we have 50 employees for 68 elderly residents, but we cannot survive financially like this." Managers thus frame personnel arrangements primarily through what is feasible from an organisational perspective, rather than through formal definitions and requirements.

6.2. Practice, Infrastructure, and Everyday Adaptation

From the managers' perspective, the legal distinction between nurses and carers is clear, especially regarding medical responsibilities such as medication administration. Nonetheless, this strict separation is not implemented in daily practice. There is a tension between formal regulation, which assigns medical authority to nurses, and everyday practice, where carers become the primary actors. Legally, professional hierarchy exists. But on the ground, there is a strong overlap between roles. "Nurses and carers mostly perform similar tasks here," explains one of the managers—while recognising straight after that this should not be the case in theory—yet they lack the funds to hire more nurses. The role of the care worker expands beyond narrowly defined tasks, particularly in settings where staffing levels are limited.

Caregivers are described as the constant presence in residents' lives: "The caregiver is the one changing, dressing, feeding…hugging them, knowing their pain….For any issue, the elderly always go to the carer first, because they are the ones always available." While workers described this overlap as part of everyday care practice, managers ascribe it to institutional constraints and funding limitations.

Managers also emphasise that one of the main challenges of everyday care practice is its physical intensity. Since care work is performed predominantly by women, workers are nevertheless expected to carry out physically demanding tasks involving lifting, repositioning, bathing, and constant bodily support. Carers could be supported in these tasks by equipment and infrastructure, such as adjustable beds. Such equipment is not always available nor financially viable to maintain and expand, however. The quality of care depends on material conditions and, when these are limited, it falls to caregivers to compensate for such absences through their own labour. In contrast to workers, who emphasised practical adaptation and cooperation, managers frame this flexibility primarily as a response to financial and infrastructural limitations.

6.3. Qualifications, Training, and Retention

Another problem highlighted by the managers is the labour shortage and persistent difficulties in recruiting and retaining staff: "You must have specialised personnel. The problem is that it's very difficult to find people willing to work in this field." Labour shortages are linked both to the demanding nature of the work and to broader labour market dynamics. In some cases, negative working conditions in certain institutions lead employees to move "from one place to another." Better pay in state hospitals and widespread labour migration attract care workers elsewhere. As a result, institutions rely on individuals with limited formal preparation, invest in training that may not secure retention, and operate within a labour market where mobility is high.

Managers repeatedly emphasise that most caregivers do not enter the field with formal qualifications: "Most of them don't have any diploma. They are people with little formal education, so to speak, and we can only employ them as caregivers." Even when nursing aide courses are completed, their content is considered insufficient: "It's useless for us to expect a nursing aide to have medical knowledge, because they will never have it." Specialised training in elderly care is described as nominal: "This specialised job of elderly caregiver…to be trained specifically for elderly care, I don't think that exists. Or—you know how it exists? On paper. You pay, and the course is done, that's it." In this sense, certification exists, but the extent to which it is in-depth and useful is questionable. Institutions attempt to compensate by offering internal training opportunities. Caregivers are encouraged to complete nursing aide courses, yet role differentiation does not necessarily follow: "For the most part, the care assistant does the same work as the caregiver, at least here in our centre." Moreover, once qualified, employees often leave. Managers refer to movement toward public hospitals, where salaries increased significantly after reforms, as well as migration abroad: "We offer them the possibility to take the nursing aide course, they stay a few months, and then they leave further abroad." Professionalisation, in this context, produces mobility and a faster turnover, rather than stability. Unlike workers, who framed learning as accumulated practical competence, managers emphasise the difficulty of translating qualifications into stable professional roles.

6.4. Emotional Labour and the Limits of Professional Recognition

Care workers described emotional labour as central to good care but understood it as something contributed beyond formal expectations: an additional form of commitment grounded in attachment, empathy, and responsibility. Managers, on the other hand, recognise the same importance of emotional engagement but frame it differently: Emotional labour is described as part of being a professional carer. Managers repeatedly describe care work as requiring emotional engagement. One manager reflects: "You can come for an inspection and find all the papers in order, everything is fine, but what is missing is the feeling like home." Another states: "There are some who do it for money and others who do it from the heart and, without heart, a residential care centre cannot be sustained." Similarly to how care workers talk about their work, managers also underline that emotional labour is not treated as separate from professionalism but as integral to it. It is framed as what ensures that a nursing home functions beyond simply formal compliance.

These aspects of care work cannot be replaced by equipment or digital tools, according to one of the interviewed managers. When asked about digitalisation, he responds: "What could you digitalise? Emotion, love, washing, personal care?" At the same time, it is exactly these aspects of care work that are not codified as professional qualities or recognised as a special skill. While the embodied and relational character of care is presented as

resistant to technological substitution, actual recognition remains the purview of informal discussions, and its status as professional competence remains weakly formalised and institutionally unsupported.

