Workplace Stressors Affecting Support Service Staff in an Acute Hospital Setting:

A Baseline study

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M. A in Health Promotion, National University of Ireland, Galway 2009

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A Thesis submitted in part requirement

of an M. A. in Health Promotion

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National University of Ireland, Galway. 2009

Abstract

This study established baseline information on support staff working in an acute hospital setting with regard to occupational stress. Specifically it identified the main sources of stress at work for this occupational category of healthcare workers from nine workplace stressors identified in the Work Positive Questionnaire. The study design was cross-sectional and quantitative which employed a self-administered questionnaire with some open questions. Participants were selected by random sampling.

The survey showed that the main workplace stressors for support staff, in order of decreasing stress magnitude, were those relating to control, concern over health and safety, reward/contribution, change, demands and support, Those which contributed less stress included issues regarding relationships, indicators and role.

The stress levels encountered by those who also experienced bullying in the workplace were significantly higher in eight of the nine dimensions. Those who sought support in dealing with general workplace issues experienced greater stress from nearly all the stress dimensions compared with those who did not seek support.

Implications for health promotion research and policy as well as recommendations for both management and staff are presented.

Key Words: Occupational stress, Psychosocial factors, Healthcare staff, Support or Ancillary staff**,** Hospitals**,** Workplace Health Promotion.

Abbreviations

BCSI	Brief Coping Style Inventory
BSI	Brief Symptom Inventory
CBT	Cognitive Behavioural Therapy
CSO	Central Statistics Office
DC	Demand Control model
DCS	Demand Control Support model
EAP	Employee Assistance Programme
EAS	Ego Aptitude Scale
EFILWC	European Foundation for the Improvement of Living and Working Conditions (Eurofound)
ENWHP	European Network for Workplace Health Promotion
Eurofound	European Foundation for the Improvement of Living and Working Conditions (EFLWC)
EWCS	European Working Conditions Survey
EQLS	European Quality of Life Survey
ERI	Effort Reward Imbalance model
ESRI	Economic and Social Research Institute
GHQ	General Health Questionnaire
HCA	Healthcare Assistant
HCW	Healthcare Workers
HEBS	Health Education Board of Scotland
HPA	Hypothalamic Pituitary Adreno-Cortical activation
HPH	Health Promoting Hospitals
HPHN	Health Promoting Hospitals Network
HAS	Health and Safety Authority (Ireland)
HSE	Health Service Executive
H&SE	Health and Safety Executive (U.K.)
HSSD	Hospital Sterile Services Department
ILO	International Labour Organisation
JCQ	Job Content Questionnaire
KILM	Key Indicators of the Labour Market

MHB	Midland Health Board
MRQ	Multiple Response Question
NIOSH	National Institute for Occupational Safety and Health
NCCP	National Centre for Partnership and Performance
NUIG	National University of Ireland Galway
OHS	Occupational Health and Safety
PEF	Person Environment Fit model
QoL	Quality of Life
SCI	Stress Coping Inventory
SAM	Sympathetic Adreno- Medullary pathway
SLÁN	National Survey of Lifestyle, Attitudes and Nutrition
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
WHP	Workplace Health Promotion
WLI	Work Life Initiative
WP	Work Positive

Acknowledgments

Dedication

I dedicate this to the memory of my wonderful mother, whose warmth, sense of fun and set of values, live on. A beautiful memory and reminder of what's really important in life.

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Chapter One: Introduction

1.1 Overall context of the study

Health in all its facets (physical, mental, emotional, social, sexual and spiritual) is a resource, which enables people to cope with and go about their everyday lives in the different environments (home, work, education and social) they inhabit. Circumstances within these different settings impact on individuals; they can experience both positive and negative influences within all of these settings, which can interact with each other.

The workplace setting is the focus of this study, more specifically the healthcare sector within an acute hospital as the specific site. Staff in this setting represent a range of different occupational groups which can be grouped as follows; medical/dental, nursing, clerical/administration, allied health professionals and support staff[1]. It is this last group that has been selected for the present study.

Conditions at work contribute to overall health status (Murphy, 1996). In an acute hospital setting a range of risk factors exist which include the following categories; physical, chemical, biological and psychosocial. These factors can impact on the physical and/or mental health of employees. Concern over stress in the workplace is increasing; it is this topic, which is the specific focus of this study.

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[1] **Support staff include:** Assistants to allied health professionals: (Therapy assistants e.g. to physiotherapist /occupational therapist, laboratory assistants and hospital sterile services operatives); Catering staff (chef I & II, domestic staff, cashier) Cleaners; Drivers; Health care assistants; Maintenance workers (plumber, electrician, fitter, bricklayer, carpenter, craftsman's' mate) and grounds staff (general operative, gardener); Porters; Religious services and Security.

1.2 Background to the study

The researcher, as part of her employment, works with many groups within the support staff category and has therefore gained considerable anecdotal insight into the issues affecting them. Inequities have been observed and 'support staff' do not appear to have a strong voice in relation to input into work related and organisational issues. Furthermore the literature reveals that they are rarely studied as an occupation based group. Where support staff are the subject of study, they are more likely to be in education or healthcare settings other than acute hospitals, such as home helps and those working in Intellectual Disability services. Therefore this study aims to redress the research deficit for this occupational group and to make recommendations from the findings that would contribute, in practical terms, to improve their working environment and thereby reduce their levels of stress.

Establishing baseline information was an initial and necessary step to highlight the current situation regarding workplace stress for support staff in the acute hospital setting.

1.3 Key contributions from the literature

1.3.1 Health of workers

Promoting the health of workers is deemed important. The Luxembourg declaration (1997) on workplace health promotion states that;

"The future success of organisations is dependent on having well qualified, motivated and healthy employees." (WHO, 1997a)

Bamford, (1995) states that countries rely on their workforce to generate the wealth needed for the provision of health and social services. Work contributes a host of benefits for the individual including; financial security, personal identity, self-esteem,

social recognition, relationships, time structure, support and participation in a collective effort which also contributes to and benefits society (Barry & Jenkins, 2007).

Occupational hazards can however threaten the health of employees. Stress leads to disease due to prolonged interaction between physiological, behavioural and psychological factors (Ogden, 2004) Stress is particularly associated with coronary heart disease and mental ill-health, with the latter being particularly affected by workplace stressors (Barry & Jenkins, 2007). Sanderson & Andrews (2006) identified four types of workplace environment which have been shown to increase the risk of onset of common mental health disorders such as depression and anxiety these are; Jobs where demands are high, little employee control over the timing of tasks, a workplace that is experienced as unjust and atypical or precarious employment (Sanderson & Andrews, 2006).

Healthcare workers reported significantly greater pressure at work than non-healthcare sectors (Rees & Cooper 2006). Physical symptoms such as low back pain are experienced more frequently by hospital workers than other groups (Karahan, 2009). One study of support staff (home helps) reported that 20% suffered physical and psychological symptoms stress symptoms (Ashitomi, 2005)

1.4 Policy and contemporary context

1.4.1 Policy context

A number of organisations from global to local level are charged with providing information and support to promote the health and well-being of workers. These include the International Labour Organisation (ILO), the National Institute for Occupational Safety and Health (NIOSH) and the European Foundation for the Improvement of Living and Working Conditions (EFILWC). Organisations such as The European Network of Workplace Health Promotion (ENWHP), the Health Promoting Hospitals Network (HPHN) and the Health and Safety Executive in the UK (H&SE, UK) set standards against which organisations can monitor their performance. Other

organisations are responsible for ensuring that legislation relating to the workplace is enforced, such as the Health & Safety Authority in Ireland (H&SA). The Irish Government has developed a National Workplace Strategy through the National Centre for Partnership and Performance (NCCP) and the Health Service Executive (HSE) has just published its' first ever Employee Well Being and Welfare Strategy (HSE, 2009).

1.4.2 Contemporary context

Across Europe, hospitals are undergoing many reforms in a restructuring which focuses on efficient spending (De Troyer, 2000). In Ireland the HSE Transformation programme represents a similar initiative. The current economic downturn has placed hospitals as well as many other organisations under severe budgetary constraints which results in reductions in staffing levels which can further contribute to stress for staff. Furthermore health and safety legislation (Health & Safety Act, 2005) places an onus on management to audit stress levels as part of risk management.

1.5 Study aim and objectives

The main aim of this study was to identify the key stressors affecting support staff from a range of 'known' occupational stressors, in an acute hospital setting. Three main objectives were identified to achieve this, they are as follows;

1)   To establish baseline information on which further studies can be expanded and possible interventions identified.

2)   To identify what are the key areas of stress for support workers in an acute hospital setting.

3)   To determine the effect (if any) of bullying and support on perceived levels of stress.

The approach used to achieve these was to survey a random representative sample of support staff, using a self-report questionnaire whose validity and reliability was already established.

1.6 Format of the study

The research is presented over the following four chapters. Relevant literature is reviewed in Chapter 2. The methodology utilised is described in Chapter 3, including the study design and instrument selection rationale. Chapter 4 presents the results from both the quantitative and qualitative aspects of the study and the analysis of it. Chapter 5 discusses the main finings of the research and compares these with those in studies described in the literature review. The limitations of the study are highlighted. The implications of the findings for research, policy and health promotion are outlined, conclusions resulting from the findings are drawn and recommendations to address the findings are made.

Chapter Two: Literature Review

2.1 Introduction

This chapter outlines the approach undertaken in conducting a systematic review of the literature for this study. The review presents the background (historical and contemporary), theoretical and evidence based contributions from relevant current literature. The context for the study is therefore established. The literature on stress is explored in terms of describing the underlying mechanisms on how stress can impact on health and its consequences. Common workplace stressors are identified, followed by the main relevant theoretical models and a range of findings from healthcare settings spanning from global to national. The scale of the problem of workplace stress is then outlined. The remainder of the chapter focuses on the related issues of bullying, social support and the policy context. Finally evidence on interventions to address stress in the workplace and more specifically in healthcare settings is reviewed.

2.2 Literature review process, search strategy and summary of outcome

2.2.1 Process

The literature review is an important starting point when research on any topic is planned and is a crucial part of the entire research process (Ridley, 2008). This literature review was conducted in three phases, each for a specific purpose.

Phase 1: The initial search was exploratory in nature and was conducted in order to assist in formulating the research questions, to identify relevant theories, to explore different methodologies and to contextualise the current investigation.

Phase 2: A more comprehensive review (see Search Strategy 2.2.2. below) was undertaken to identify the body of knowledge underpinning this research project, in order to allow for comparisons and to make meaningful connections. The snowball technique (Ridley, 2008) was also employed, where references from bibliographies of books and articles were followed up. Key authors were also investigated. It was at this stage that the literature review was structured, as different themes emerged.

Phase 3: Involved looking for specific information, which was needed, as the structure was further developed. Later the review involved focussing more on comparisons with previous findings. It was an on-going process, which lasted for the duration of the research period.

2.2.2 Search Strategy

Gash (2000) defined the literature search as 'a systematic and thorough search of all types of published literature in order to identify as many items as possible relevant to a particular topic'. This definition appropriately describes the approach taken in this dissertation. Varied sources were used for information and included the following:

- The library Catalogue in NUIG was consulted for books on workplace stress. This led to further references being sourced from the back of relevant chapters.

- Peer reviewed journals in the following relevant data bases were explored; CINAHL, Cochrane, Ovid (Medline and Psych-info), Science direct (Lancet, JAMA, BMJ. and NEJ Med.), Sage, Scopus, Swetswise, Web of Science, Social Sciences Citation Index via Web of Knowledge and Wiley.

- Internet Search engines, Google scholar and Dogpile.

- Grey literature (Reports, theses)

- Key Websites e.g. WHO, HSA.

- Networking with health promotion researchers and practitioners.

Searches were conducted using key words, (workplace stress, stressors, hospital staff and ancillary staff). Additional key words were utilised based on the lists of keywords found in journal articles. Searches were limited using Boolean operators.

2.2.3 Summary outcome of literature review

A wealth of information exists for many of the broad contextual topics relating to this study. These include health, mental health, settings for health promotion, workplace, hospitals, stress and interventions. However on narrowing the focus of the research to the acute hospital setting and furthermore to a subgroup of staff ('support staff', see introduction) within this setting, there is a paucity of information. It was observed from the search that in the acute hospital setting much of the research focussed mainly across occupational groups such as medical, nursing and administrative staff. Support or ancillary staff were studied much less frequently. When this category was studied, it was more often in their role as home helps or as support staff for those with Intellectual Disabilities. Other settings where support staff were studied included educational and other healthcare settings such as primary care and psychiatric hospitals. The author could not find any study, which focussed specifically on support staff in the acute hospital setting.

2.3 Context: Historical Background

2.3.1 Health

Etymology reveals that the word "health" is derived from hal or whole (Tones & Tilford, 2001) and hale or healing, indicating that health concerns the whole person and their well-being (Naidoo & Wills, 1996). This holistic and positive essence was captured by the World Health Organisation (WHO) and incorporated into its' constitution when health was defined as:

"A state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (WHO, 1946).

In the decades that followed the multidimensional components of health were emphasised (Aggleton & Homans 1987; Ewles & Simnett, 1992, cited in Naidoo & Wills, 1996) and some authors argue that having a holistic understanding of health is vital to the definition and practice of Health Promotion (Nutbeam, 1998). The WHO support this stance as one of the seven key principles outlined to guide all Health Promotion activity is in fact a 'holistic' approach (WHO, 1988).

Later the WHO redefined health as:

"The extent to which an individual or group is able, on the one hand to realise aspirations and satisfy needs; to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the object of living; it is a positive concept emphasising social and personal resources as well as physical capabilities" (WHO, 1986)

This definition views health more as a dynamic concept as opposed to the static view adopted initially by the WHO in its constitution. This more dynamic definition was used in the Ottawa Charter to define health, at the first International Conference of Health

Promotion held in Canada (WHO, 1986). It is however significant that the role which mental health plays in overall health is common is common to both definitions.

2.3.2 Mental Health

The centrality of mental health in overall health has been recognised as far back as 400 BC by Hippocrates who believed that health was an evident state of equilibrium between mind, body and environment, (cited in Ryan et al, 2006). Galen, born in AD 129, shared a similar view. It   was not until the 17th century that Decartes, a French philosopher, created a distinction between mind and body, thus becoming the forefather of the reductionist approach. The tendency towards reductionism is rooted in Cartesian dualism, which leads to artificial divisions such as physical, mental, social, and spiritual health, (Ryan et al, 2006). Ryan et al. (2006) argue that these divisions are inconsistent with a holistic view of health and the ethos of health promotion.

The WHO recognised the importance of mental health and well-being in its constitution as outlined above. Later mental health was defined as:

'A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community', (WHO, 2001).   Subsequently the WHO proclaimed that: "*There is no health without mental health",* (WHO, 2004).

The importance of mental health in overall health therefore cannot be separated and would appear to be undisputed.

In essence health with its' many interrelated dimensions (physical, mental, emotional, social, sexual and spiritual, Naidoo & Wills, 1996), is the resource that enables us to go about our everyday lives and cope with whatever that entails within the context of

our different living environments e.g. (home, work, education, social) more commonly referred to as 'settings'.

2.3.3 Settings approach to promoting health

The origin of the settings approach is generally considered to have emerged from the Lalonde report in 1974, (Tones & Tilford, 2001). However, this report was conceptually based on the health field concept, put forward by Laframboise a year earlier in 1973. (Poland, Green & Rootman, 2000). The health field concept identified four key factors which influence health as: genetics, lifestyle, medical services and the environment. This reference to environment appears to have been the conception of the settings approach. Over twenty years later the Ottawa Charter stated that,

'Health is created and lived by people within the setting of their everyday life: where they learn, work, play and love'. (WHO, 1986)

Creating supportive environments was also one of the five pillars of Ottawa (WHO, 1996). This could arguably be viewed as the birth of the settings approach. The WHO has, through its' series of international conferences, reinforced this concept. The Declaration from the Sundsvall meeting emphasised the appropriateness of creating supportive environments to enable individuals take control of their health, (WHO, 1991). The Jakarta conference highlighted the settings approach as one of the main strategies for health promotion in the 21st century (WHO, 1997b). The essence of the settings approach is that it aims to address all the determinants of health within the setting at the same time, it is not restricted to addressing specific topics or population groups, but aims to capture the totality of the setting and sees the setting itself as a determinant of health. Evidence shows that the settings approach is the most effective approach to health promotion (Poland, Greene & Rootman, 2000).

One of the earliest settings projects established by the WHO was Healthy Cities, later other key settings were identified as priority, and these included schools, market place, primary care, workplace and hospitals (Kelleher, 1998 cited in Davies & Mc Donald)

2.3.4 The Workplace as a priority setting for Health Promotion:

According to Naidoo & Wills (1996) there are a number of reasons for prioritising the workplace as a key setting for health promotion. It allows access to a target group of healthy adults, who can be difficult to reach in other ways. Workers may not have access to community based initiatives due to the long hours spent at work. Secondly they are a captive audience for health promotion messages; it is particularly useful for reaching adult men who are not as likely to come in contact with health services, (Naidoo & Wills, 1996). Furthermore workplaces have established organisational structures including unions, occupational health services and employee assistance programmes, which all serve the well-being of employees and enhance the communication process.

