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Social and Healthcare Educators' Competence in Well-Being at Work – A Cross-Sectional Study

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Abstract

The study's purpose was to describe the competence in well-being at work of social and health care educators and the factors influencing it. Cross-sectional study. Data were collected using a questionnaire from social and health care educators (n=243) working at ten randomly selected educational organizations. K-means clustering was used to identify three distinct educator profiles. Educators belonging to profiles 1 and 2 exhibited low competence in managing work well-being. All profiles exhibited intermediate competence in promoting work well-being. Competence in appreciating the work of educators was either intermediate or high in all three profiles. Managers working in educational organizations need to ensure and support educators' well-being.

Introduction

Well-being at work is essential for the resilience of employees in their working lives. Studies have shown that educators experience stress and exhaustion in their work, which affects their well-being at work and the quality of the teaching they provide (Carolan et al., 2017; Siu et al., 2014). The stress experienced by educators has been defined as unpleasant emotions originating from the levelled expectations that they strive to meet (Shackleton et al., 2019). The work of educators is both mentally and physically demanding (Pérez-Chacón et al., 2021). In addition to transferring knowledge about the subject being taught, educators must account for the needs of different learners, including their economic, socio-cultural, and health situations (Pérez-Chacón et al., 2021), in order to help students achieve their goals (Carvalho et al., 2016). Society is constantly changing, which affects the competence requirements of social and health care educators (Mikkonen et al., 2019a). The need for social and health care educators is growing, so it is important to pay attention to their well-being at work and the factors that affect it (Chung & Kowalski, 2012; Wang & Liesveld, 2015).

Educators in the social and health care fields, including rehabilitation, must possess strong competence in both their professional field and pedagogy (Arian et al., 2018; Mikkonen et al., 2019a; Saaranen et al., 2020), as well as competence in ethics and culture, action, collaboration and networking, administration and leadership, evidence-based health care, and self-development (Mikkonen et al., 2019a). Well-being at work is another important area of competence for social and health care educators that can be evaluated based on

1) the employees and the nature of their work (in which case key factors are health; mental, cognitive and physical workload; and personal resources),
2) working conditions (with key factors being the physical work environment and occupational safety),
3) professional competence, and
4) the work community (with key factors being management, organization, and social support at work) (Saaranen et al., 2007; Saaranen et al., 2020).

It is enhanced by doing work that is productive, safe and healthy, and performed with qualified employees in a well-run organization. Well-being at work is also strengthened by work that is perceived to be meaningful and supportive of life management (European Agency for Safety and Health at Work, 2013). Well-being at work can be understood in terms of an employee's feelings and attitudes towards working life, with job dissatisfaction being reflected in the employee's professional and personal life (Arian et al., 2018). Personal and professional self-care are also important for well-being. Factors contributing to personal self-care include hobbies, well-being in relationships, humor, and exercise, while factors contributing to professional self-care include workload management, professional development, and time management (Martin et al., 2020).

Stress has been associated with poor management and work that is demanding, requires great effort, and is poorly rewarded. Exhaustion among educators is influenced by their perceptions of school safety, and support, as well as students' attitudes to learning (Shackleton et al., 2019). Psychosocial risks facing social and health care educators include mental exhaustion, work-related stress, interpersonal problems with colleagues and supervisors, job responsibilities, poor job performance, competition, and lack of time with family (Carvalho et al., 2016). Occupational well-being can be analyzed from personal, organizational, managerial, academic, professional, and financial perspectives (Arian et al., 2018), and studies have shown that burnout is more common in fields involving close interaction with other people such as health and education (Siu et al., 2014).