Moreover, in three of the managers' interviews, it became apparent that emotional engagement is simultaneously recognised as indispensable and treated as personal disposition rather than labour requiring organisational support. Unlike care workers, who framed emotional engagement as something offered in addition to formal duties, the managers we interviewed increasingly described it as a precondition to being suitable for care work in the first place. Emotional engagement thus shifts from an additional contribution to an expected professional disposition. Through such processes of misrecognition, this moral investment becomes detached from its material value and framed as vocation, dedication, or personal suitability—rather than as the labour that keeps the institution functional.

7. Conclusion

This article asked what forms of professionalisation can be identified in care work in Romanian nursing homes and what institutional and organisational conditions shape and constrain this process. Our findings show that professionalisation processes are unfolding but are uneven and partial. Rather than emerging through formal qualifications, stable occupational boundaries, or coordinated institutional reform, professional roles develop largely from below through everyday adaptation, informal learning, emotional engagement, and practical knowledge accumulated in care practice.

Across both care workers' and managers' accounts, four interconnected dynamics became visible. First, formal occupational categories remain only weakly differentiated in everyday work, with boundaries between care, nursing, domestic, and emotional tasks continuously overlapping. Second, formal qualifications function as only one pathway into care work and often follow, rather than precede, practical involvement in care. Third, competence develops substantially through tacit and experience-based learning, transmitted horizontally through observation, repetition, cooperation, and problem-solving in concrete situations. Finally, emotional labour emerged as one of its central organising principles, framed differently by care workers and managers.

Our analysis demonstrates that emotional labour and tacit knowledge are not peripheral elements of care work but core professional resources that sustain residential care under conditions of labour shortages, institutional fragility, and weak role differentiation. Yet these competences remain difficult to formalise and are rarely translated into professional status, remuneration, or institutional recognition.

The comparison between workers' and managers' perspectives further demonstrates that professionalisation is understood differently depending on position within the institution. Care workers describe professional competence as accumulated through practice and often frame emotional engagement as something offered beyond formal expectations, but crucial for doing the job well. Managers, by contrast, tend to interpret competence through organisational sustainability, staffing constraints, and employability. Emotional engagement becomes indispensable while simultaneously being reframed as a personal disposition, rather than a recognised labour skill. Professionalisation, therefore, appears not as a coherent professional project but as an uneven and negotiated process shaped by institutional constraints and everyday adaptation.

The Romanian case offers a particularly revealing setting for examining these dynamics. In a context where care for older persons remains predominantly organised within families—and alternative forms of formal state-supported care remain weakly developed—nursing homes are among the few institutional spaces in which care workers are visible as a professional category. At the same time, because state provision remains limited and residential care is dominated by private providers, private nursing homes become the main arena where processes of care work professionalisation can currently be observed. This makes Romanian residential care analytically valuable, showing a process in the making with open-ended outcomes.

At the same time, this specificity also defines the limits of our study. By focusing only on private nursing homes in one economically stronger region, we do not capture other existing and emerging forms of elder care provision or claim representativeness for Romanian LTC as a whole. Instead, we deliberately set ourselves a narrower analytical task: to examine how professionalisation is negotiated in one institutional setting where care work becomes formalised, visible, and organised through paid labour. Within these limits, the study demonstrates that professionalisation in residential care is neither absent nor linear but emerges through everyday practice. Professionalisation in Romanian residential care, therefore, appears less as an accomplished institutional project than as an ongoing process sustained by workers' everyday expertise, yet only partially recognised within the structures that depend on it. Future research should extend this analysis to other forms of care provision and explore how different institutional arrangements shape the recognition and organisation of care work.

Acknowledgments

This article was produced as part of the project Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe (CareOrg, 2023–2026; https://careorg.eu), funded by the Volkswagen Foundation within the programme "Challenges and Potentials for Europe." We would like to thank the research assistants who supported us with the empirical data collection: Dana Solonean, Cătălina Codiță, Mária-Magdolna Lukacs. Special thank you goes to Anca Simionca for the valuable feedback, as always.

Funding

Publication of this article in open access was made possible through the institutional membership agreement between Babeș-Bolyai University and Cogitatio Press.

Conflict of Interests

The authors declare no conflict of interest.

Data Availability

The data are not available for public use.

LLMs Disclosure

During the preparation of this work, the authors used Claude (Sonnet 5, Anthropic) to assist with reference formatting and language editing. After using this tool, the authors reviewed and edited the output as needed and take full responsibility for the content of the publication.

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