The workplace health promotion movement was strengthened with the establishment in 1996 of the European Network for Workplace Health Promotion (ENWHP), which provided a platform for member states to exchange information, experiences and models of good practice of workplace health, (HPU, 2005). The movement was further reinforced by the Luxembourg Declaration of 1997, which stated that;

"The future success of organisations is dependent on having well-qualified, motivated and healthy employees. Workplace Health Promotion (WHP) has a significant role to play in preparing and equipping people and organisations to face these challenges", (WHO, 1997b).

From an economic perspective, worker health is vital. Countries rely on their workforce to generate the wealth needed for the provision of health and social services (Bamford, 1995), consequently it is logical to safe-guard the health and welfare of workers. Kickbusch (1998) goes one step further and asserts that, "almost all organisations have not only a vested interest, but also a social responsibility, in maintaining and improving their members' health" (Kickbusch, 1988, cited in Tones & Green, 2004) This notion of corporate social responsibility was also reinforced in one

of the four key commitments of the Bankok Charter for Health Promotion (WHO, 2005).

2.3.5 Hospitals as a Health Promoting Workplace Setting:

Hospitals are 'unique' workplaces; they are staffed 24hrs a day, all year round. Like many of the other settings for health promotion, international and national networks now exist for the Health Promoting Hospital (HPH). In 1989 WHO-Europe commenced an international consultation process which resulted a year later in the first Hospital pilot site being established to introduce health promotion programmes. This later expanded to become the European Pilot Hospital Project which included twenty hospitals across eleven European countries. (WHO, 2005a) The framework for the HPH pilot project was based on the 1991 Budapest Declaration on HPH. Since then, the Ljubljana Charter on Reforming Healthcare (1996), the Vienna Recommendations (1997), as well as the principles of the Ottawa Charter (1986) have all influenced the HPH movement, which by 2005 included more than seven hundred hospitals in over twenty five member states, (WHO, 2005a). The Irish HPH network was launched in 1997, and currently has approximately 120 full members including the hospital within which this study was conducted.

"A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organisational structure and culture, including active participatory roles for patients and all members of staff, develops itself into a health promoting physical environment, and actively cooperates with its community," (Garcia-Babero, 1998 cited in WHO, 2005a).

The WHO recognised the need for standards for health promotion in hospitals and established a working group at the ninth International Conference of the HPH in Copenhagen in 2001. Following a process of thorough analysis and consultation with many different working groups, a set of five core standards for HPH has been developed to ensure quality in this area. The standards are mainly generic with a

focus on patients (# 2 & 3), staff (# 4) and organisational management (# 1 & 5) (WHO, 2005a). Standard 4 specifically allocates the responsibility to management to establish conditions for the development of the hospital as a healthy workplace (WHO, 2005a). WHO has produced a self assessment tool incorporating measurable elements and indicators to facilitate planning, implementation and assessment of health promotion activities in hospitals in the European network (WHO, 2005a).

2.3.6 Hierarchy, Hospitals and Health.

Various analogies have been used to describe organisational structure; the most commonly used analogy is that which views the organisation as a machine or an organism (IPA, 2007). The 'machine' represents organisations characterised by rational, formal and relatively stable structures and processes, while the 'organism' is characterised by a more fluid, adaptive type functioning, thus organisations are now commonly described as either mechanistic or organic. Henry Mintzerg in the 1970's put forward a model consisting of six basic parts for describing organisational structure. He categorised the structure which describes the hospital setting as a professional bureaucracy. This structure is characterised by a substantial operating core of skilled and professionally trained staff and many layers of middle management. Support staff provide day to day services that support the provision of healthcare, while senior management and professional codes determine the functional operation of the organisation (IPA, 2007).

Research by Hotopf & Wessely (1997) suggests that position at work is an important determinant of health, workers with lower status doing less well than those at the top of the hierarchy. The amount of control employees have over their work is thought to be an important determinant of psychiatric disorder (Hotopf & Wessely, 1997). This aspect of work showed an important interaction with hierarchy in the Whitehall II study described by Stansfield et al. (1999).

While all workplaces may share commonalities regarding how employees are affected by workplace conditions, hospitals may have factors specific to their setting. These include the risk of infection from blood and body fluids (Tarantola et al. 2003, Dement

et al. 2004) as well as needle-stick injuries (Panlilio, et al.2004). The various occupational groups within the hospital are likely to experience different risk factors or perceive risk factors differently.

Support staff are at the lower end of the workplace hierarchy thus they do not enjoy the same autonomy or status which perhaps those in the medical and other professions, who occupy a position closer to the top of the hierarchy, do.

2.3.7 Contemporary Context

The Healthcare sector, like many other areas, would appear to be facing uncertain times both nationally and globally in terms of the current economic downturn. Economic recession results in organisational restructuring (Tsutsumi & Kawakami, 2004). De Troyer (2000) highlighted that throughout Europe the hospital sector is undergoing many reforms in a restructuring which is focussed on efficient spending. Undoubtedly this restructuring will affect work organisation (Carpentier-Roy, 1990 cited in De Troyer, 2000) leading to great uncertainty for staff, and many recruitment and retention issues for management. Kurt Lewin in the 1940's proposed a three stage model to describe change as, unfreezing the present, moving to a new level, refreezing the new level, (Maher & Hall, 1998). Applying this model, healthcare could be considered to be in stage one, with uncertainty over what stage two might look like. Job insecurity has been identified as a serious risk to health (Tsutsumi & Kawakami, 2004).

2.4 Role of Work in relation to Health

2.4.1 Unemployment

Though unemployment is not the focus of this study, it is nonetheless important to contrast how it can impact on health. Unemployed people have higher mortality rates and poorer physical and mental health compared to employed people (Barry & Jenkins, 2007). Unemployed people report higher levels of anxiety, depression, uncertainty about the future, anger, shame and loss of self-esteem following job loss

(Breslin & Mustard, 2003). Furthermore a number of studies have reported an association between suicide and unemployment (Johansson & Sundquist, 1997; Blakley et al. 2003), though Barry & Jenkins (2007) advise caution in determining the direction of causality, and highlight the need to consider the role of mental health problems in both suicide and unemployment.

2.4.2 Underemployment

Benavides et al. (2000) reported an increasing trend in Europe of new forms of work organisation and flexible employment which lead to various types of underemployment. These include involuntary part time employment and insecure employment. Precarious employment has been defined as work which is characterised by low work control, low income, low social or legal protection and is unstable (Rodgers, 1992 cited by Benavides et al. 2000). Knowledge of the impact on health of these employment types is limited (Benavides et al. 2000)

2.4.3 Employment - the benefits.

The importance of work in peoples' lives is well recognised. According to Barry & Jenkins (2007) work not only provides financial security but it provides a host of other benefits such as; time structure, personal identity, self-esteem, social recognition, relationships, support and participation in a collective effort which contributes to and benefits society.

2.4.4 Employment - the risks.

The workplace can also be the source of a range of occupational hazards (physical, chemical, biological and psychosocial) which can be deleterious to the health of employees. Traditionally the health and well being of employees has been addressed through occupational health and the enforcement of Health and Safety legislation. The Safety Health and Welfare at Work Acts, (1989 & 2005) and the General Applications Regulations (1993-2006) have resulted in management having to make improvements in the workplace, thus safe-guarding the health of employees. Other

legislation which has also benefited employees includes the Working-Time Act (1997) and the Equal Status Act, (2002-2004). Occupational Health has played a significant role in supporting health promotion in the workplace, by helping to prevent a range of occupational illnesses, though the focus has been largely on physical health and safety issues rather than on mental health (Barry & Jenkins, 2007).

There is increasing concern regarding the association between mental health and the workplace, with depression and anxiety being among the most common causes of occupational disability (Blisker, 2006). A recent systematic review revealed that most workers with such common mental disorders are in fact at work, despite their symptoms. Many suffer some degree of what is termed 'Presenteeism' (at work but working at a reduced level of productivity), (Sanderson & Andrews 2006).

2.4.5 Type of Work

Work, or more specifically the type of work, is a key component in determining economic circumstances, (Marmot & Wilkinson, 1999). Conditions at work contribute to overall health status, (Murphy, 1986) with mental health in particular being affected by workplace stressors, (Barry & Jenkins, 2007). According to a recent systematic review Sanderson & Andrews (2006) identified four types of workplace environment, which have been shown to increase the risk of onset of common mental disorders i.e. (depression and anxiety). They were jobs where demands are high (whether due to time pressure, long hours or conflicting demands) with little employee control over the timing of tasks. Secondly environments where employees perceive that the effort required to do the job exceeds the rewards gained. Thirdly, where the workplace is experienced as unjust, whether in terms of unfair decision-making or disrespectful treatment by managers. Finally, 'atypical or precarious employment' (jobs that are not permanent and have a transient nature such as part-time or casual) as well as being associated with mental disorders (Sanderson & Andrews, 2006) showed a positive association with job dissatisfaction, fatigue, backache and muscular pains compared to full time permanent workers (Benavides, 2000). However, overall full time workers

tended to report worse health outcomes than part time workers with the exception of those on temporary contracts (Benavides, 2000).

2.4.6 Development of workplace health promotion initiatives:

Chu et al. (2000) suggest that WHP has undergone "a significant evolutionary process", with activities in the early stages being focussed on either single illness/risk factor, or changing some lifestyle behaviour of individual workers. This was followed by a predominance of 'Wellness' programmes which aimed to be more comprehensive in nature and offered a broader range of interventions targeted towards identified risk factors, e.g. provision of health information and screening, stress management courses, healthy options in canteens, exercise and back care programmes, (Chu et al, 2000). However the focus was geared towards the individual and had an element of 'victim blaming'. Chu, (2002) explains that with an increased understanding of the multi-determinants of workers' health, such as organisational, socio-economic and environmental factors, WHP has become more holistic with multi-strategy integrated interventions which aim to address both individual and organisational factors, resulting in a more effective approach and further reinforcing the concept of the 'Health Promoting Workplace'. Sanders, (1993) highlights that workplace HP initiatives which have been effective exhibit six key features, including involvement and participation of all staff, management support, are well resourced and long term in nature (Sanders, 1993 cited in Naidoo & Wills, 2004). Chu, (2002) suggests that health, well-being and WHP programmes, have become an integral part of a workplace culture that values, supports and reinforces health, however Johnson & Baum, (2001) point out that there is still a long way to go until health promotion is anchored to organisational culture and structure.

2.5 Stress

2.5.1 Introduction

Some researchers disapprove of the use of the term 'stress' owing to its' non-specific nature (Wilkinson, 1991). The term has been widely utilised by the media, lay population and the medical professions (Wessely, 1996) with no doubt differences in their interpretation. Stress is a complex concept and needs some clarification to explain its' diverse effects (which range from physiological and psychological to behavioural) with consequences for the physical, mental and emotional well-being of the individual.

2.5.2 Historical background

Some of the early researchers in the field of stress helped to establish the foundations for current understanding. Cannon, (1932) proposed the flight or flight model, which emphasised the physiological changes associated with stress. Selye, (1956) developed the three-stage general adaptation model, which referred to the stages of alarm, resistance and exhaustion in response to stress (cited in Ogden, 2004). The most generally accepted model was that of Lazarus & Launier (1978). Termed the Transactional Model, this includes the element of 'appraisal'. According to this model when a person is faced with stress they carry out a primary appraisal of the event itself, (is the event stressful?) and a secondary appraisal of their ability to cope with it. Whether they show a response or not is thus determined by their appraisal (Ogden, 2004). Other researchers have emphasised a role for self-control in mediating the stress response. Bandura et al. (1982) reported a role for self-efficacy, Kobasa et al. (1982) referred to the hardiness of an individual, while Karesek & Theorell (1990) identified a sense of mastery as important in determining the level of stress response (Ogden, 2004). These all emphasise the psychological factors relating to stress.

2.5.3 Mechanisms

Most current researchers acknowledge the role of both psychological and physiological factors. There are two main physiological pathways involved:

1.   The Sympathetic Adreno-Medullary pathway (SAM)

2.   Hypothalmic Pituitary Adreno-Cortical Activation (HPA)

The SAM pathway is primarily concerned with an acute stress response. When an event has been appraised as stressful it triggers the sympathetic nervous system, which stimulates the adrenal medulla (part of the adrenal glands) to produce the catecholamines; epinephrine and norepinephrine, these cause changes such as increased heart rate and blood pressure. Blood flow increases to the muscles which tighten (Taylor, 2006). The word "stress" comes from the Latin word *stringere* which means "to draw tight," (Cox.1978, cited in Furnham, 2005) thus sore muscles can result from ongoing stress. Prolonged production of adrenalin has been associated with increased blood clot formation, the laying down of artheroma in blood vessels and immunosupression. Chronic stress is more likely to involve the HPA pathway which results in the production of the stress hormone cortisol whose effects are not as immediate as those of adrenalin. Cortisol acts to conserve carbohydrate stores; prolonged production can also lead to decreased immune function and also to neuron damage in the hippocampus, which can result in loss of concentration and memory and can lead to psychiatric problems, (Taylor, 2004). The two pathways are intrinsically linked. Stress is particularly associated with coronary heart disease and mental ill-health including anxiety and depression. Krantz et al, 1981, cited in Ogden, outlined another possible pathway for the stress-illness link. This referred to behavioural changes, which can result from stress. Behaviour such as smoking, alcohol consumption, (commonly associated with cancer, coronary heart and liver disease) poor diet coupled with lack of exercise is also generally associated with stress. Increases in risk taking, resulting in more injury have also been reported as well as an increase in aggression and violence (Ogden, 2004). Individual variability in stress reactivity, recovery, allostatic load and resistance moderate the stress response, (Ogden 2004). A more recent development in the area of stress research is Psychoneuroimmunology (PNI) which emphasises the role an individual's psychological state can play in influencing the immune system via the nervous system (Taylor, 2006). In summary, stress leads to disease due to prolonged interaction between physiological, behavioural and psychological factors. All of these are relevant in addressing stress in the workplace as they represent the underlying processes, which take place and show the possible illnesses that can result.

2.5.4 Summary of Occupational stressors

Harrington et al. (1992) have identified ranges of possible workplace stressors. They can be categorised as follows:

1) Physical environment Examples include noise, temperature, space, lighting, exposure to hazards and ergonomics. Interventions to address these are usually through Occupational Health and Safety (OHS).

2) Relationships factors Examples include harassment (sexual, racial) and bullying. These are dealt with through policies, disciplinary procedures and through promotion of a culture of respect.

3) Factors specific to certain types of work. Examples include; fear of infection from needle stick injury or biological fluids (a concern for hospital staff), burnout: a phenomenon resulting mainly as a result of job strain in relation to 'caring for people' (Bowden, 1994). It is referred to as a syndrome characterised by emotional exhaustion, in conjunction with a response to self (reduced personal accomplishment) and a response to others (depersonalisation) (Maslach 1993).

4) Organisational factors. Examples include structure, culture, management style and communication.

5) Psychosocial factors. These will be discussed below with reference to three specific theoretical frameworks, which serve to explain the work-stress relationship, see Section 2.6 below.

2.5.5 Contribution of non-work related stress

The NIOSH advise that it is worth considering both work-related and non-work related stress (NIOSH, 2009 a). A full investigation of non-work related stress was beyond the

scope of this study. Though participants were asked how much of their total life stress comes from their work. The Whitehall II study (North et al.1996) revealed that poor mental health and absenteeism due to psychiatric disorder were associated with both stress at work (excessive demands with poor rewards) and stress at home (experiencing difficulties in the closest relationship outside work). When there are stressors at home and at work individuals believe that their problems at home are due to those at work (Cherry, 1978). This finding is consistent with those reported in a study by Leiter & Durup (1996) who reported that the '*spill over*' effect of work stressors on mood at home was greater than that of the effect stressors at home on mood at work.

Other researchers argue that the role of the workplace is over emphasised as a causal factor in relation to the origins of psychological distress and that other areas of social life are de-emphasised. They attribute this to the predominance of the demand-control-support and the effort-reward imbalance models (Marchand et al. 2005). These models are outlined below in section 2.6

2.6 Main Theoretical Models of Stress

2.6.1 Person-Environment Fit Model (PEF)

The Person–Environment Fit model refers to the level with which a person's abilities match the demands of the work, and secondly how the person's goals/aspirations match the opportunities offered by the job (French et al, 1982).

2.6.2 Demand-Control Model (DC)

The concept of control is crucial to understanding the stress response, especially in the workplace. Karesek & Theorell (Karesek, 1979; Karesek and Theorell 1990) put forward the Demand-Control Model (DC), which focuses solely on job characteristics. Jobs defined by high demands (pace, conflicting demands) in combination with low control (regarding decision latitude and skill discretion) are considered stressful as they induce autonomic arousal. Conversely high demands in combination with high

control results in greater stimulation and job satisfaction, which enables learning and sense of achievement (Peter & Siegrist, 1997). Later the construct of support was added to the DC Model to give the Demand Control Support Model (DCS), which suggests that support at work can reduce the impact of stress (Johnson & Hall, 1988). See Section 2.10.3 below for theories on the possible mechanisms for this.

2.6.3 Effort-Reward Imbalance Model (ERI)

Siegrist (1996) moved the emphasis from control to reward in his Effort-Reward Imbalance model (ERI). This emphasised that high effort (working long hours, high energy input,) with low rewards (financial, status, and esteem) would result in higher levels of stress. This model proposes a lack of reciprocity between costs and gains at work, with high cost/low gain conditions resulting in emotional distress, autonomic arousal and associated strain reactions. The ERI model is independent of and complementary to the job DC model (Tsutsumi & Kawakami, 2004).