Previous research has shown that well-being at work is affected by a person's feelings about his or her own work, and dissatisfaction is reflected in their work output (Arian et al., 2018). Factors affecting well-being at work include welfare and the amount of work to be done (Arian et al., 2018, Chung & Kowalski, 2012) as well as unequal workload distribution (Saaranen, 2020) and a lack of mentoring (Chung & Kowalski, 2012). Well-being at work can affect the quality of teaching provided (Siu et al., 2014; Wiklund Gustin et al., 2020) and is associated with burnout and work-related stress (Chung & Kowalski, 2012), which can lead to a decline in self-esteem, depression, absenteeism, and reduced work performance (Siu et al., 2014). Occupational well-being has also been linked to staff retention (Arian et al., 2018; Wang & Liesveld, 2015).

There is considerable variation between countries with respect to the requirements that must be met by social and health care educators working in vocational colleges (training students including future practical nurses) and institutes of higher education (training students including future registered nurses) (Salminen et al., 2021). For example, in Finland, it is recommended that social and health care educators hold a master's degree in health science and have completed 60 ECTS credits of pedagogical studies while also having 3-5 years' work experience relevant to the taught curriculum or a relevant degree in social or health care (University of Applied Science Act 1129/2014, 2014). Educators can obtain accreditation via education in teaching health sciences teacher,

professional teacher training, or education in educational science (Mikkonen et al., 2019b). Conversely, nurse educators in the USA are required to have competencies in 1) facilitating learning, learner development, and socialization 2) the use of assessment and evaluation strategies 3) participating in curriculum design and evaluating program outcomes 4) acting as a change agent and leader, and 5) improving the role of nurse educators (National League for Nursing, 2022).

Additionally, educators must be registered with the appropriate health care licensing authority (for example nursing), hold a postgraduate degree, and have more than three years' working experience (NLN, 2022). The WHO defines nurse educators' competence in terms of 1) theories and principles of adult learning, 2) curriculum and implementation, 3) management, leadership and advocacy, 4) monitoring and evaluation, 5) nursing practice, 6) research and evidence, 7) ethical/legal principles and professionalism, and 8) communication, collaboration and partnership (World Health Organisation, 2016). In all cases, the role of nurse educators is to promote students' professional development and learning (Salminen et al., 2021).

There has been relatively little research on well-being at work as a competence area of social and health care educators (Baker et al., 2011; Saaranen et al., 2020). While there have been several studies on well-being at work in health care, they have focused mainly on the well-being of health care staff (Baker et al., 2011) rather than educators' competence in welfare. In addition, there has been research on how problems and workloads affect the well-being of health care professionals (Saaranen et al., 2020). However, research on well-being at work in other professions may not be directly applicable to the well-being of social and health care educators. Consequently, there is a need for reliable data on the well-being of social and health care educators that is not based on analyses of problems and workloads (Arian et al., 2018). Also needed is information on the relationship between nurse educators' well-being at work and the quality of their teaching (Carolan et al., 2017; Siu et al., 2014).

The purpose of this study was to describe the competence of social- and health care educators in well-being at work and the factors influencing it. The results obtained provide insight into the welfare competences that educators must apply in their daily work to be functional and effective and could help guide leaders in building stronger support systems when leading and managing institutes of higher education.

The research questions addressed in the study were:

1) How do social and health educators working in vocational colleges and universities of applied sciences assess their competence in well-being at work?
2) What factors influence educators' competence relating to the occupational welfare of social and health teachers working in vocational colleges and universities of applied sciences?

Method

Research design

An observational cross-sectional study design was used. Data were collected from ten randomly selected vocational colleges and ten universities of applied sciences in Finland.

Participants

All social and health care educators from the chosen organizations were invited to participate in the study (N = 1179). The inclusion criterion for educators were employment as an educator in the social and / or health care field at a vocational college or university of applied sciences. The sample size was decided by performing a power analysis based on a previous study sample (Mikkonen et al., 2019c) in which a Cohen's d effect of moderate size (Cohen, 1992) was achieved with 200 responses. Additionally, low response rates of 10-30% were obtained in similar previous studies. Therefore, 1179 educators were invited to participate in this study to maximize the likelihood of obtaining sufficient responses.