2.6.4 Models of Coping

Theories on efforts of coping with stress identify two distinct styles; active or problem-focussed and passive or emotion-focussed (Peter & Siegrist, 1997). Evidence shows that these two styles differ not only in overt behaviour but also in physiological response (Henry & Stephens, 1997; Mason 1968, cited in Peter & Siegrist, 1997). Active coping under demanding conditions with limited control has been associated with over commitment (excessive striving) (Peter & Siegrist, 1997) and the simultaneous activation of at least two stress axes SAM and HPA (already outlined in section 2.5.3) (Peter & Siegrist, 1997). Passive coping involves avoidance or withdrawal behaviour with excessive activation of the HPA pathway. Furthermore it has been suggested that active coping under sustained conditions of low control adversely affects the cardiovascular system, whereas passive coping under limited control is associated with depressed mood, reduced immuno-competence and 'giving up' behaviour (Peter & Siegrist, 1997) which results in sickness absence. Peter & Siegrist, (1997) tested the theory of different coping styles within the framework of the ERI model to ascertain if different outcomes could be predicted. They conducted a

study of middle managers in a car production company in Germany) and found that those who experienced high effort and low reward (active coping) were at substantially greater risk of hypertension, while managers who exhibited passive coping (low occupational rewards only) were more likely to experience sickness absence. The study was however restricted to a specific population group (middle aged males) and employed a cross sectional design therefore the findings can only offer preliminary support for the differential prediction of health outcomes according to coping style with work demands (Peter & Siegrist, 1997). There appears to be no similar research in a healthcare setting.

2.6.5 Mental Health Models

Two key models utilised in mental health promotion namely; the Risk Reduction model and the Competence Enhancement model (Barry & Jenkins, 2007) have relevance to the study. The names of the models explain the particular focus for each. In relation to occupational stress the aim is to reduce risks in the first place, then to enhance or promote coping mechanisms. This author suggests that these models would serve as a sound basis for the construction of a conceptual framework for effective workplace stress interventions.

2.7 How workplace stress has been studied in Healthcare

A range of healthcare settings has been studied in relation to workplace stress across the different occupational groups, in various countries. A variety of methodologies has been employed to study different dimensions of stress and to establish some causal relationships in longitudinal study designs. The validity of different dimensions (based largely on the DCS and ERI models) in predicting specific outcomes for the employee (physical, psychological, behavioural) and the organisation (productivity levels, sickness absence) have been studied. Other studies were conducted with the purpose of devising appropriate interventions to address the stress identified (Rees, 1995). The essence of a range of these studies will now be presented.

Most studies were cross sectional in design therefore causality can not be presumed, however significant correlations and associations can be identified.

2.7.1 International Studies

In the United States of America (USA) Karesak et al, (1998) conducted a cross-national comparison of a large sample of males and females from six studies in four advanced industrial countries; the US, Canada, the Netherlands and Japan. The reliability of the instrument used, the Job Content Questionnaire (JCQ), is assessed. The instrument measures scales associated with psychosocial job characteristics including; physical demands, psychological demands, decision latitude, social support and job insecurity. The researchers found that psychological job characteristics are more similar across national boundaries than across occupations. According to Karesek, one of the reasons that the JCQ is successful is due to the predictive validity of the scales in relation to stress-related chronic disease. The fact that the questionnaire is relatively short (49 core questions), can be completed in about 15minutes and is presented in language which can be understood by those in all levels of education would also appear to contribute to its success. Furthermore, active international collaboration by JCQ researchers has led to the development of comparative databases, which serve to further enhance the data interpretability of each study (Karesak et al, 1998). It is not without limitations however, the JCQ does not include; any personality orientation scale, any measures of non-job stressors or any organisation-level job factors (Karesak et al, 1998) which are important considerations when looking at factors that influence workplace stress.

A Japanese study conducted by Ashitomi, (2005) with a population of almost one thousand females workers employed as home helpers (with an 85.5% response rate) showed that 20% of this category of support staff suffered physical and psychological symptoms as measured by the Japanese version of the General Health Questionnaire (GHQ-28). This comprehensive study also looked at different influencing factors such as coping strategies and personality factors, which were measured by the Lazarus-type Stress Coping Inventory (SCI) and the Ego Aptitude Scale (EAS) respectively.

Findings suggested that key areas to target for the management of stress in this group include organisation characteristics (working conditions and job characteristics) as well as factors such as personality, stress coping style and social support both from colleagues and from supervisors (Ashitomi, 2005)

In Korea a study by Han (2004) to identify the factors influencing stress amongst hospital staff nurses revealed a significant and positive correlation between the scores for symptoms of stress and work stress. The most powerful predictor of symptoms of stress was social support, which showed a negative correlation as did self-efficacy and hardiness. These factors, along with work stress and coping style, influenced symptoms of stress in the study's cohort (Han, 2004).

In a Flemish study by Verhaeghe (2003) of the relationship between perceived job stress and sickness absence in healthcare workers (HCW), perceptions of job stress were measured by the scales of the DCS model of Karesek. A mixed gender group of middle-aged nurses was compared with a control group of similar age, gender and education. HCW showed a positive association between absenteeism and job demands, while showing a clear negative association between absenteeism and social support (Verhaeghe, 2003)

Physical symptoms such as low back pain, are experienced more frequently by hospital workers than by other groups according to a Turkish study published recently (Karahan, 2009). Back injuries are most often the result of bending, twisting, frequent heavy lifting, awkward static posture and psychological stress. This study reported that 65.8% of respondents, which included all occupational groups in the hospital setting, had experienced back pain though a cross-sectional study design was employed. Another Turkish study (Yayli et al. 2003) conducted in order to evaluate the relationship between work-related stress and work-life variables used two instruments. The Brief Symptom Inventory (BSI) to measure psychological symptom status and the Brief Coping Style Inventory (BCSI), to measure main coping style. The study showed that females had higher depression and anxiety scores than males,

however the sample size was relatively small (n=152) and no allowance was made for personality, which could be a confounding factor.

A recent study in the United Kingdom (UK) of all occupational groups within a large Health Authority conducted by Rees & Cooper (2006) revealed that healthcare workers reported significantly greater pressure at work than non-healthcare sectors. Nurses reported the highest levels of pressure while general managers reported the lowest. Job satisfaction and psychosomatic ill-health were related to sickness absence (which was also reported by Verhaeghe, 2003) however ancillary staff or support staff, scientists and technicians reported very low levels of job satisfaction and high sickness absence (Rees & Cooper, 2006). Another large study conducted by Hardy et al. (1997) with a representative sample of the major healthcare occupational groups in the UK, revealed that levels of fatigue were higher in healthcare staff compared to the general population. Higher levels of general fatigue (the subjective sensation of tiredness) was reported among doctors (especially female), allied health professionals and managers. The study which also included a high number of support staff (n=492) reported that fatigability (tiredness after exertion) was higher in this group and in nursing staff (Hardy et al. 1997). The authors suggested that fatigue arises from a combination of poor mental health and high work demands.

A health needs survey of acute hospital staff in a Trust in North Wales was conducted to determine baseline information about employees' expressed health needs and concerns with a view to these being addressed by hospital management. There were some positive findings regarding employee health such as the majority of respondents reported that their current health status was good, that they did not smoke and alcohol consumption was within recommended levels. However issues such as men's health, weight control and exercise emerged as areas that needed attention. According to Jinks et al. (2003) the most notable finding was the general lack of pride in working for the Trust and the pervasive feeling amongst employees that the Trust did not care about its employees. These findings have significant implications for managers in terms of recruitment and retention (Jinks et al. 2003)

2.7.2 Irish Studies

In Ireland studies of workplace stress have been conducted with teachers (Wynne et al. 1991) and nurses (Wynne et al. 1992) amongst others. In a number of healthcare settings stress has been studied using the questionnaire from Work Positive (WP); the instrument that was chosen for this study. Work Positive refers to a five step risk assessment system which can be used to: identify and reduce the potential causes of workplace stress within an organisation and to asses an organisation's performance against the Management Standards for Work-related stress laid down by the UK Health & Safety Executive (H&SE) (Work Positive, 2005). The system uses a survey questionnaire (based largely on the DCS and ERI models) and an excel data analysis tool which reveals the organisational profile when data has been entered (Work Positive, 2005). The questionnaire measures nine different dimensions of stress: demands, control, support, relationships, reward/contribution, role, change, safety & health and indicators) and exhibits many similarities with the constructs measured by the JCQ (Karesek, 1998). WP was developed in 2002 so data to date is limited. The Work Positive Project, which ran from June 2008-May 2009 involved participation of twenty different organisations (including healthcare) known as 'Work Positive partners'. The project should generate more comparative data (not available at the time of writing up this study). This is similar to the collaboration of those involved with the JCQ discussed earlier.

A comprehensive study was undertaken in the former Midland Health Board (Wynn et al. 2003) across all occupational groups. The WP questionnaire was used as part of their study instrument. More than a quarter of respondents worked in the acute hospital setting and nursing grades accounted for the greatest proportion of all respondents (Wynn et al. 2003).   A survey of Community Services Staff in Roscommon was also conducted using WP, in this study the highest proportion of responses (37.5%) came from home helps (Harrington & Evans, 2003). The questionnaire was also used in a survey in Mayo General Hospital in the Women's Health Division across all occupational groups, however the only support staff category included was portering staff (Falvey & O' Donnell, 2007)

The review of the literature presented here serves to demonstrate the range of different instruments, which have been used by researchers to study workplace stress. It also serves to highlight the difficulty in comparing studies owing to factors such as the different occupational contexts and methodologies, which influence generalisability.

2.8 Scale of work- related stress

In the European Union (EU) 41million workers (28% of the workforce) reported suffering from work-related stress (Paoli, 1997). In the Republic of Ireland 13,000 people suffer from stress, depression and anxiety (CSO, 2009). More than 10% of total claims for occupational diseases are attributed to stress at work (Williamson, 1994) and according to the Department of Social and Family Affairs 1.7% of all occupational injury benefit claims upheld in the Republic of Ireland in 2006 related to stress.

Evidence suggests that overall stress in healthcare workers may be higher than in other occupational groups (Verhaeghe, 2003; Rees & Cooper, 2006; Karahan 2009). Michie (2003) found that levels of psychological ill health have been reported as higher in healthcare workers than in non-healthcare workers.

2.9 Bullying

2.9.1 Evolution of research on workplace bullying

Research in the area of workplace bullying only began in the 1980s, initially in Scandinavia where it was termed 'mobbing' (Leymann, 1996 cited in O' Connell et al. 2007). During the 1990s other European countries such as Germany, Austria and the Netherlands conducted to research in this area (O'Connell et al. 2007). In Ireland one of the earliest studies was conducted by O'Moore et al. (1998) following the establishment of the Anti-Bullying Centre (ABC) in Trinity College, Dublin in 1996. A few occupational groups in healthcare have been surveyed namely; nurses (Condell, 1995), physiotherapists (Seager, 2004) and doctors (Cheema, 2006). Bullying is now recognised as a significant issue in the workplace with considerable implications for both individuals and organisations (O'Connell et al. 2007). In Ireland the Government recognised the importance of dealing with the issue of workplace bullying with the establishment of the Taskforce on the Prevention of Workplace Bullying in 1999. This taskforce produced a survey report in 2001. The Government established the Expert Advisory Group on Workplace Bullying in 2004. Its report in 2005 recommended that

an up to date survey similar to the 2001 report should be conducted. This resulted in the publication of the Bullying in the Workplace Survey Reports (O'Connell et al. 2007) and is the most recent information available on bullying in Ireland. The report combines the results of two national surveys relating to workplace bullying, one of employees (those currently at work and those not currently at work but held a job within the last six months) the other of employers in both the public and private sectors. Key findings reveal that the overall incidence of bullying is 7.9%. Increased risks were associated with gender, (women more likely than men to report bullying, though the gender difference was not statistically significant), higher levels of education and public sector employment particularly in Education, Public Administration, Health Services and Transport (O' Connell et al. 2007)

2.9.2 Consequences of bullying in healthcare organisations

Bullying in hospitals and other healthcare organisations has been associated with depression, anxiety, job dissatisfaction, job stress and propensity to leave (Quine, 1999). It has also been associated with dissatisfaction (Frank et al. 1999), sickness absence (Quine, 1999; Frank et al.1999; Barker et al, 1999; Kivimaki et al. 2000) and additionally, to negatively affect employees other than the victim in work areas where it exists (Barker et al, 1999).

2.10 Social Support

2.10.1 Definitions

Social support can be defined as: the perceived comfort, caring, esteem or help a person receives from other people or groups. (Cobb, 1976; Wallston et al.1983; cited in Ogden, 2004). It has also been described as the resources provided by other people. (Cohen & Syme, 1985).

Five basic types of social support have been identified (Sarafino, 2002):

- Emotional support, the expression of empathy, sympathy, caring and concern, it provides a sense of comfort and belonging.

- Esteem support, associated with affirmation, expression of positive regard, it builds feelings of self-worth and competence.

- Instrumental or tangible support, is direct help or assistance, it provides practical "hands on help," could include financial support or performing a task for someone.

- Informational support, takes the form of information, advice and feedback.

- Network support involves membership of a group and provides a feeling of belonging.

2.10.2 Research on social support

There is a growing body of research on the beneficial effects of social support on health and well-being. The evidence suggests that the availability of social support is associated with good long-term health outcomes and reduced risk of mental and physical ill health and mortality. Social support is one of the many psychosocial factors that influence health. Some of the earliest evidence on the effect of social support on health, related to mortality, (Berkman & Syme, 1979). Most studies of these studies focussed on social networks but not the functional aspects of support. Morbidity and social support have also been studied extensively, the main areas studied include: Physical health (particularly cardiovascular disease and stroke), Illness recovery, chronic diseases and mental health.

In the late nineteenth century, Durkheim showed that social isolation was associated with high rates of suicide (Durkheim, 1897, cited in Marmot & Wilkinson, 2007). Since that time many studies (including Durkheim 1951, cited in Marmot & Wilkinson, 2007) have reported a link between social support, mental health & well being, as well as mental ill health. The presence of an intimate confiding relationship is a protective factor for women and depression (Brown & Harris, 1978)

2.10.3 How does social support affect health?

Cohen & Willis (1985) suggest that two opposing explanations exist. The Main-Effects hypothesis and the Buffering hypothesis. According to the Main-Effects hypothesis, social support or the lack of it has a direct effect on people's health. Support from others may encourage health related behaviours, e.g. giving up smoking, taking exercise or reducing fat intake in the diet. Support may increase a person's perception of control over the environment and give a sense of self worth which can, in turn, improve well-being and immunity from disease (Bisconti & Bergeman, 1999, cited in Marmot & Wilkinson, 2007). Environmental stressors may have direct effects on bodily systems. According to the Buffering hypothesis social support does not have any direct effect on health but helps to moderate the impact of chronic or acute stressors on health and so buffer their effects. Discussion with a supportive person may help reappraise the threat, making it more manageable or possibly even help in avoiding it. It is linked to the process of cognitive appraisal. Practical help or emotional consolation may help to weaken the impact of the stress, and help the person to deal with the consequences which might otherwise be damaging to their health. It therefore modifies the response to a stressor. Other factors such as stress reactivity and allostatic load also impact. It is postulated that the reason why some people do not experience ill health due to stressful events, and others do, could be due to the availability of protective factors such as social support. Though according to Stansfeld (1998) it is more likely that vulnerability factors such as lack of support, predispose the person to ill health following stress (Stansfeld, 1998, cited in Marmot & Wilkinson, 2007). Evidence for both the Main effect and Buffering hypotheses exist.

2.10.4 Social support at work

While the above models may help to explain the health benefits associated with receiving support from colleagues, supervisors and managers at work, another important theory is also proposed which contributes to these benefits. The Organisational Support theory (Eisenberger et al. 1986). According to this theory, employees develop a perception regarding the extent to which the organisation values their contribution and cares about their well being. Perceived organisational support (procedural fairness, supervisor support, and organisational rewards such as

pay, promotion, training and job security) is related to positive outcomes for employees (positive mood and increased job satisfaction) and the organisation (increased employee performance and decreased absenteeism) according to Rhoades & Eisenberger (2002).

2.11 Policy Context

2.11.1 Global

The International Labour Organisation (ILO) is the United Nation's specialised agency, which deals with labour issues. It comprises 183 member states (Headquarters are in Geneva) and provides information and support to promote decent work for all. It produces a publication on alternate years entitled; *Key Indicators of the Labour Market* (KILM). This contains a set of twenty core indicators, which cover different facets of decent work deficits globally (ILO, 2009).

2.11.2 United States of America (U.S.A)

In the U.S.A the National Institute for Occupational Safety and Health (NIOSH) has been providing world leadership in understanding and preventing work-related disease and injury, since its' establishment under the Occupational Safety and Health Act of 1970 (NIOSH, 2009 a). Research has demonstrated that practices and policies that take account, not only of the work environment (both physical and organisational) but also the personal health risks of individuals, are more effective in preventing disease and promoting health and safety than each approach taken separately (Chu, 2002). NIOSH has embraced this and emphasised that many of the factors, which determine health cannot be artificially, divided between 'at work' and 'non-work', as both environments impact on each other. To address this NIOSH has initiated a Work Life Initiative (WLI), a major part of which was the production of a framework document; *Essential Elements of Effective Workplace Programmes and Policies for Improving Worker Health and Well being.* This identifies twenty key components to guide organisations that seek to develop effective programmes for their workers (NIOSH, 2009 b). The document emphasises the importance of worker participation,

engaging mid-level management, promoting a 'human centred culture' within a context of demonstrated leadership and effective communication. It also addresses the need for tailoring interventions to suit the specific workplace along with adequate resources and a long-term outlook to ensure sustainability (NIOSH, 2009 b). Work is considered to be one of the most important determinants of peoples' health with the potential of addressing up to as much as 70% of all health determinants through workplace programmes (NIOSH, 2009 a)

2.11.3 European

The European Foundation for the Improvement of Living and Working Conditions (EFILWC, Eurofound) based in Dublin, is a tripartite body whose role is to provide findings, knowledge and advice based on comparative research to those involved in social and economic policy making across Europe (Eurofound, 2009). Two recent surveys are relevant to working life These are, the second European Quality of Life Survey (EQLS) Anderson et al. (2009) and the fourth European Working Conditions Survey (EWCS) (Parent-Thirion et al. (2007)

The first of these, the second European Quality of Life Survey (EQLS) just published in Spring, 2009 indicated that Europeans are generally satisfied and happy with life. On average citizens of the EU27[2] report a value of 7 for life satisfaction and 7.5 for happiness (on a scale of one to ten). Having a job generally increased life satisfaction as did being able to achieve sustainable work-life balance. However almost half (48%) of those in paid employment in the EU27 report being too tired at least several times a month as a result of work to do household work, while nearly a quarter (22%) reported that they are too tired several times a week. While income and standard of living are considered key elements of quality of life (QoL). Europeans generally ranked health and quality of family relationships as the most important

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[2] EU 27 (The 27 member states of the European Union) comprises the 15 original EU countries (EU 15) and the 12 New Member States (NMS 12). Summary: [EU27 = EU15+NMS12]

aspects. However, many workers reported that they have difficulties fulfilling family responsibilities due to the amount of time they spend at work. Almost a third (29%) indicated this to be the case several times a month while 11% reported this happens several times a week (Anderson et al. 2009).

The second important publication refers to the fourth European Working Conditions Survey (EWCS) (Parent-Thirion, 2007). Eurofound have conducted this survey every five years since 1990, the questionnaire has expanded from twenty questions in the first edition to almost one hundred currently. Topics cover a wide range of issues including work time, pay, work organisation, access to training, health and well-being and job satisfaction. Overall the findings highlight that most (over 80%) of EU31[3] workers are satisfied with their working conditions.

One of four key policy areas, which the EWCS survey focuses on, is in maintaining the health and well being of workers. The survey found that 35% of European workers consider their health and safety to be at risk due to their work and 25% reported that they have to work at very high speed nearly all of the time (Parent-Thirion, 2007). A four year work programme titled '*Europe at Work; Better Life and Opportunities* for all' was launched by Eurofound in late 2008 and will run from 2009-2012.

2.11.4 Irish

The Irish Government in 2001 established the National Centre for Partnership and Performance (NCPP) to promote and facilitate partnership-led change and innovation in Irish workplaces. Innovation is a critical element of the State's response to the current economic downturn as highlighted by Government in the *Framework for*

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[3] EU31 includes EU27+ 3 Candidate Countries (CC3) i.e. Croatia, Turkey and Macedonia + Norway. Summary: [31 Countries = EU27+ CC3 + Norway]

Sustainable Economic Renewal (NCPP, 2009). Increased employee involvement and engagement are key ingredients in achieving innovation in the workplace. The NCPP is also responsible for overseeing the implementation of the National Workplace Strategy; '*Working to our Advantage'* which is the Governments blueprint to transform Irish workplaces into '*Workplaces of the Future'*. The strategy identified five priority action areas, among them is to enhance the quality of working life. In *Towards 2016* (The National Social Partnership Agreement) a high level of commitment and agreement in principle has been reached on a number of initiatives designed to deliver a new model of employment rights, standards and compliance. In January 2007 the NCPP was placed on a statutory footing as part of the National Economic and Social Development Office (NCPP, 2009) this coupled with the implementation of the priorities identified in the aforementioned documents sets the context within which transformation of Irish workplaces can occur.

The Health Service Executive (HSE) has just published its' first employee wellbeing and welfare strategy for all health sector staff; Integrated Employee Wellbeing and Welfare Strategy 2009-14 (HSE, 2009a). In 2008 the HSE conducted a national survey of employee wellbeing and welfare of 9,000 of its employees. Ipos MORI was commissioned to conduct data processing, analysis and reporting of the completed surveys. The Strategy, which was developed through the Human Resources (HR) Directorate of the HSE, is the response to the findings of this survey (HSE, 2009a). Key areas such as; the need to better support line managers, the need to increase awareness of and integrate Occupational Health, Employee Assistance and Health Promotion Supports and the need for clear lines of communication were all identified in the survey. Additional policies at various stages of development which also address employee health and well being include; Prevention & Management of Stress Policy, Policy to support Lone Workers, Prevention and Management of Alcohol and Drug Abuse and a Rehabilitation Policy. While the *Integrated Employee Wellbeing and Welfare Strategy* has identified six strategic objectives (Prevention, Promotion, Rehabilitation, Staff Development, Information systems, and Communications) it does not include an implementation plan. It does however include mechanisms for monitoring and evaluation (HSE, 2009a, p36).

2.12 Interventions to address occupational stress

2.12.1 Primary Interventions

Interventions to address the stressors outlined have been categorised by Cooper and Cartwright, (1997) as: Primary, secondary and tertiary interventions. These refer to stressor prevention/reduction in the first instance, stress management techniques when stress is inevitable and remedial strategies when the impact of stress is evident (Cooper & Cartwright, 1997). These authors explain that the focus of primary interventions is in adapting the environment to 'fit' the individual. Possible strategies include redesign of the task/work environment, flexible work schedules, inclusion of employees in decision making, career development, provision of social support and teambuilding, establishing fair policies and sharing rewards (Elkin & Rosch, 1990 cited in Cooper & Cartwright, 1997). "Primary interventions are often a vehicle for culture change" (Cooper & Cartwright, 1997) which is a slow process and definitely does not represent a 'quick fix' approach to dealing with stress. These authors point out that the type of intervention required will vary according to the specific stressors which interact in a given organisation and therefore suggest the need for some prior diagnosis or risk assessment, in order to ensure that the interventions match the actual needs. One such initiative, which is used to carry out a diagnosis of the organisation regarding stress, is the Work Positive initiative. Eircom reported favourable outcomes from this initiative. (Work Positive, 2005). Primary/organisational interventions are rare compared to secondary and tertiary ones (Murphy, 1984). Consequently the literature on their effectiveness is limited. Cooper & Cartwright however claim that what exists has been consistently positive especially with regard to long term benefits. Job satisfaction has been shown to improve from primary prevention strategies, but mental health has not. (Tennant, 2001)

2.12.2 Secondary Interventions

Secondary interventions are aimed at increasing self-awareness in order to promote prompt detection of stress and include a range of strategies to improve stress management skills (Cooper & Cartwright, 1997). These include muscle relaxation,

assertiveness training, time management, cognitive behavioural therapy (CBT) and lifestyle modification programmes. Happy Heart at Work is one such intervention, which targets stress, exercise, smoking and diet. Murphy (1996) carried out a review of sixty-four studies which were all peer reviewed, based in the workplace and assessed a specific health outcome. He found that the effectiveness of the intervention varied according to the health outcome measure used. When physiological outcomes were measured, muscle relaxation proved to be most effective, whereas CBT was most effective for psychological outcomes. Meditation was most consistent across outcomes but was only used in six studies; the most positive results across the various outcomes were obtained with a combination of two or more techniques (Murphy, 1996). It can be concluded from these studies that stress management in the work setting can be effective in enhancing the physical and psychological health of workers but is not effective in addressing job/organisation outcomes such as job satisfaction or absenteeism. To produce changes in these types of measures the sources of stress in the work environment itself need to be addressed (Murphy, 1996).

2.12.3 Tertiary interventions

Tertiary interventions are concerned with treatment, recovery and rehabilitation of workers who have suffered ill health as a result of stress, and are generally provided through employee assistance programmes (EAP), (Cooper & Cartwright, 1997). This can involve counselling on site or referral to appropriate support services externally. There is evidence to suggest that counselling is effective for the psychological well being of employees and also has considerable cost benefits for the employer, (Cooper & Cartwright, 1997). These authors also highlighted the effectiveness of counselling in dealing with non-work related stress, which of course spills over. Approximately a quarter of all problems presented concern relationships outside work, (Cooper & Cartwright, 1997). An example of a highly effective tertiary intervention is the case study of counselling in the (U.K) Post Office. The client group showed improvements in all areas of psychological well being, improved self-esteem, decreased anxiety and depression, reduced dependence on alcohol and smoking as coping mechanisms and greater use of exercise and relaxation techniques. The

scheme used a multi strategy approach including counselling and training for occupational health professionals to train line managers in the identification and management of stress. From the organisational viewpoint, absenteeism dropped significantly from an average of 32.5 days to 11.1 days over a six-month period. (Allinson et al. 1989: Cooper & Sadri, 1991 cited in Scriven & Orme, 1996)

In conclusion, individual level interventions such as those employed in secondary and tertiary programmes can be effective in addressing some aspects of workplace stress, but need to be complemented with primary interventions, which address the underlying causes. Effectiveness can be enhanced by comprehensive, integrated approaches. Primary interventions in particular need more research in order to establish a stronger evidence base, which when coupled with the individual interventions, can serve those involved in promoting, health promoting workplaces to implement more effective interventions.

Literature that deals specifically with the effectiveness of interventions designed to prevent stress in healthcare workers is very limited. The review of the literature found only one review by Mimura & Griffiths (2003) which dealt primarily with stress management in the nursing profession. The authors of a recent Cochrane review on preventing occupational stress in healthcare workers concluded that evidence is limited, that person-directed or work-directed interventions can reduce stress in healthcare workers, with results at best being apparent six months to two years post intervention. One trial indicated that interventions with cognitive elements yielded better results than those with behavioural elements (Roustsalainen et al. 2006).

2.13 Conclusions

The literature on workplace stress indicates that conditions at work are important in promoting the health and well being of employees. Stress can lead to physical, mental and behavioural problems and can result from circumstances outside of work as well as from within the workplace. The experience of bullying in the workplace exacerbates perceived stress while social support can reduce the level experienced. The healthcare sector is reported to experience greater stress levels compared to

other workers. Within this sector studies are generally conducted across all occupational groups with fewer occupation-specific studies, which tend to concentrate on medical and nursing professions. While support staff are studied in educational and healthcare contexts (mainly as home help or in Intellectual Disability settings), there is a dearth of information relating to support staff in the acute hospital setting. This current study aims to address this.

Chapter Three: Methodology

3.1 Introduction

This chapter will outline the approach taken and procedures employed in conducting this research, from the initial selection of the research topic through to the production of the final dissertation. The methodology chosen to conduct research is determined largely by the nature of the research question and what is already known about the research topic (Bowling, 2002). The type of data gathered in turn determines the type of analysis performed. Qualitative data generates main themes and can give insightful and rich data on complex issues (Bowling, 2002). In quantitative studies the category of data (nominal, ordinal, interval or ratio) dictates which measure of centrality to employ and along with the pattern of distribution (normal or skewed) of data determines which statistical test to employ. Every attempt is made when conducting research to be objective. Researchers need to be aware of and acknowledge factors, which may influence and has the potential to cause bias (Naidoo & Wills, 1996). Bowling (2002) asserts that research is not value-free and researchers cannot be divorced from the social, political and cultural contexts of their topics. Finally, the principles of ethical research should underpin all research (Ryan et al. 2006). How all of these facets were addressed in this study will now be outlined.

3.2 Role of the researcher

The choice of research was determined by a combination of factors including; the interest of the researcher in promoting 'workplace health'. This includes issues concerning the health of workers but, it also includes concerns regarding the 'Health' of the organisation. In addition, the desire to conduct research which would not only contribute to the body of academic knowledge but would also contribute in very practical terms to 'workplace health' in the workplace of the researcher. This could be achieved by initially generating the baseline information necessary to highlight the issues and to formulating recommendations, which could be presented to both staff and management and through a process of collaboration could result in bringing

about changes to existing policy and practice, thereby improving the well-being of workers while simultaneously promoting a healthy organisation.

The experiential knowledge of the researcher also contributed in deciding the scope of the research and the population group to study. The researcher as part of her work, works with many of the support staff, has gained considerable insight into the issues affecting them and has become aware that, as an occupational group, they are not as extensively studied or as well catered for as perhaps some of the professional groups. This view is also bourn out by the dearth of information in the literature specific to this occupational group.

3.3 Study design

3.3.1 Choice

The overall design employed was a descriptive, cross–sectional, retrospective and correlational study design (Bowling, 2002). A quantitative methodology was used to conduct a postal survey of a random stratified sample of the population under study, using a self -administered questionnaire. The questionnaire incorporated a qualitative dimension with the inclusion of two open questions.

3.3.2 Rationale

A cross-sectional design was the most feasible for the current study due to time constraints and the logistics of a sole researcher. The choice of a quantitative study or a fixed design as it is sometimes known (Anastas & Mac Donald 1994) to conduct this research was influenced by a number of factors including; Firstly, a quantitative design is appropriate for collecting data from large numbers of participants, (Robson, 2002). Secondly quantitative research is suitable in situations where there is pre-existing knowledge (Bowling, 2002) as is the case regarding known workplace stressors. Thirdly this design is appropriate when attempting to establish baseline information on a study group (one of the objectives of this study). Such information is

an essential first step before any recommendations can be made, for example regarding the introduction of suitable interventions.

While a qualitative study design would perhaps yield richer data and more in-depth information, this was not a realistic option within the time constraints of this study period. It would have entailed staff having to secure time off work to attend focus groups, a choice which was not viable in the current climate of staff shortages. It was vital to have management support for this survey to ensure that managers would encourage staff within their area of responsibility to complete the questionnaire. This support would be more forthcoming with minimal disruption to work. Two qualitative questions were included in order to gain some insight into what staff considered to be the greatest sources of pressure for them and how they considered such pressures could be addressed.

3.3.3 Advantages of this design:

- Cross-sectional surveys are economical as regards time and resources (Bowling, 2002)

- Surveys are conducted in the natural setting of the participants (Bowling, 2002)

- Random probability sampling is readily achievable with a survey, thus allowing statistical inferences to be made in relation to the population under study, facilitating generalisations which greatly enhances the external validity of the study (Bowling, 2002)

3.4 Research Instrument:

3.4.1 Introduction

Text books on research methodology (Neuman, 1997; Sarantakos, 1998; Bryman, 2001; Bowling, 2002; Robson, 2003) and a review of the methodologies in the literature indicated that a highly structured or quantitative approach to data collection

was appropriate e.g. a formal written instrument such as a self-report questionnaire. The questionnaire used in this study was a combination of questions from pre-existing questionnaires, which were deemed by the researcher to be suitable in addressing the key research questions for the population under study. It comprised four different parts; the contents of these will now be outlined as well as their sources:

Part 1. Looked as general **demographical** information such as age, gender, hours worked and level of education. These questions were adopted from the National Survey of Lifestyle, Attitudes and Nutrition (SLÁN) (Kelleher et al., 2003) and the Midland Health Board (MHB) survey (Wynne et al. 2003).

Part 2. Looked at the issue of **support** in the workplace. The literature review indicated that social support is a protective factor in promoting positive mental health (Barry & Jenkins, 2007) and support can diminish the effects of stress either by buffering the effects or due to the actual support itself. These questions were taken from the Midland Health Board survey (Wynne et al. 2003).

Part 3. **The Work-Positive questionnaire:** Looked as work related stress using the Work-Positive Questionnaire. Work-Positive was originally developed by the Health Education Board of Scotland (HEBS) and the Health and Safety Authority (HSA, Ireland) to assist organisations in addressing the important health and safety issue of work-related stress, in line with requirements under the Management of Health and Safety at Work Regulations, 1999 (Work Positive, 2002). It has since been updated to allow organisations measure their performance in managing stress against six Management Standards, which the UK Health and Safety Executive (H&SE, UK) issued in 2004 (Work Positive, 2005). The questionnaire consists of 68 questions in total. Questions1-35 have been categorised under six separate themes, which represent the six management standards referred to above.   Work-Positive has grouped questions 1-67 into nine dimensions, which represent different categories of known workplace stress (see below i-ix). Question 68 was an open question, which seeks to elicit what the main pressures are for respondents and gives them the

opportunity to identify issues that might have been missed. Three additional questions were added at the end of the Work-Positive section. One to ascertain possible solutions to the main stressors identified by respondents and the other two to assist in determining the level of stress stemming from work and the types of coping mechanisms used by respondents. These additional questions were taken from the MHB survey, (Wynne et al. 2003).