Instrument

The data were collected under the auspices of the data consortium of the (author-blinded) research group. Fourteen new items relating to competence in well-being at work were developed for use in this study based on previous publications (Mikkonen et al., 2019a; Saaranen et al., 2020). The content validity of these items was evaluated by nine experts in social-, health care and rehabilitation education using the content validity index method (CVI-I & CVI-Ave) (Polit et al., 2007). The CVI-I varied between 0.77 and 1 with the cut-off being set at < 0.78. Items scoring below the cut-off were either modified or removed. The CVI-Ave score for relevance was 0.97 (cut-off: <0.80) and that for clarity was 0.96 (cut-off: <0.80). After evaluating their content validity, the items' construct validity was tested using exploratory factor analysis. Each item was answered using a 4-point Likert scale (1 = strongly disagree, 2 = partially disagree, 3 = partially agree, 4 = strongly agree).

The responses to the competence-related items were evaluated using the Kaiser-Meyer-Olkin test (0.810) and Bartlett's Test of Sphericity (1365.508; df = 66, p <0.01) to test the suitability of the data for exploratory factor analysis. All of the factors had eigenvalues greater than unity, indicating that they explained an acceptable amount of the scatter in the observed variables. In addition, their communality was 0.30, indicating that there was relatively little common variance and that much of the variance for each item was explained by a single factor (Munro, 2005; Williams et al., 2012). Exploratory factor analysis was conducted using principal axis factoring and varimax rotation to maximize the variance for each factor (Munro, 2005). Two items were removed from the study because their correlation coefficient was below 0.30.

The final factor model used in the study included three factors and 12 items (see Table 1). The first factor (4 items) represented educators' management of work well-being; this factor had an eigenvalue of 4.71 and explained 39.3% of the variance in the data. The second factor (4 items) represented educators' promotion of work well-being; its eigenvalue was 1.93 and it explained 16.1% of the variance in the data. The third factor (4 items) represented educators` appreciation of their work; its eigenvalue was 1.40 and its percentage of explained variance was 11.7%. Collectively the three factors explained 67.1% of the observed variance and their Cronbach's alpha values ranged from 0.748 to 0.86, indicating adequate internal consistency (DeVon et al., 2007).

Table 1. Instrument for Assessing the Occupational Well-Being Competence of Social and Health Care

Educators (n=243).

Items	Factor 1	Factor 2	Factor 3
Factor 1 – Work well-being management			
1. I have not experienced work-related stress in the past year	0.832		
2. I have not experienced feelings of exhaustion during the past year	0.826		
3. I find the job requirements and workload suitable	0.721		
4. It is easy for me to combine work and personal life	0.640		
Factor 2 – Promoting work well-being			
5. I can promote the well-being of learners		0.744	
6. I can promote the development of emotional competence in learning communities		0.712	
7. I can promote the well-being of the work community		0.693	
8. I can create community-related practices related to well-being at work through networking		0.634	
Factor 3 – Appreciation of educators' work			
9. I can appreciate my own work as an educator			0.809
10. I can appreciate myself as an educator			0.694
11. I find my work meaningful			0.682
12. I feel that I am valued as an educator and I get enough feedback from it			0.465
Eigenvalue	4.717	1.933	1.404
Percentage of variance explained	39.3	16.1	11.7
Total percentage of factor model			67.1
Cronbach `s alpha	0.860	0.817	0.738

Extraction method: Principal axis factoring with Varimax rotation, presented in Pattern matrix, only loadings ≥.300 are presented in the table.

Data Collection

Data was collected between August and November 2020. A cover letter and an electronic link to the study were sent to prospective participants via contact persons at each institution. The survey was completed electronically using the Webropol software. Three reminder messages were sent to invited participants in each organization at biweekly intervals. The survey included 14 items relating to educators' well-being competence and 12 background questions relevant to the study.