Main dimensions of stress as categorised by Work-Positive

i.   **Demands.** Refers to factors which place high demands on workers, these include workload (speed, breaks), work pattern (long hours), working environment (lay-out, welfare facilities), nature of work (repetitive and boring, emotionally distressing) and incidents (threat of redundancy, death of a colleague, etc.)

ii.   **Control.** Refers to how much 'say' a person has as regards how they work (speed), what they do, when they take breaks, involvement in team and organisational decision making and job security.

iii.   **Support.** Refers to employees' perceptions of the support they receive at work from colleagues, line manager and senior management. Support in the form of encouragement, feedback, training and provision of equipment adequate for the job.

iv.   **Relationships.** Covers issues such as fair treatment, quality of relationships at work (strained relationships due to friction or anger) and harassment and bullying.

v.   **Role.** Covers issues such as role clarity, reporting structures, being informed about team and organisational decisions and policies

vi.   **Change.** How organisational change is communicated and managed and if the pace of change (whether fast or slow) affects staff.

vii.   **Reward and Contribution.** Refers to pay and non-monetary rewards (receiving positive feedback and feeling valued)

viii.   **Safety and Health.** Concerns over Health and Safety issues at work

ix.   **Indicators.** Issues such as morale or pressures at work causing staff to come to work when unwell, to perform less well when at work or to take time off due to pressure at work.

There is a degree of overlap between some categories, and indeed previous versions of Work-Positive have used different headings to categorise the questions (Work Positive, 2002).

Part 4. Looked specifically at the issue of **bullying**. The section started with the definition of bullying as used by the Health & Safety Authority Ireland. This was followed by a filter question to establish if bullying had taken place in the last six months. The answer 'No' at this point meant the participant had completed the questionnaire. However the answer 'Yes' resulted in the participant having to answer five additional questions, to ascertain the source and nature of the bullying and whether support was sought and from whom. These questions were adopted from the MHB survey (Wynne et al., 2003).

3.4.2 Rationale for instrument choice

The availability of pre-existing, valid and reliable questionnaires, which were easy to comprehend and lend themselves to self-administration were important considerations for a number of reasons.

i.   Poor literacy skills may be an issue for some participants therefore simplicity was vital.

ii.   Data could be collected through the internal mail system, thus reducing costs.

iii.   Email was not an option, as many support staff do not have direct access to the email system.

iv.   The instrument was used in similar settings in Ireland, and would therefore facilitate meaningful comparisons.

3.5 Pilot Study:

3.5.1 Method and Purpose

A total of seven staff representing all the categories of staff (see 3.6.1) in the study and three additional non-staff participants who had attended second level education for varying durations, were selected by convenience sampling. The pilot group was asked to complete the survey, to record the length of time it took them to complete it and how they found the task of answering the questionnaire. The information regarding duration was then used to inform participants, both in the cover letter and in the instructions for the questionnaire. This was deemed important, as highlighting the time can be an influential factor in ensuring that participants complete the entire questionnaire (Bryman, 2001).

3.5.2 Consultation

The consultation process included discussion of the draft questionnaire with the hospital's Support Staff Partnership Forum (includes management and union representatives of support staff) as well as with the occupational health physician to help to establish if there were any important omissions.

Piloting was conducted to;

i.   Establish the feasibility of using the questionnaire in the format presented.

ii.   Gain feedback regarding clarity of instructions and length of time to complete

iii.   Establish if there were any patterns in answering it.

iv.   To assist the researcher in gaining experience on how best to process the data generated and to help in establishing appropriate templates for the main study.

3.5.3 Changes introduced as a result of Pilot

The feedback from the pilot group resulted in minor changes being made to the layout of the questionnaire and to improving the clarity of instructions.

3.6 Materials

A survey pack was prepared for each participant, which included the following:

i.   A clear letter of protocol on headed notepaper (Bowling, 2002) indicating the researchers background and why the project was being conducted. The random nature of the selection was explained as was the fact that participation was voluntary. The time needed to complete the questionnaire was indicated as well assuring anonymity and confidentiality. A closing date was specified along with an explanation of how the results would be used. (Appendix 1)

ii.   The questionnaire (with comprehensive instructions) was produced in booklet form, stapled along the left margin and printed on both sides of the paper in order to reduce the amount and cost of paper used (Appendix 2). Coloured paper was used to enliven the questionnaire (Bowling, 2002) and to capture the attention of recipients. Bowling (2002) suggests that the colour of the questionnaire can potentially influence the mood of respondents; yellow is associated with optimism and was consequently used in this study.

iii.   An information leaflet was prepared for participants with the contact details of services, which are available to support all staff in the hospital, in the event that completing the questionnaire may have caused certain issues to surface. (Details not provided in the appendix in order to preserve the anonymity of the hospital)

iv.   A return self-addressed envelope

3.5 Procedure

A survey pack (as above) was sent through the internal mail system to each participant selected at random. No incentive was offered. The Heads of all departments/wards/units were emailed to inform them about the project and to ask them to encourage staff within their area of responsibility to respond. Approval of key committees within the hospital was also sought (see below). Two weeks after the

closing date an acknowledgement was sent, this also doubled as a reminder to those who had not yet responded (Appendix 3).

3.6 Sample

3.6.1 Sample size and description.

The population of support staff working in the Hospital is in excess of 900. For populations of this size a 50% sample is recommended, (Gay 1996 cited in Leedy and Ormond, 2001) However due to time constraints and logistics, it was decided to sample one third of the population. The majority (n=661) of these staff are employed directly by the Health Services, while others (n=287) are employed directly by private companies that are contracted by the Health Services. These two groups are referred to as 'internal' and 'external' respectively for the purpose of this study, in order to differentiate between the employers. However, the support staff (regardless of employer) work in the same setting and perform similar roles, though the same range of roles (see 3.6.3.) are not studied in the external group. Some procedural details differ for both groups regarding collection of questionnaires these are highlighted in section 5.6.2.

3.6.2 Sampling frame and strategy

A Probability sample (Maisel & Hodges Persell, 1996) within a stratified population was employed in this study. A list of support staff (using personnel number as specific identifier) was requested and provided through the current human resource (HR) system. The sampling frame was sorted into each of the categories listed below (see 3.6.3). Excel was used to generate a random sample of one third of the population within each category. HR supplied the names and work addresses of those selected, following the approval of the Services Manager to release this information to the researcher.

3.6.3 Categories of staff in the sampling frame

The Health Service Executive divides staff into five main categories namely: Medical/dental, nursing, allied health professionals, clerical/ administration and support staff. The support staff category represents a broad range of occupations, for the purpose of this study these were divided into seven main categories based similarities in the following criteria: Role, working environment and/or reporting structure.

Category 1: Assistants to allied health professionals: (Therapy assistants e.g. to physiotherapist/occupational therapist, laboratory assistants and hospital sterile services operatives)

Category 2: Catering staff (chef I & II, domestic staff, cashier)

Category 3: Health care assistant

Category 4: Laundry worker (seamstress, linen supply worker)

Category 5: Maintenance (plumber, electrician, fitter, bricklayer, carpenter, craftsman's' mate) and grounds staff (general operative, gardener),

Category 6: Porters

Category 7: Other (security, cleaner, driver and religious services.) These were grouped together due to low numbers in each sub group

3.6.4 Quality issues regarding sampling.

The aim in research is eliminate or minimise the potential for error. Systematic error can be introduced into the results of a study if the sampling frame is not an exact replica of the population (Maisel & Hodges Persell, 1996). Therefore before the random sampling procedure on the sample frame for each group of staff commenced, four criteria were assessed to ensure accuracy, as recommended by (Maisel & Hodges Persell, 1996) these were;

i.   Missing cases, checked to ascertain if members of the population excluded.

ii.   Excess cases, checked to ascertain if members were included that do not belong to the population.

iii.   Duplicates, checked to ascertain if members were listed more than once (for internal staff a unique personnel number was used).

iv.   Clusters, checked to ascertain if members of the population were clustered in any way.

3.7 Data Analysis

3.7.1 Data entry

Two computer software packages were used for data management and analysis in this study;

i.   Data from Work-Positive (Section 3 of the questionnaire) was entered into a specifically designed analysis tool supplied by the Health and Safety Authority of Ireland as part of the Work-Positive pack. (Work Positive, 2005) This generated scores (see 3.7 4 below) for each of the nine dimensions of stress described earlier in 3.4. All the raw data (scores for each question for each individual respondent from the Work-Positive section) was then imported into the Statistical Package for Social Sciences (SPSS) by first copying into a Microsoft Excel spread sheet. The data was then imported into SPSS to correspond with the rest of the questions for each individual. Individual data was then available for each respondent. By using an SPSS syntax document a 'grouping formula'[4] for each dimension of stress was created, this was then applied to calculate mean scores for each participant for each of the nine dimensions

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[4] The grouping formula was created from information obtained in the sub totals view of Work-Positive, which shows the questions that comprise each dimension]

ii.   SPSS version 15.0 for Microsoft Windows was used to conduct analysis on all the data. All the other questions from the questionnaire were entered as different variables and given appropriate labels and values. Responses were then entered using the coding system set up. Data was then analysed using the appropriate statistical tests (see 3.7.3 below) in order to identify trends and relationships.

3.7.2 Data Accuracy

Following data entry and coding accuracy was checked, as errors made at this stage can cause results to be misleading or indeed threaten the validity of the measures (Neuman, 1997). In order to check the accuracy of input for Work-Positive, a questionnaire was chosen at random, then every tenth questionnaire was checked. It was important here to remember how the questionnaire scoring was handled by Work-Positive see 3.7.4. below. The accuracy of coding, sometimes referred to as 'data cleaning' was checked using wild code checking (Neuman, 1997) this involves checking the categories of all variables for impossible codes. For instance Work-Positive data could only have a score of between zero to five and many of the SPSS codes were coded 1 or 2 to correspond to different categories.

3.7.3 Statistical Analysis

Both descriptive and inferential statistics were employed for analysis in this study. Descriptive statistics describe numerical data and depending on the number of variables described can be categorised as univariate, bivariate or multivariate according one, two or three or more variables respectively. Inferential statistics use probability theory, allow inferences to be made from a sample to a population and test whether descriptive results are likely to arise as a result of random factors (chance) or due to a real relationship (Neuman, 1997). Because of random sampling there is a possibility that a relationship could be found in the sample that does not exist in the population. Statistical significance is used to indicate the likelihood of this happening. At the 0.05 level one can be 95% confident that the results are due to a real relationship in the population, not to chance in the sample (Neuman, 1997). Pearsons chi-square was used for comparing two nominal/categorical variables. Ordinal

variables were compared using the Mann-Whitney U test. Where there were more than two categories in the grouping variable

Kruskal-Wallis was used. Student t-test was used to compare means of scale variables (2 groups).

3.7.4 How the Work-Positive questionnaire is scored

This study used the most recent updated version of the Work-Positive questionnaire. While many of the questions are similar to previous versions they differ in how they are phrased (they are either positively or negatively framed). Responses are organised on a five point Likert-type scale from never-always or strongly agree-strongly disagree. Each response is given a score between 1 and 5. If the question is positively framed the scale for scoring runs from 1-5 where a score of 5 (highest score) indicates the best situation and 1 (lowest score) the worst. Conversely if the question is framed negatively the programme will reverse the scale to run from 5-1, indicating again 5 the highest score as the most positive situation and 1 the most negative. Therefore the higher the score the less the associated stress with that dimension, while the lower the score the greater the stress.

3.8 Delimitations of Study

This study was confined to the category of 'support staff' as other hospital occupational categories have been studied more extensively particularly the Medical and Nursing professions. This current research aims to address this deficit.

3.9 Ethical considerations

3.9.1 Approval procedure

The approval of the Chairperson of the Hospitals Research Ethics Committee was granted. The Services Manager, the Partnership Committee and the Support Staff Partnership Forum within the Hospital endorsed the research.

3.9.2 Participant involvement

A letter of protocol highlighting confidentiality, anonymity and the voluntary nature of the study was sent to all participants. Clarification on the implications of possible findings for both management and staff was provided. Details of existing supports available for staff were highlighted should the survey initiate any issues or concerns for staff.

3.9.3 Data protection

Questionnaires were stored securely and were accessible only to the researcher. All computerised data was stored on the researcher's laptop, which was encrypted.

3.10 Underlying key assumptions

- The sample reflects the population of the target group (random sample)

- Respondents will answer the questionnaire truthfully

3.11 Timeline

Time	Research Stage (Task)	Writing/reporting
Sept. '08 – Jan.'09 Jan. 2009	Phase 1 of Literature review Develop research proposal	 Submit research proposal
Jan. – Mar. 2009	Refine research plan based on feedback Identify protocol and timeframe for ethical approval Finalise research proposal	Present aims/objectives & Proposed Methodology Seek ethical approval Submit research proposal
April-May 2009 Early May Mid May Early June	Conduct Phase 2 of literature review Attend meetings with relevant groups in the Hospital to present proposal and gain approval Send out Questionnaires, Send out Acknowledgements/Reminders	Draft literature review Present draft questionnaire for approval Draft methodology
June	Analyse data	Write up results
July	Pulling together. Draft discussion, conclusions and recommendations	Finalise literature review, discussion, conclusions and recommendations
Early August-mid August	Proof read thesis	Submit thesis

Chapter Four: Results

4.1 Introduction

A random stratified sample of support staff working in an acute hospital setting was surveyed, regarding different dimensions of known workplace stressors, using a self-report questionnaire. The sample comprised those who were employed by the Health Service Executive directly (internal) and those who were employed by two private companies contracted by the Health Service Executive (external). The following section presents the findings. Details of the sample profile will be presented followed by the findings on stress from Work-Positive in order to address objectives one and two of the study, namely: To establish baseline information and to identify key areas of stress for support workers in an acute hospital setting. Work-Positive identifies nine key dimensions of stress, as outlined in the Methodology (see 3.4.1). The influence of bullying and support on these dimensions will be presented to address objective three of the study, namely: To determine the effect (if any) of bullying and support on perceived levels of stress.

4.2 Response Rate

In total 317 questionnaires were distributed, 116 responses were received, thus yielding an overall response rate of 36.6%. The response rate from internal staff was 30.9%, compared to 49.5% for external staff. See Table 1.

Table 1: Response Rate According to Category of Employer

Employer	Total no. of support staff	Questionnaires sent. (1/3 of pop. sampled)	Questionnaires received	% Returns
Internal	661	220	68	30.9%

| External | 287 | 97 | 48 | 49.5% |

4.3 Sample Profile

See Table 2 below for a summary of the sample profile details.

4.3.1 Gender

Overall the sample comprised 60% female and 40% male, with both internal and external groups showing a similar gender breakdown. Pearsons Chi Square showed that there was no significant difference in gender according to employer, p=0.643.

4.3.2 Distribution of Age amongst Respondents

While the majority (58.3%) of respondents reported belonging to the 20-39 year old age group, the age profile differed for the internal and external group. The greatest proportion of support staff employed internally fall within the 30- 49 year old age group (55.3%), none of the internal group were less than 20 years, while 7.5% were more than 60 years. Conversely the external group had a younger profile with 77.1% falling in the 20-39 year old age group, with 2.1% of respondents less than 20 years and none were over 60 years. The Kruskal-Wallis test established this to be a significant difference, p=0.007.

4.3.3 Level of Education of Respondents

The majority of respondents (63.2%) had received second level education (Secondary or Vocational School). Internal staff differed in that a small percentage (7.5%) had not received education beyond primary or first level (Primary school), while none of the external staff belonged to this category. The latter also had a higher percentage (42.6%) that attended third level (College) compared to 25.4% for internal staff. The Kruskal-Wallis test established this to be a significant difference, p=0.041.

4.3.4 Nature of Contract and Job Tenure

Most respondents had permanent work contracts (82.7%). The proportion of those on permanent contracts was higher for external staff compared to internal staff. Pearson's Chi Square showed that this difference was not statistically significant. About three quarters (75.7%) of respondents reported that they worked full-time. A higher proportion of internal staff however (82.1%) had full-time hours as opposed to part-time hours (17.9%), compared with external staff who worked full-time hours (66.7%) and part-time hours (33.3%) respectively. Pearson's Chi Square showed that this difference was not statistically significant.

Table 2: Breakdown of Sample Profile According to Category of Employer

		Total sample n=116	Internal n=68 (58.6%)	External n=48 (41.4%)
Gender	Male	40%	41,8%	37.5%
	Female	60%	58.2%	62.5%
Age group	<20	0.9%	0%	2.1%
	20-29	29.6%	17.9%	45.8%
	30-39	28.7%	26.9%	31.3%
	40-49	20.9%	28.4%	10.4%
	50-59	15.7%	19.4%	10.4%
	>60	4.3%	7.5%	0%
Level of Education	1st level (only)	4.4%	7.5%	0%
	2nd level	63.2%	67.2%	57.4%
	3rd level	32.5%	25.4%	42.6%
Nature of Contract	Temporary	17.3%	22.4%	9.3%
	Permanent	82.7%	77.7%	90.7%
Work-time	Part-time	24.3%	17.9%	33.3%
	Full time	75.7%	82.1%	66.7%

4.4 Findings from the Work- Positive Questionnaire

The questions from Work-Positive can be found in Part 3 of the questionnaire. (Findings from Questions 1-67 are presented in this section). Support staff employed by both internal and external employers exhibits very similar scores for each of the dimensions of stress categorised by Work-Positive. See Figure 1. Scores range from 1-5, a low score signifies a high risk of stress; a high score signifies a lower risk of stress.

Figure 1: Mean Scores for 9 Dimensions of Stress According to Category of Employer.
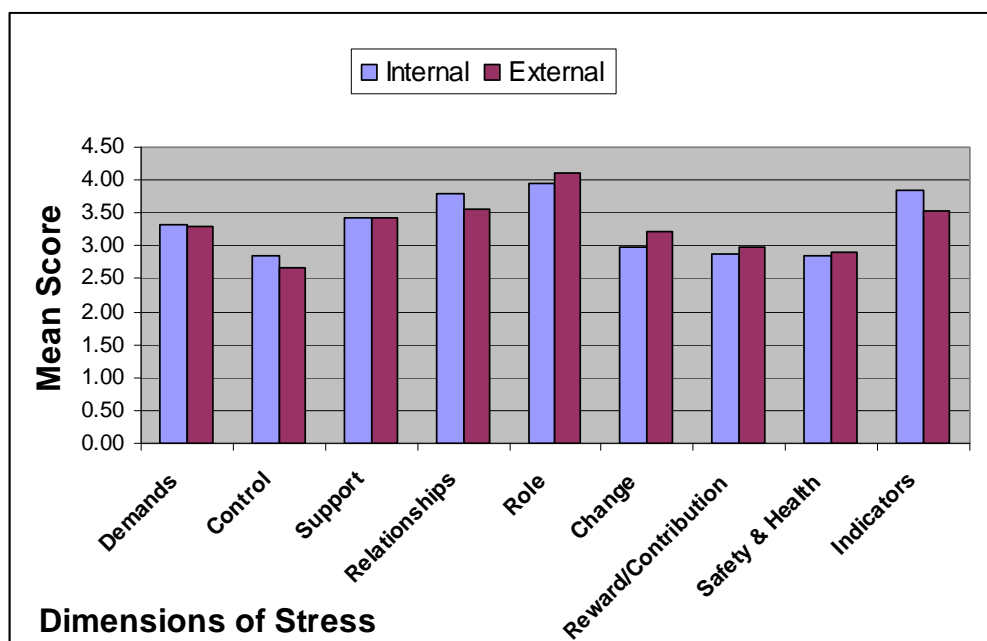
The order in which the dimensions rank from highest to lowest risk is also very similar for internal and external employers see Table 3. The order is identical except for Relationships and Indicators as these are in reverse order for the external group. The top three dimensions causing stress for support staff were identified as Control, Safety and Health and Reward and Contribution, all having a score of less than 3. Change, Demands and Support are next two dimensions, with scores of around 3-3.5. Both groups place Role as the highest scoring dimension, which means this, is the least problematic dimension in relation to stress. A Mann Whitney U test of each of the nine stress dimensions against employer, gender, age, level of education, job

tenure and contract all yielded p values greater than 5. This indicates that these factors are not statistically significant in contributing to the scores for stress reported in this study.

Table 3 Dimensions of Stress Ranked from Most Stressful to Least Stressful for Internal and External Employers.

Ranked	Dimension	Internal Mean -Score	External Mean -Score	Overall Mean -Score
1 Highest	Control	2.85	2.68	2.78
2	Safety & Health	2.85	2.92	2.88
3	Reward/Contribution	2.88	2.98	2.92
4	Change	3.32	3.30	3.07
5	Demands	3.33	3.29	3.31
6	Support	3.44	3.44	3.44
7	Relationships	3.78	3.57	3.69
8	Indicators	3.85	3.54	3.72
9 Lowest	Role	3.96	4.11	4.02

The lower the score the higher the risk of stress associated with that dimension.

Each dimension will now be examined individually in order to clarify the issues associated with each. The sequence identified above in Table 3 will be used as this reflects the order of the dimension causing most stress to least stress.

4.4.1 Control

This dimension had the lowest overall score (2.78, see Table 3) indicating that lack of control over work is the biggest stressor for this group. Looking at the individual questions which comprise this dimension (Figure 2) it can be seen that decisions on what work to do and how to do it, along with flexibility around work-time and break-time as well as involvement in decision making at team and organisational level all score less than 3. Only three questions had a score greater than 3.

Figure 2: Breakdown of Control According to Components
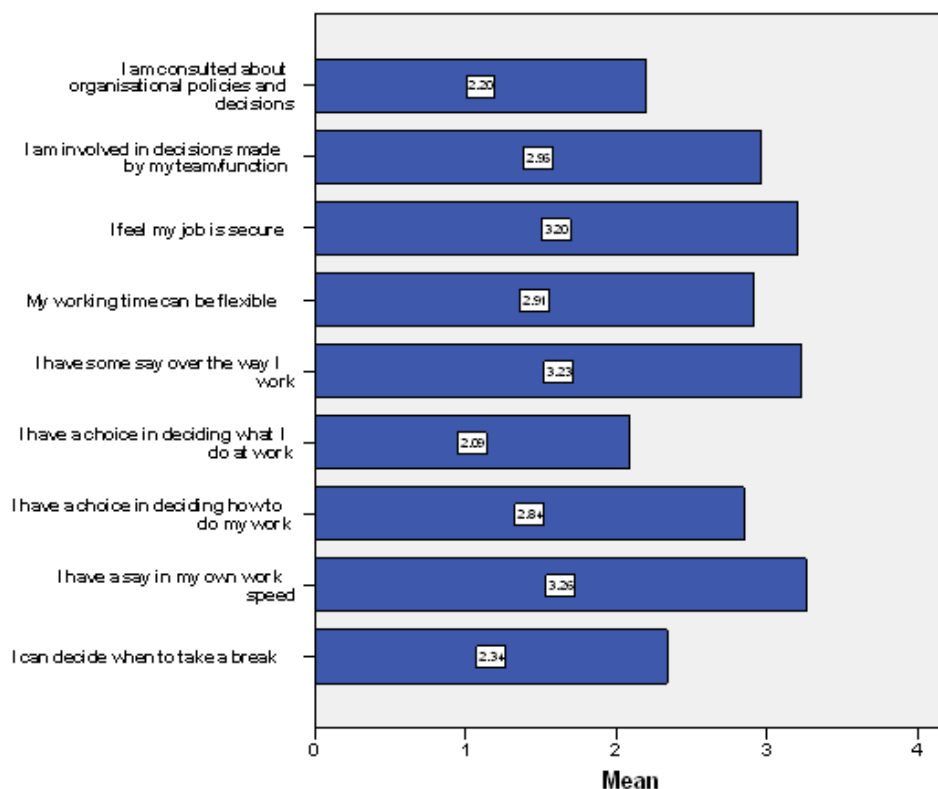
 1- 5 Denotes High – Low risk for each dimension

4.4.2 Safety and Health

Safety and Health ranked as the second highest dimension causing stress for support staff, with an overall score of 2.88 (Table 3). Safety at work resulted in marginally less stress being reported than concerns about health (Figure 3).

Figure 3: Breakdown of Safety & Health according to components
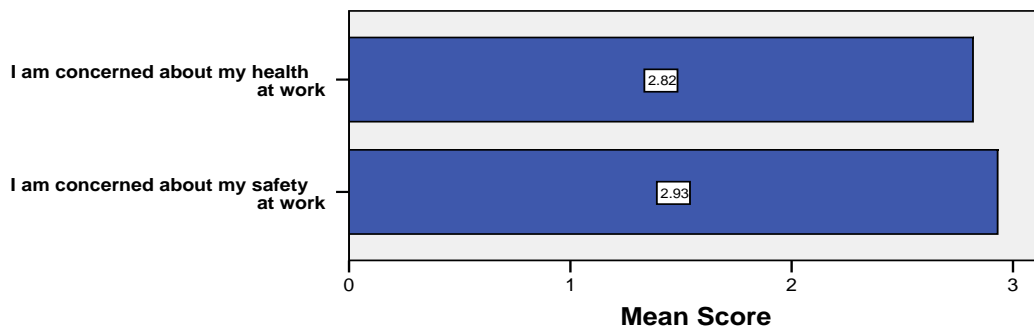
1- 5 Denotes High – Low risk for each dimension

4.4.3 Reward/Contribution

Reward/ Contribution ranked third with an overall score of 2.92.

In this dimension non-monetary benefits and pay scored lowest indicating that these are the two components of this category, which cause staff most stress. Lack of feedback and feeling undervalued also contributed to stress in this dimension.

Figure 4: Breakdown of Reward/Contribution according to components. (**1- 5 Denotes High – Low risk for each dimension)**
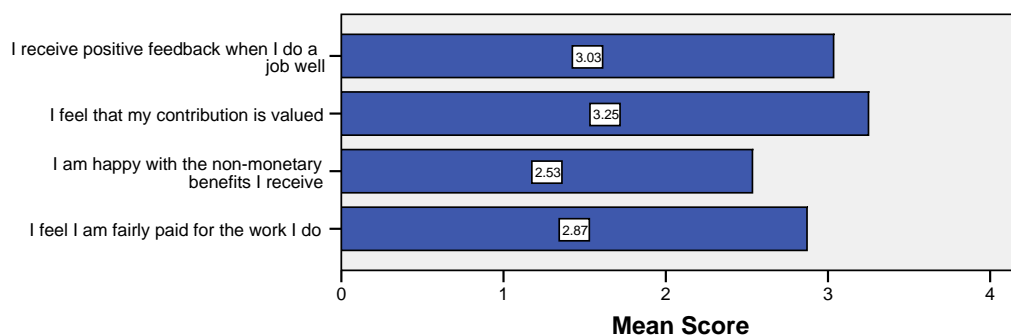
4.4.4 Change

Overall, change at work ranked high on stress with a score of 3.07 (Table 3). The lack of consultation regarding change, the pace of change (whether fast or slow) and the lack of opportunity to question managers regarding change were the biggest stressors in this category. Staff are relatively clear on how change will impact on the workplace (Figure 5)

Figure 5: Breakdown of Change according to components

Component	Mean Score
The pace of change is a source of pressure for me	2.97
When changes are made at work, I am clear how they will work out in practice	3.35
Staff are always consulted about change at work	2.94
I have sufficient opportunities to question managers about change at work	3.03

Mean Score
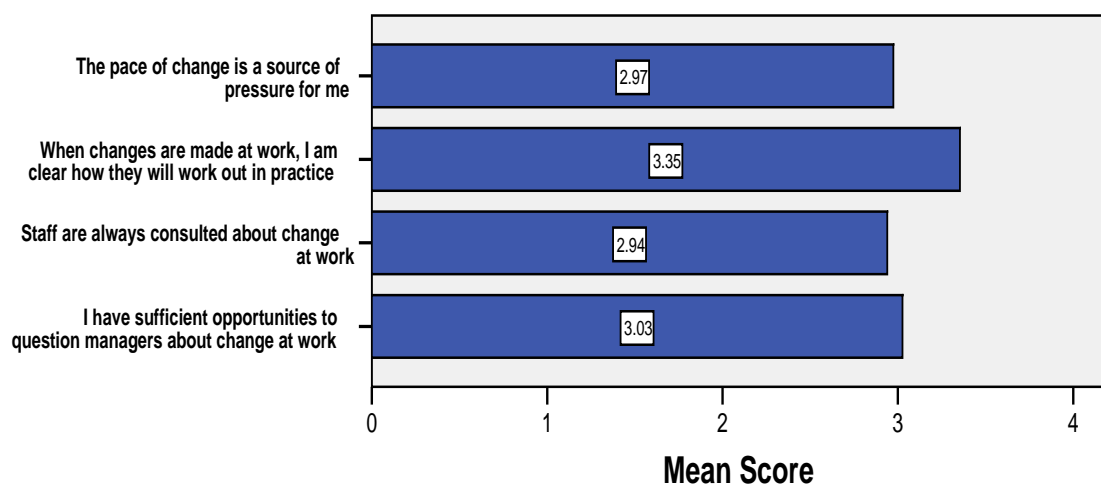
1- 5 Denotes High – Low risk for each dimension

4.4.5 Demands

Demands at work scored 3.31 (Table 3), with work intensity and poorly designed work areas reported as the key issues in this category. However working long hours (more than 48hrs per week) scored highly which means that this is not a major contributor to stress for support staff. Other indicators here are, finding the work boring, repetitive and emotionally distressing and a lack of skills needed to do the job.

Figure 6: Breakdown of Demands According to Components

Horizontal bar chart showing mean scores for demand components:

Component	Mean Score
I work more than 48 hours per week	4.53
I find the work I do repetitive and boring	3.63
The type of work I do is emotionally distressing	3.26
The welfare facilities are adequate (e.g. toilets, wash facilities etc)	3.21
I lack the skills I need to do my job	3.76
Recent incidents at work have been a source of pressure	3.10
My work area is well designed and laid out	2.78
The work environment is comfortable	3.16
My work patterns/arrangements (e.g. hours, shifts) suit me	3.52
I have unrealistic time pressures	3.57
I have to work very fast	2.34
I am pressured to work long hours	4.02
I am unable to take sufficient breaks	3.62
I have to neglect some tasks because I have too much to do	3.11
I have to work very intensively	2.21
I have unachievable deadlines	3.29
Different groups at work demand things from me that are hard to combine	3.21

Mean Score

1- 5 Denotes High – Low risk for each dimension

4.4.6 Support

Support scored 3.44 (Table 3). Lack of supportive feedback was highlighted as the area of support causing most stress in this category, with support from colleagues and line managers being reported more positively (Figure 7).

Figure 7: Breakdown of Support according to component questions

Question	Mean
Senior managers are supportive of employees	3.28
I receive the training I need to do my job	3.62
The equipment I use is adequate to do my job	3.20
My line manager encourages me at work	3.28
I am supported through emotionally demanding work	3.12
My colleagues are willing to listen to my work-related problems	3.53
I can talk to my line manager about something that has upset or annoyed me at work	3.70
I receive the respect at work I deserve from colleagues	3.59
I get the help and support I need from colleagues	3.65
I can rely on my line manager to help me out with a work problem	3.75
I am given supportive feedback on the work I do	2.90
If work gets difficult, my colleagues will help me	3.65

1- 5 Denotes High – Low risk for each dimension

4.4.7 Relationships

Relationships at work overall scored 3.69 (Table 3). While strained relationships and friction between colleagues were the biggest stressors in this category. Two questions about bullying in this category scored greater than 4, which indicate that bullying may not be the biggest factor in causing stressful relationships at work, though it is nonetheless an issue. The results on bullying are presented in Section 4.6.

Figure 8: Breakdown of Relationships according to components
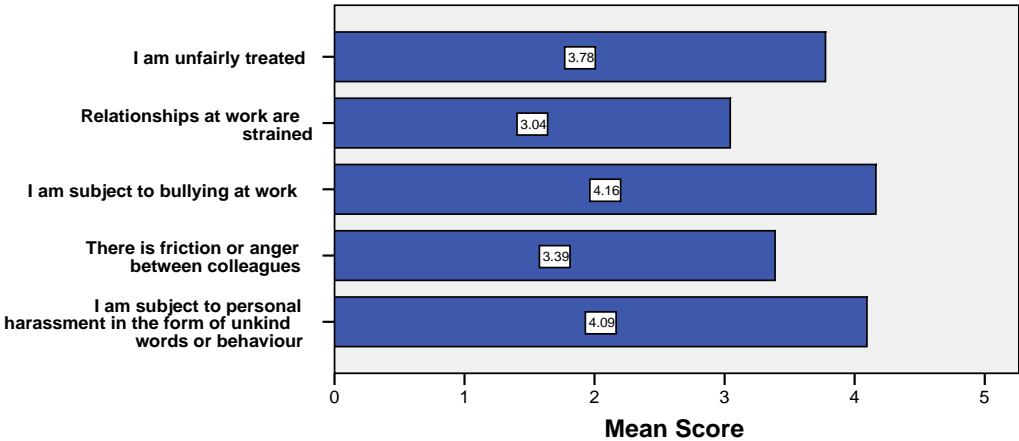
1- 5 Denotes High – Low risk for each dimension

4.4.8 Indicators

The Indicators dimension looks at factors such as pressure, morale, absenteeism and intention to leave as indicators of organisational health. The score was 3.72 (Table 3). Low morale ranked as the biggest stressor in this dimension (Figure 9)

Figure 9: Breakdown of Indicators according to component questions
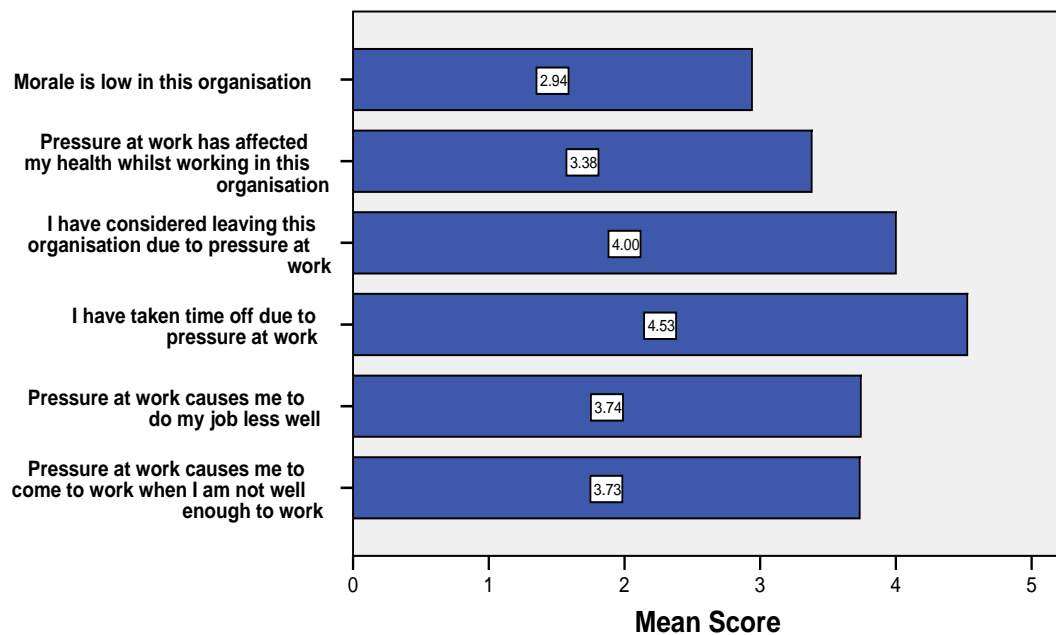
1- 5 Denotes High – Low risk for each dimension

4.4.9 Role

Role was the dimension that scored the highest with a mean of 4.02 (Table 3). Lack of information regarding decisions within the team and organisation were cited as the biggest stressors in this category (Figure 10). Role-clarity, responsibilities and knowing how to get the job done represented the least stress, indicating that staff are clear about what is expected from them and how to go about it.