Data Analysis

The data were analyzed with IMB SPSS 26.0. To manage missing values, a missing values analysis was performed using the Missing at Random (MAR), Missing Completely at Random (MCAR), and Missing Not at Random (MNAR) tests; no missing values were observed. K-means cluster analysis was performed to identify three distinct educator profiles based on the sum variables pertaining to competence in well-being. K-means clustering is an algorithmic method that groups observations (in this case, survey respondents) into clusters based on their similarity to the cluster mean (Rauf et al., 2012). The competence levels associated with each profile were classified as low if their mean Likert scores were < 2.29, intermediate if their scores were 2.5-3.49, and high if > 3.5. The statistical significance of differences between profiles was evaluated using the Kruskal-Wallis test with the Bonferroni correction and the Mann-Whitney U test. Factors relating to well-being competence were identified by one-way ANOVA and cross-tabulation. The threshold of statistical significance was set to $p < 0.05$. Results are reported as means, standard deviations, and percentages.

Ethical Issues

Permission to conduct the study was received from all 20 involved organizations, in accordance with the requirements of national law and policies on the handling of research data (Personal Data Act 523/1999). Good scientific practices based on honesty, accuracy, and diligence in research work were followed throughout. The study was designed, implemented, and reported in accordance with the requirements for scientific information (Finnish National Board on research Integrity, TENK, 2019) and appropriate research permission was obtained (Research Ethics Consultation Board, 2012). The study followed the guidelines of the Personal Data Act (523/1999) and Declaration of Helsinki (World Medical Association, 2013) regarding the collection, processing, and storage of personal data. The data of the participants are stored on university computers in password-protected files (523/1999). Participants were reminded of the voluntary nature of their participation in the study and the possibility to suspend their participation at any stage of the research. Equations should be provided in a text format, rather than as an image. Microsoft Word's equation tool is acceptable. Equations should be numbered consecutively, in round brackets, on the right-hand side of the page. They should be referred to as Equation 1, etc. in the main text.

Results

Participants' Demographics

Survey responses were obtained from 243 social and health care educators, giving a response rate of 20.6%. The mean age of the respondents was 51.43. The majority were women (89%). 57% of the respondents worked at a university of applied sciences; 43% worked at vocational colleges. A majority (72%) held a master's degree from a university; 13% held a master's degree from a university of applied sciences, and 11% held a PhD. Of the respondents, 45% had completed teacher training in health sciences, 44% had completed vocational teacher training and 11% had completed teacher training in education. Their current fields of education were health care (64%), social care (23%), rehabilitation (5%), and other (5%), and their average work experience as an educator was 13.5 years. 73% were lecturers, 16% full-time educators, 5% principal lecturers, 4% part-time educators, and

1% education leaders.

Educators' Competence in Well-Being at Work and Related Factors

Profile 1 contained 48 educators (20%) with a mean age of 50.0 years, of whom 85% were women and 15% were men (see Table 2). 60% worked at a university of applied sciences and 40% worked at vocational colleges. Their average year of graduation was 2007. Among these educators, 77% held a master's degree from a university, 10% held a master's degree from a university of applied sciences, and 6% held PhDs. On average they had 13.0 years' work experience as educators. Within this profile, 44% of respondents had undergone education in health science education, 40% had completed vocational teacher training, and 17% had trained as teachers of educational sciences. 73% worked as lecturers, 17% as full-time educators, 4% as part-time educators, and 4% as principal lecturers. 75% taught health care, 17% social care, and 2% rehabilitation.

Table 2. Educators' Occupational Welfare Competence and Factors Relating to it (n=243)

	Profile 1 (n = 48)	Profile 2 (n = 98)	Profile 3 (n = 97)
Age in years	50.0 (8.7)	52.0 (8.2)	52.3 (9.1)
Gender %			
Female	85.4	88.8	92.8
Male	14.6	9.2	6.2
Current work organization %			
Vocational college	39.6	39.8	48.5
University of applied sciences	60.4	60.2	51.5
Year of graduation for highest degree	2007 (7.8)	2007 (8.6)	2006 (8.7)
Work experience in a field corresponding to the degree	15.4 (8.6)	16.9 (9.7)	17.7 (9.1)
Work experience as an educator	13.0 (7.5)	13.7 (8.4)	13.9 (9.3)
Education %			
Vocational college/University of applied sciences (Bachelor`s degree)	0.0	1.0	2.1
University of applied sciences (Master`s degree)	10.4	11.2	16.5
Master`s university degree	77.1	76.5	61.9
Doctoral university degree	6.3	10.2	15.5
Other	6.3	1.0	4.1
Teacher training %			
Vocational teacher training	39.6	38.8	52.6
Teacher training in health sciences	43.8	51.0	40.2
Teacher training in education sciences	16.7	10.2	7.2
Job description %			
Part-time educator	4.2	0.0	0.0