Figure 10: Breakdown of Role according to component questions
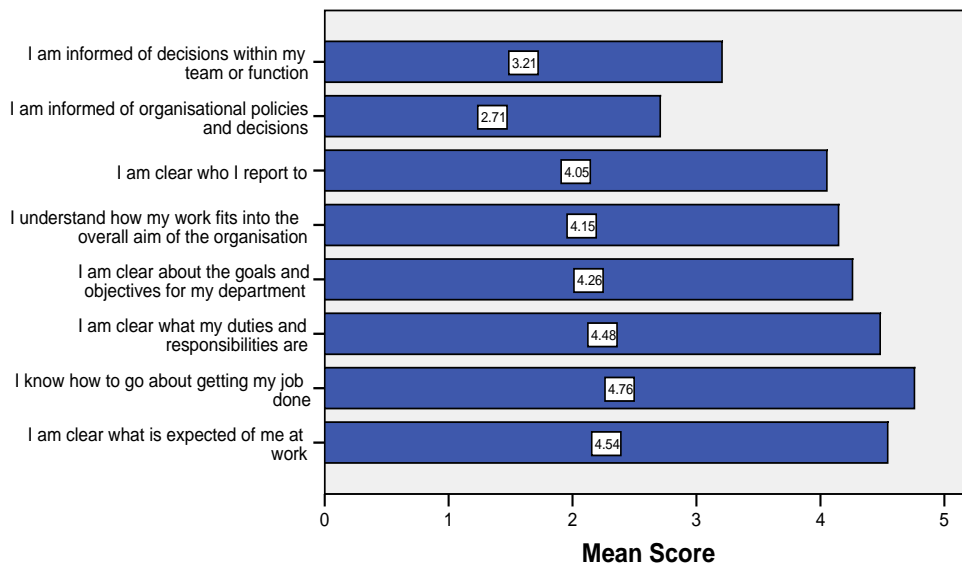
1- 5 Denotes High – Low risk for each dimension

4.4.10 Proportion of Total Life Stress that Comes from Work.

Almost sixty percent of respondents (58.5%) reported that between zero and 40% of the total stress in their lives comes from work, whereas only 23.5% reported that between 60% and 100% of total life stress comes from work. This indicates that the majority of respondents feel that work accounts for a smaller proportion of the stress in their lives and that most of their stress can be attributed to causes outside of work. In fact almost half (49.5%) of the respondents reported stress levels as low as 30% due to work.

Figure 11: % Total Life Stress that Comes from Work
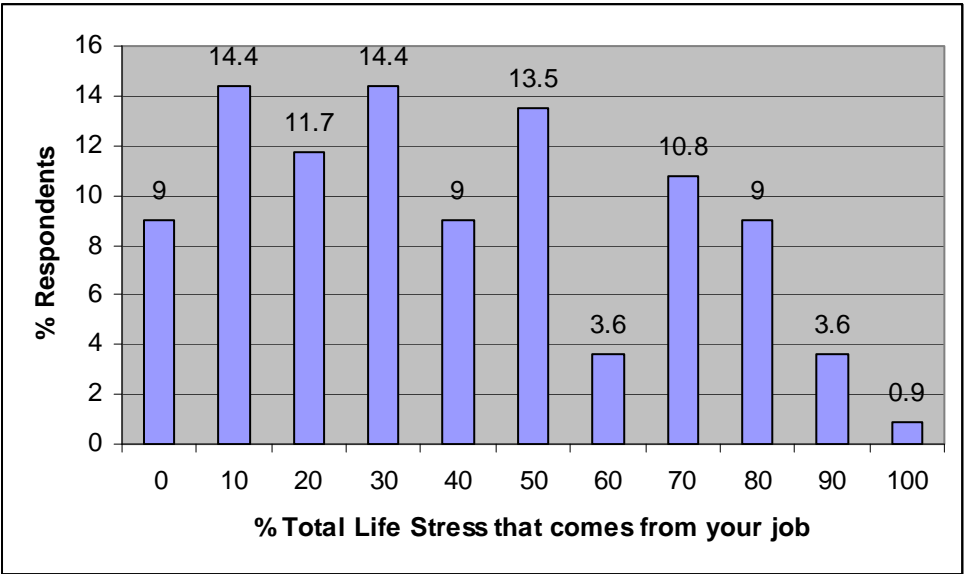
4.5 Findings from Qualitative Questions

The findings from the open questions (q67 and q68) of the questionnaire are presented in Table 4. Analysis of the results showed that a number of themes emerged, these were then categorised according to the nine dimensions of stress identified by Work-Positive.

Table 4: Main Sources of Pressure at Work

Dimension	Theme	Main Sources of Pressure at Work (Figures in brackets represent the number of times for this response)
Demands	Staffing levels	Not enough staff (20). Lack of Nursing and clerical support. Too much responsibility. No replacement staff provided for annual or sick leave (3). Immense pressure for the audits. Responsibility across two sites. Repetitive and boring work. Have to find own cover for holidays and days off. Major stress when staff levels are down. One HCA covering all areas of ward at times. When staff are sick, must do own duties and become operational for their duties. (Double Day). Too many people calling you at the same time.
	Workload & Working conditions Working Hours Clients	Too much work to do (10). Expected to do extra work with no extra help (2). Everyone under pressure to get work done for next shift. Often work ten days straight. If ward is very busy not enough time to do all duties. Staff not doing their fair share of the workload. Evenings very busy. Parking problems (3) even before I get to work at all. Overcrowded workspace (Beds, chairs, leads etc.) Lack of facilities. No lockers. Work area too small. No Canteen room for porters as other areas. Long hours. 84hrs on call. Erratic sleeping pattern due to bleep. Too many working days in the month. Stress when work hours are reduced.Dealing with angry customers (2). Behaviour of patients. Food suppliers, no room for errors, patients have to be fed.Visiting hours not taken seriously at meal times.
Control	Security Speed Lack of say	Not sure what is going to happen to our job. (2) Pressure is put upon me to work quicker (2).Not having break in certain Departments. Not enough flexibility. Not allowed to work in other areas. Work organisation. Some policies and Procedures. Too much time spent cleaning and putting away stores, not enough time to spend with clients.

Dimension	Theme	**Main Sources of Pressure at Work** (Figures in brackets represent the number of times for this response)
Support	Support Training & Equipment	Lack of back up support (2). Working alone. Inadequate training and lack of relevant training. Inadequate amount of Wheelchairs (2) Inadequate resources (3) No maintenance of wheelchairs. Shortage of stock (Bread, jams, etc.)
Relationships	Unfair treatment	Lack of or poor communication (6) Work with staff who are not competent (2). Lack of teamwork. Unhelpful staff.(2) Poor relationships. Moody staff (2). Working with staff that avoid work. Lack of understanding. Bullying by colleagues (2). Bad Supervisors (2). Managers dictating not talking. Expected to be professional when management are not. Your point of view is never taken into account. Talking to other members of staff about you. Supervisors put pressure on employees. If something happens, it is first blamed on the cleaner. Being moved from units to suit full time staff. Certain people getting Sunday nights work (double time) over the Saturday night. Poor rostering (3), unfair distribution of shifts. Irish employees have lots of time for their work. Foreign workers have to do more work.
Role		There appears to be no job description for Healthcare assistants. Would like to be a nurse, but mature student entry is unfair. More tasks should be allocated to HCA 's
Change		We are not asked our opinions and changes are made without consulting us.
Reward/ Contribution	Pay Reward Recognition	Supporting two people on my wages, the pension levy has made my life very difficult. Cut backs have direct effect on pay. No recognition for Fetac course done by HCA's (2). No gratitude from the manager. Seldom any feedback. Not valued.
Indicators		Afraid to voice my opinion in case I loose my job. (2) I feel obliged to work over-time. Too much red tape. I am afraid to look for holidays in case I loose my job.

Table 5: How to reduce pressure at work

Dimension	Theme	How to reduce Pressure at Work (Figures in brackets represent the number of times for this response
Demands	Staffing	More staff (23) not managers. More time to do job (4) Better distribution of staff when things get busy (2). Provide cover for sick & annual leave. Provide clerical support. More help. Annual leave when needed. Cancel audits, pointless as we know when they are coming. Change around staff to different duties. Replace retired and those on long term sick leave.
Control	Workload & Conditions. Hours	Work should be equally distributed, or help given when busy. Relieve us of some duties. Share workload fairly. Plan and organise workload better. Have a break for at least 10mins during 4hrs of work. Provide proper parking (2). More space between beds. Better Conditions. Provide lockers. Provide canteen for porters. Reduce long working days (2). Get rid of 13 hour days. Give more working hours (2) and do not change them.
Support	Security Speed Lack of say	Permanency (2). Give enough time to HCA's to do jobs properly. To be left to complete a task without being called away by nurses. Less cleaning and putting away stores, more time with clients. Too much time lost seeking approval. More powers. Include in decision-making.
Relationships	Support Training & Equipment	More support from management. Staff to support each other. More and better training. More resources. More and proper equipment (6). When all equipment is working. When kitchen is left clean. More wheelchairs (2)

Dimension	Theme	How to reduce Pressure at Work (Figures in brackets represent the number of times for this response)
Role	Communication Unfair treatment	Better Communication. 9) Listening. Teambuilding (2) Being able to speak to our line manager. Staff to have more manners. Remove the bully. Manager more understanding. Staff to work together, good companionship and courtesy. Better communication between senior staff and HCA's. Organise social events and supportive groups. Better support from supervisor (4) Supervisors should put less pressure and be more tolerant and kind. Treat cleaners with respect (3) We can't eat in kitchen we are people too. Share work equally between employees (2). Change work roster system (two days off in week together) Fair distribution and consultation on 'off duty' and line managers to take more responsibility for same. All staff should be rotated to different wards, not the same few all the time (3) Change is good for all. Allocate tasks fairly (2). No favouritism. Treat all fairly. Everyone to do fair share. Draw up a job description for HCA's. Simplify structures.
Change		We should be consulted about matters we can help. More updating about changes. To be more involved in staff meetings
Reward/ Contribution Health & Safety	Pay/Recognition	Pension levy should be means tested. Better wages (2) Sensitivity of job not properly recognised. Acknowledgement for doing a good job (3) Management to treat us as competent people. More feedback including dialogue. Not to be undermined. Provide a safe work environment. More security on the job. Health and safety checks to be carried out. Provide equipment to help carry chairs.

4.6 Results on Bullying in the Workplace

4.6.1 Prevalence, Source and Type of Bullying

Participants were asked if they had been subjected to bullying in the past six months. Those who answered yes comprised 21.2% of the sample, of which 58.3% indicated that the bullying was currently taking place. The most common source of the bullying was from another staff member (60%), followed by 24% reporting that the bullying came from a patient or visitor (Figure 12). supervisor, line manager and senior manager followed, accounting for 24%, 23% and 20% respectively. Total percentages add up to greater 100%, as this was a multiple response question (MRQ). The type of bullying most commonly reported was verbal abuse (68%). While there were no reports of sexual abuse, exclusion and physical abuse were each experienced by 28% of staff.

Figure 12: Main Sources of Bullying Reported by Respondents
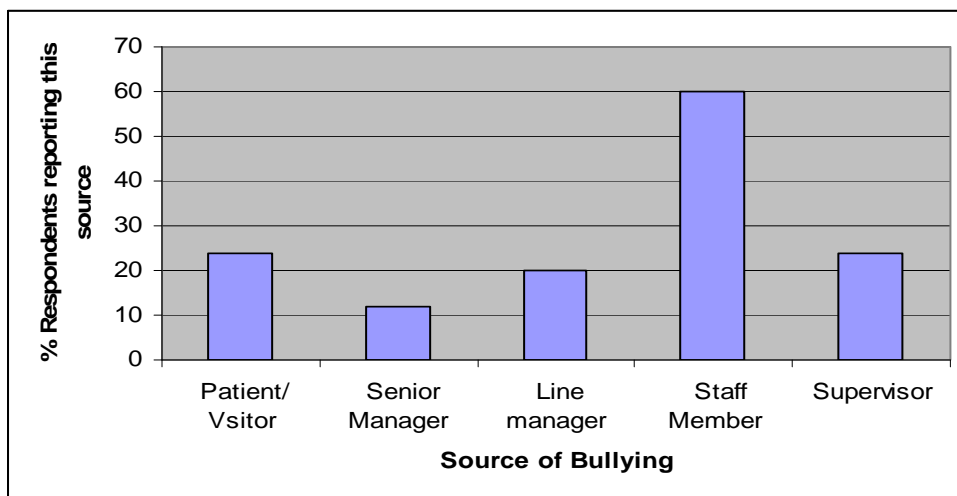
Figure 13: Main Categories of Bullying Experienced
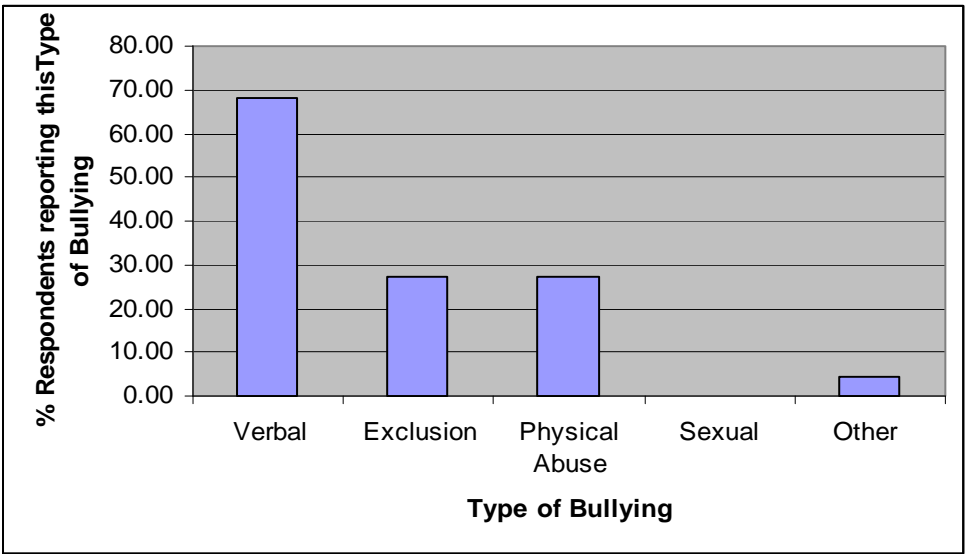
4.6.2 Source of Support in Relation to Bullying

The majority of staff reported that they did seek support (71%) following an incident of bullying; however 29% of those who experienced bullying did not look for support. The overall results show (Table 6) that the supervisor and family were the most common sources of support. Senior management and workmates followed this. However these overall results mask differences in patterns where support is sought by internal and external staff. Internal staff seek support mainly from family and workmates, this accounts for 77.7% of the support they seek. They also report seeking support from their union representative. Conversely the external staff reported that they did not seek support from a union representative and were more likely to seek support from their supervisor (54.5%) and senior manager (45.5%).

Table 6: Breakdown of Sources for Support Following Bullying for the Sample of Support Staff Overall and by Employer.

Source Where Support	*Overall %	*Internal %	*External %

Was Sought	(n=20)	(n=9)	(n=11)
Supervisor	35.0%	11.1%	54.5%
Family/Spouse/Partner	35.0%	44.4%	27.3%
Senior Manager	30.0%	11.1%	45.5%
Workmate	30.0%	33.3%	27.3%
Line Manager	20.0%	22.2%	18.2%
Union representative	10.0%	22.2%	0.0%
Counselling service	5.0%	0.0%	9.1%

*Total percentages add up to greater than 100% as this was a MRQ

4.6.3 Bullying and the Nine Dimensions of Stress Categorised by Work-Positive

Those who were subjected to bullying consistently scored lower scores across all nine dimensions of stress compared with those who did not experience bullying (Table 7). The mean scores were compared using an Independent samples t-test, which revealed that for every dimension, (with the exception of Role) the difference between the mean scores was statistically significant. This implies that those who were bullied experience more stress due to the dimensions investigated here than those who were not bullied. The difference in scores reported for Role is not significant, which implies that, being subjected to bullying does not significantly influence this group in relation to issues such as role clarity and responsibility.

Table 7: Comparison of Mean Scores for Those Who Were Subject to Bullying Versus Those Who Were Not. (Significance Values Are Shown).