Full-time educator	16.7	9.2	21.6
Lecturer	72.9	80.6	66.0
Principle lecturer	4.2	5.1	6.2
Head of degree program	0.0	2.0	1.0
Other	2.1	3.1	5.2
Current teacher work field %			
Social services	16.7	21.4	28.9
Healthcare	75.0	67.3	60.8
Rehabilitation	2.1	6.1	7.1
Other	6.3	5.1	3.1
Factor 1 – Work well-being management	1.71 (.46)	1.90 (.40)	3.21 (.42)
Factor 2 – Promoting work well-being	2.72 (.45)	3.20 (.43)	3.34 (.53)
Factor 3 – Appreciation of educators' work	2.60 (.44)	3.66 (.27)	3.68 (.37)

Profile 2 contained 98 educators (40%) with a mean age of 52.0 years, of whom 89% were women and 9% were men. 60% worked at a university of applied sciences and 40% at vocational colleges; their average year of graduation was 2007. 77% of the educators held a master's degree from a university, 11% held a master's from a university of applied sciences, and 10% held PhDs. Their mean work experience as educators was 13.7 years. 51% were health science educators, 39% had completed vocational teacher training, and 10% were teachers of educational sciences. 81% were lecturers, 9% were full-time educators, 5% were principal lecturers and 2% were heads of education. 67% taught health care, 21% social care, and 6% rehabilitation.

Profile 3 contained 97 educators (40%) with a mean age of 52.3 years, of whom 93% were women and 6% were men. 52% worked at a university of applied sciences and 49% at a vocational college, and their average year of graduation was 2006. 62% held a master's degree from a university, 17% held a master's degree from a university of applied sciences, and 16% held PhDs. Their average work experience as an educator was 13.9 years. 53% had attended vocational teacher training, 40% had trained in teaching health science, and 7% had been trained in teacher education. 66% were lecturers, 23% full-time educators, 6% principal educators, and 1% heads of education. 61% taught health care, 29% social care, and 7% rehabilitation.

Profiles 1 and 2 had the lowest levels of work well-being management competence (mean score 1.71 ± 0.46, 1.90 ± 0.40, $p = 0.01$), while profile 3 educators evaluated their work well-being management competence to be greater than that of profile 1 and 2 respondents (mean score 3.21 ± 0.42, $p < 0.01$ when compared to both other profiles). Profile 1 respondents had the lowest level of competence in promoting work well-being (mean score 2.72 ± 0.45, $p < 0.01$ when compared to both other profiles). Profile 2 and 3 respondents showed greater competence in promoting well-being at work (mean scores 3.20 ± 0.43 and 3.34 ± 0.53, $p = 0.08$). Appreciation of educators' work was lower in profile 1 (mean score 2.60 ± 0.44, $p < 0.01$ when compared to both other profiles) than in profiles 2 and 3 (mean 3.66 ± 0.27 and 3.68 ± 0.37, $p = 0.21$).

Discussion

The purpose of the study was to describe the competence of social and health care educators in well-being at work and the factors influencing it. Competence in management of well-being at work was found to be low among educators belonging to profiles 1 and 2, whereas those in profile 3 exhibited intermediate competence in this area. Conversely, all three educator profiles had an intermediate level of competence in promoting work well-being. Competence in appreciating educators' work was intermediate among profile 1 educators and higher among educators of profiles 2 and 3.

Profile 1 educators had lower levels of self-assessed competence than those of educators in other profiles. Educators in this profile were younger than those in profiles 2 and 3; additionally, profile 1 contained a greater proportion of men than profile 3 as well as a greater proportion of educators working in higher education institutions, holding a master's degree, and teaching in the health care sector. The transition from education to work after graduation can be a source of stress in educators; a study on health-oriented leadership by Arnold & Rigotti (2021) concluded that the well-being of young professionals can be supported by identifying those educators with weaker internal and external resources and supporting them by minimizing their stressors. Offering such educators personally designed interventions and support can improve their well-being at work. Because all social and health care educators have previously trained in some health care field (e.g., nursing), newly graduated educators must adopt new professional identities as they go from being social and health care professionals to social and health care educators. This transition can be supported through mentoring (Sodidi & Jardien-Baboo, 2020). Supporting the transition of recent graduates like this is another way of supporting the well-being of social and health care educators. Consequently, it would be helpful to take this into account during the training of new social and health care educators by giving them tools to ease the transition into working life. Educational organizations should also provide support in this transition, for example by offering mentoring and giving newly graduated social and health care educators more time to plan their teaching.

Profile 2 educators also had low self-assessed competence in all areas. Most educators in this profile taught at a university of applied sciences. This result is consistent with those of Hyvärinen et al. (2017), who found that educators teaching at universities of applied sciences experienced work-related stress and had lower well-being at work than their peers in different institutions because they were obliged to base their teaching on the best available research. According to Wakibi et al. (2021) the use of evidence-based practices in teaching can affect the ability of graduate nurses to provide evidence-based, high-quality, cost-effective, multi-dimensional care to patients. It is therefore essential that educators base their work on research and evidence-based teaching, even if this requires a greater investment of resources on their part. Our results support the finding that educators teaching at universities of applied sciences perceive their well-being at work to be lower than those teaching at vocational colleges. Future research should therefore investigate this difference and the factors contributing to it.

Profile 3 educators considered their competence in all areas to be higher than that of educators in profiles 1 and 2. This profile had the lowest proportion of men, the longest work experience in education, and was equally distributed between vocational colleges and universities of applied sciences. In addition, Profile 3 had more educators holding PhDs or master's degrees from a university of applied sciences, as well as more vocational

teacher educators and full- or part-time educators teaching in the field of social care. Such educators have more extensive prior continuing professional development than most of their peers, which seems to be important for competence in work well-being. Previous career development has been shown to influence both well-being and job satisfaction among healthcare professionals (Niskala et al., 2020). Accordingly, a study using a scale developed to assess social and health care educators' continuing professional development (Koskimäki et al., 2021b) found that professional development activities for such educators focus on developing pedagogical competence, skills in managing challenging situations in teaching, leadership competence, self-directed learning skills, clinical competence, and understanding of the benefits of continuing professional development. It was also emphasized that continuing professional development for social- and health care educators should address the way in which educators approach the development of their professional competence and their motivation for doing so (Koskimäki et al., 2021a). A commitment to lifelong learning and competence development strengthens educators' professional competence and may also affect their well-being competence. Leaders and organizations should therefore give educators support and opportunities to develop their competence, for example by offering postgraduate and continuous training tailored to the personal needs of individual educators.

The surveyed full-time educators rated their well-being competence more highly than part-time educators. This is consistent with the results of Wang and Liesveld's (2015), who attributed the difference to the fact that part-time teachers often do other work alongside teaching. Accordingly, Snook et al. (2019) concluded that it is important for sessional faculty members to be accepted as educators and to be encouraged to identify as such, and that doing so can enhance the quality of their teaching. Lee et al. (2017) found that educators without a permanent position were motivated to succeed and earn a permanent position, which may also partly explain the difference in self-assessed well-being competence between full- and part-time educators. On the other hand, full-time educators may have greater workloads and more responsibilities than part-time educators, which would be expected to reduce well-being.

In this study, the self-assessed well-being at work of older and female respondents was higher than that of male and younger respondents. Beutel et al. (2018) found that factors affecting incapacity for work among educators included stress and age, but that gender had no effect even though previous studies had concluded that female educators are more burdened than their male counterparts. According to Arian et al. (2018), age, gender, and their relationship are commonly studied background variables when investigating well-being at work, but their reported impact on well-being at work varies. Both et al. (2018) examined the well-being of physical education educators and its relationship to gender, showing that men were more satisfied with their work and had better interpersonal relationships and stress management skills than women. Conversely, our results suggest that higher age and female gender both have positive effects on well-being at work. One could thus conclude that age increases competence in well-being at work and that male health care educators have weaker well-being competencies than their female counterparts, or that men evaluate their well-being competence more critically. However, the vast majority of the respondents in this study were female and the proportion of male respondents was very low, so no reliable conclusions about the influence of gender on well-being at work can be drawn from these results; this topic warrants further investigation.

All profiles exhibited an intermediate level of competence in appreciating educators' work. This is consistent with an earlier study by da Penha Silveira et al. (2017)in which educators, despite their workload, were satisfied with their work as educators. It should be noted that the current COVID-19 pandemic has greatly affected the work of social and health care educators; Hancher-Rauch et al. (2020) found that health care educators have had to shift their work priorities due to COVID-19 as the focus of teaching has shifted towards the pandemic. Li et al. (2020) reported that educators' anxiety has increased during the pandemic, especially among female and older educators. However, it should be noted that although the COVID-19 pandemic was underway when the study was conducted, it was not addressed directly by any of the research questions. Direct questioning about well-being and COVID-19 could have provided a deeper understanding on the impact of well-being on educators' responses to the COVID-19 situation.

Limitations

This study has several limitations. First, the survey response rate was relatively low (20.6%) even though reminder messages were sent to eligible prospective participants. A higher response rate would have generated a more comprehensive research data set. Nevertheless, Cohen's d effect sizes ranging from medium (0.5) to very large (3.16) were obtained when comparing profiles (Cohen, 1992). Another limitation is that the questionnaire was part of a larger data gathering exercise; as a result, respondents had to answer a large number of questions, which may have reduced their willingness to complete the questionnaire. This was accounted for by adding a questionnaire recording option in the middle of the response, allowing respondents to take breaks and return to the survey at will. Additionally, educators may have been somewhat overwhelmed with surveys relating to the ongoing COVID 19 pandemic, which could have reduced their willingness to complete the survey. The reliability of the findings was strengthened by strictly following the STROBE guidelines (The Strengthening the Reporting of Observational Studies in Epidemiology Statement) during the study (von Elm et al., 2007). Care should be taken when generalizing the findings to other national contexts because well-being competence may be affected by the nature of the educational systems in different countries and variation in the duties and competence requirements of social and health care educators. The Conclusions section should clearly explain the main findings and implications of the work, highlighting its importance and relevance.

Conclusion

Three distinct profiles of self-assessed competence in well-being at work were identified among social, health care, and rehabilitation educators. The self-assessed competence of the participating educators ranged from low to high. Two of the profiles exhibited low competence in managing well-being at work, indicating that this competence area should be addressed at the management and organizational levels. All three profiles reported intermediate levels of competence in promoting the well-being at work of social and health care educators, indicating that educators have the necessary competence to promote their own well-being at work as well as that of students and other members of the work community. Levels of competence in valuing the work of educators ranged from intermediate to high, showing that educators value their own work and feel that their work is adequately appreciated by others. This is demonstrated by the fact that educators take professional pride in their

work and consider it to be important and relevant. The results presented herein could be used by managers working in educational organizations to increase educators' well-being at work and thereby help improve their quality of teaching and allow them to cope better with the stress of their position. Future research in this area could focus on the development and testing of educational interventions designed to give educators tools and strategies to support well-being at work as well as self-management skills in autonomous work. It would also be beneficial to further investigate the impact of respondents' backgrounds on their well-being at work, with particular emphasis on gender and age differences.

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