Stress Dimension	Have you been subjected to bullying? Yes (n=24), No(n=89)	Mean Score	+/-Std. Deviation	p Value
Demands	Yes	2.90	0.63	

	No	3.43	0.57	<.0001
Control	Yes	2.51	0.55	0.019
	No	2.85	0.76	
Support	Yes	2.84	0.54	<.0001
	No	3.59	0.77	
Relationships	Yes	2.62	0.95	<.0001
	No	3.98	0.61	
Role	Yes	3.81	0.50	0.061
	No	4.09	0.67	
Change	Yes	2.69	0.66	0.007
	No	3.20	0.83	
Reward/ Contribution	Yes	2.45	0.84	0.003
	No	3.05	0.87	
Safety & Health	Yes	2.35	0.87	0.004
	No	3.01	1.13	
Indicators	Yes	3.25	0.68	0.001
	No	3.87	0.85	

4.7 Support and Coping

4.7.1 Sources and Adequacy of Support

In total almost three quarters of employees, 74.8% (n=86) reported they would look for support in relation to issues at work. 61.6% of internal staff would look for support compared to 38.4% of external staff. Workmates were cited as the source of support

most often sought, followed by supervisor, line manager and spouse/partner/ family/friends (Table 8).

These overall results do not reflect the differences in patterns where support is sought by internal and external staff. Though the top four sources are similar in both groups, the order in which each group seek support differed. Internal staff report workmates, line manager, spouse/partner/family/friends and supervisor as the top four sources, while external staff report supervisor, workmate, spouse/partner/family/friends and line manager as the order (Table 8).

Table 8: Shows Sources Where Employees Seek Support in Relation to Work Issues. (*Total percentages add up to greater than100% as this was a MRQ)

Who would you ask for support in relation to work	*Overall % (n=113)	*Internal % (n=67)	*External % (n=46)
Workmate	54.0%	65.7%	37.0%
Supervisor	36.3%	25.4%	52.2%
Line Manager	33.6%	43.3%	19.6%
Spouse/Partner/Family/Friends	31.9%	31.3%	32.6%
Senior Manager	16.8%	19.4%	13.0%
Union Representative	14.2%	16.4%	10.9%
Employee Assistance	8.0%	13.4%	0%
Health Professional Outside of work	7.1%	6.0%	8.7%

Over half of the respondents (58.1%) n=65 reported that the support they receive in relation to work issues was either adequate or very adequate. While 26 respondents (23.4%) reported it as neutral. 3.4% of the sample reported that the support was not at all adequate and a similar percentage (n=4) did not answer this question. See Figure 14.

Figure 14: Adequacy of the Support Received by Respondents
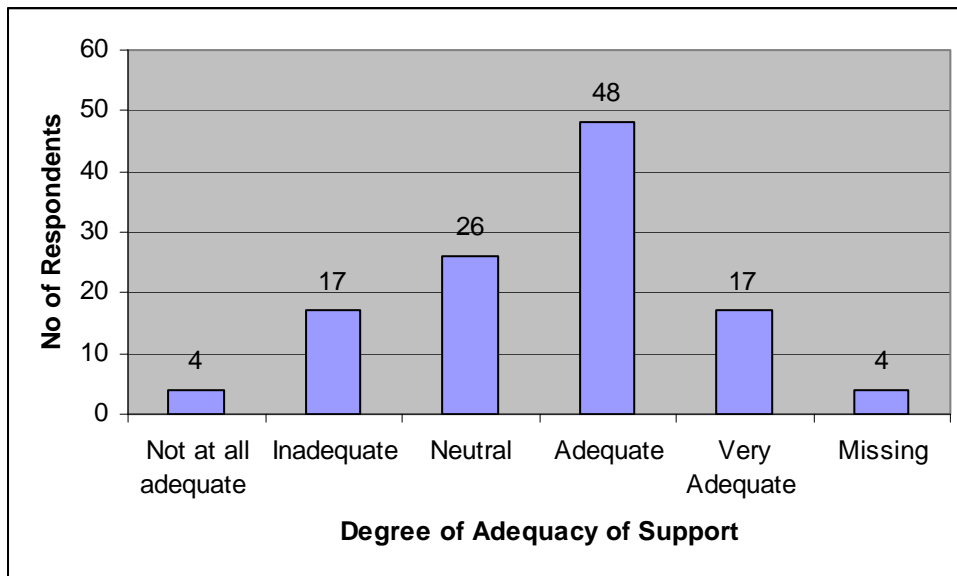
4.7.2 Support and the Nine Dimensions of Stress Categorised by Work-Positive.

Those who seek support in relation to work issues have consistently lower scores across nearly all nine dimensions of stress (except Reward/Contribution) compared to those who do not seek support (Table 8). The mean scores were compared using an Independent samples t-test, which revealed that the difference between mean scores was statistically significant for three of the nine dimensions; Demands, Relationships and Role. This implies that those who suffer from stress as a result of high work demands, poor relationships at work and lack of clarity around their role at work are more likely to seek support than, for instance, those experiencing stress due to stressors such as Change, Health & Safety issues, Control or any of the other dimensions measured. The difference between seeking support or not, is not statistically significant for six of the dimensions, but all scores were lower or equal with respect to seeking support. Therefore while staff may experience stress from these dimensions, they might not look for support as a way of dealing with it.

Table 9: Comparison of Mean Scores for Those Who Look for Support on Work Issues versus Those Who Do Not in Relation to the Dimensions of Stress Categorised by Work- Positive

Stress Dimension	Do you look for Support in relation to Work issues? Yes (n=86), No (n=29)	Mean Score	+/-Std. Deviation	p Value
Demands	Yes	3.24	0.62	0.056
	No	3.49	0.58	
Control	Yes	2.76	0.73	0.577
	No	2.85	0.70	
Support	Yes	3.37	0.80	0.132
	No	3.62	0.72	
Relationships	Yes	3.59	0.89	0.018
	No	4.04	0.84	
Role	Yes	3.93	0.66	0 026
	No	4.24	0.53	
Change	Yes	3.00	0.87	0.109
	No	3.25	0.63	
Reward/ Contribution	Yes	2.92	0.92	0.886
	No	2.90	0.81	
Safety & Health	Yes	2.82	1.13	0.510
	No	2.98	1.05	
Indicators	Yes	3.67	0.87	0.412
	No	3.83	0.92	

4.7.3 Coping Behaviours

The questionnaire also asked about a range of common strategies used to help reduce or cope with stress. Figure 15 provides an overview of the frequency of these different coping behaviours adopted by respondents.

The three most common strategies employed were; to talk to someone (64.4%), exercise more (35.8%), or sleep more (34.9%). All three were used by more than a third of the respondents. Less than a quarter used smoking, less than a fifth used drinking, less than an eighth ate more and less than a tenth visited the doctor or took tablets as a way of coping.

Figure 15: Frequency of a Range of Coping Behaviours
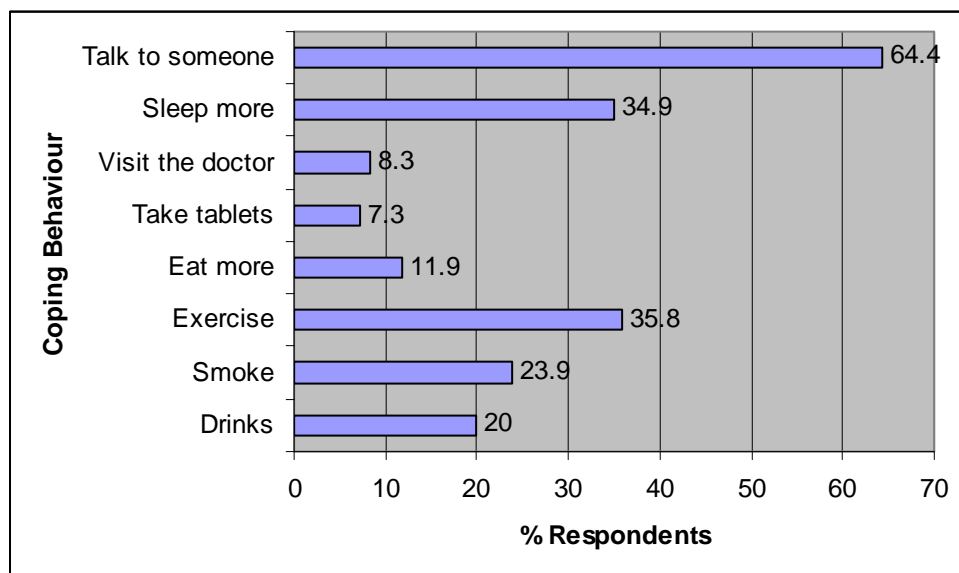
4.8 Summary of findings at baseline

Overall the sample profile for support staff working in the hospital revealed that most of respondents were female, less than 40 years of age, with predominantly second level education. The majority had full time and permanent contracts.

Work positive revealed the order (ranked from highest to lowest risk of causing stress) for the nine dimensions of stress measured as; control, safety & health, reward/contribution, change, demands, support, relationships, indicators and role. None of the nine dimensions of stress studied yielded scores at the extremities of the scoring scale, either extreme stress or no stress and only three were in the more stressful half of the scores (i.e 3 or below, see Fig.1). The implications and significance of these findings are discussed elsewhere (see 5.3). The most stressful components identified within the dimensions were lack of choice in deciding what work to do, lack of consultation regarding organisational policies and decisions and working intensively. The majority of respondents reported that work accounted for between 0% and 40% of total life stress. Almost half of them reported that it accounted for less than 30% of their total life stress. Almost three quarters reported that they looked for support in relation to work issues.

The main sources of social support used to deal with workplace issues were workmates and management. The most frequently used behaviours to help cope with stress were to talk to some one, exercise or sleep more. Just over one fifth (21.2%) of the respondents reported having been subjected to bullying in the previous six months with the majority indicating that this was still ongoing. Other staff members were cited as the most common source of bullying with verbal abuse being the predominant form. The majority reported that they seek support in relation to bullying; the internal group seek support mainly outside of work, whereas the external group seek support in the workplace from management. Those who reported bullying suffered significantly more stress across eight of the dimensions studied. These findings will be discussed in the next chapter.

Chapter Five: Discussion

5.1 Introduction

Previous sections have presented the context for the study, comprising a review of current literature and the study rationale (see Chapter 2), the approach taken (see

Chapter 3), followed by the findings and analysis (see Chapter 4). This section discusses these findings within the context of current knowledge of stressors in the workplace, measuring stress at work and studies of stress at work among other staff groups. Study limitations are highlighted and recommendations presented within current context of healthcare.

The main aim of this study was to identify the key stressors affecting support staff from a range of 'known' occupational stressors, in an acute hospital setting. Three main objectives were identified to achieve the aim, they were;

1) To establish baseline information on which further studies could be done and possible interventions identified.

2) To identify what the key areas of stress are for support workers in an acute hospital setting.

3) To determine the effect (if any) of bullying and support on perceived levels of stress.

5.2 Baseline information

5.2.1 Importance of baseline data

Baseline information has been collected as an essential step in creating a stress monitoring system within the organisation. Such information is a prerequisite for the introduction of any intervention or programme, which may be initiated to address the issues identified. The target audience for the findings from this study will be those with overall responsibility for staff well being and specifically those with responsibility for support staff. This would include the hospital general manager, support services manager, human resources, health promotion, health & safety, occupational health, employee assistance, union representatives, line managers and support staff.

5.3 Key sources of stress for support staff

5.3.1 Non work-related stress

This study focused on the experience of stress in the workplace. However participants were also asked to identify how much of their total life stress comes from their work. NIOSH advise it is worth considering both work related and non-work related stress (NIOSH, 2009 a). However that was beyond the scope of the current study. The majority of respondents (58.5%) in the current study reported that work accounted for 40% or less of their total life stress, this is similarly reflected in the findings reported in a large study conducted with healthcare staff across all occupational groups in the former Midland Health Board (MHB), where 53.2% of staff reported that work accounted for 40% or less of their total life stress (Wynn et al, 2003).

In the current study almost half of the respondents (49.5%) reported that work accounts for less than 30% of their total life stress. This would suggest that over 70% of stress experienced by support staff is due to non-work related issues and could lead to the conclusion that their work environment is not excessively stressful. Nonetheless almost a quarter (23.5%) reported that 60% or more of their stress comes from work sources.

"*Work-related stress is as unacceptable and preventable as other occupational illnesses*" (Cassells, 2001, in Armstrong, 2001, p4).

Health & Safety legislation identifies workplace stress as an occupational hazard and "requires every employer to ensure, as far as is reasonably practicable, the safety, health and welfare at work of all his/her employees" (HSA, 1995)

5.3.2 The main sources of work-related stress

The main dimensions which cause stress for support staff were identified as: control, safety & health, reward/contribution, change, demands and support, these are ranked in order of decreasing stress. These will all be discussed individually initially in order to highlight the key features relating to each dimension. Key strands emerging from the main findings will be highlighted in order to portray key aspects of organisational life. The implications of these will then be discussed in relation to health promotion practice and policy for management and staff.

Control

Working conditions reported in this study were characterised by; low control over deciding what work to do, how to do it, when to take breaks and flexibility around working times. These factors all indicate lack of autonomy, for these workers who occupy positions at the lower end of the organisational hierarchy. Lack of consultation regarding organisational and team decisions also ranked as a concern for respondents. The former ranked as the most common source of stress for healthcare staff in the MHB (Wynn et al. 2003). Poor decision latitude and lack of consultation is consistent with an authoritarian management style as described by the classic work of Tannenbaum & Schmidt (1958, 1973) and Tannenbaum & Massarik (1950).

Health and Safety

Concern over health and safety at work was the second most stressful dimension reported. According to the fourth European Working Conditions survey, 35% of European employees and 23.5% of Irish employees consider their health or safety to be at risk because of work Parent-Thirion, et al. 2007). This was also highlighted by healthcare staff (all occupations) in the MHB study (Wynn et al. 2003) and an unpublished study in Mayo General Hospital (Falvey & O'Donnell, 2007) of staff in the women's health division. The qualitative information in the current study revealed that lifting is a particular concern, as is staff security on the job.

Reward /Contribution

Reward /Contribution was the third most stressful dimension for support staff. Respondents reported that both non-monetary and monetary benefits were not adequate. Lack of positive feedback was reported as a key stressor, this would appear to be a feature of healthcare work environments and was reported in a number of Irish studies (Wynn, 2003; Janas & Harrington, 2003; Falvey & O' Donnell, 2007)

Change

Lack of consultation regarding change was highlighted as a stressor, this concurs with the lack of consultation on organisational and team decisions reported under the dimension of control. These factors coupled with a lack of opportunity to question management regarding change suggest a didactic management style.

Demands

Demand covers not only workload, (working under pressure, un-achievable deadlines, unable to take breaks, conflicting pressures), but also the working environment both physical (layout and design, welfare facilities) and emotional (work is emotionally distressing). Lack of training (not possessing the necessary skills to do the job) is also included. Working hours coupled with pressure to work long hours and whether the work is found to be boring and repetitive are also included. In this dimension pressure to work long hours and working more than 48hours were the least stressful whereas all of the other components ranked as more stressful which indicates high demands. This in combination with low control discussed earlier comprise the constructs of the Demand Control model (Karesek, 1990) with its' implications for health. The demands dimension in the most recent version of Work-Positive (2005) includes stressful once off incidents which was categorised as a separate dimension in the earlier version of Work Positive (2003).

Support

The elements that comprise the support dimension include not only support (practical and emotional) from colleagues and line managers, but support in relation to the working environment (physical and psychosocial) in the form of adequate equipment (also highlighted in the qualitative results) to do the job, encouragement from line manager, and respect from colleagues.

Overall lack of supportive feedback caused the most stress, this has been highlighted in other Irish studies of healthcare staff (Wynn et al. 2003; Harrington & Evans, 2003; Falvey & O' Donnell, 2007). In contrast, perceived levels of support from colleagues and line managers in relation to work was reported more positively, with the latter resulting in marginally less stress. The pattern in the current findings is similar to those reported in a survey conducted across all occupations of HSE staff (HSE, 2009), which showed that the levels of support reported from colleagues, and line managers (while generally perceived as good) differed. Eighty percent of respondents in the HSE survey agreed that colleagues were supportive if work got difficult, while significantly fewer, 63% agreed that line managers were supportive in similar circumstances (HSE, 2009). However, the data presented were overall aggregate results and only highlighted subgroups when significant differences existed. Support staff were not highlighted as perceiving a difference in support from colleagues relative to line managers. Given that the current study revealed less support from colleagues than line managers it suggests a need to develop peer support groups in order to increase the level of perceived and actual support from colleagues.

The importance of support from colleagues has been demonstrated in a number of studies. Ford and Honnor (2000) reported that this was the most important source of support at work. Dryer & Quine (1998) found a negative association between burnout and support of colleagues, while Ito (1999) reported a similar association with support from supervisors. These latter three studies refer to community residential staff in direct-care of clients with learning disabilities. Though the methods and setting differ from the current study, the findings relate to all staff in these facilities, which include support staff and emphasise the importance of support at work from different sources. Respect from colleagues (or the lack thereof) resulted in greater stress in the current study relative to

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support from colleagues and line managers. The HSE staff well being survey (HSE 2009a) reported that support staff were less likely than other grades to feel treated with respect by colleagues. These findings suggest a need to heighten awareness for support staff of the Health Service Dignity at Work policy; the provision of peer-support groups may also help in engendering a culture of respect for colleagues.

5.3.3 Sources of work-related stress of lesser priority

The sources of stress, which are of lesser significance for respondents, highlight some of the more positive aspects of working life experienced by this group. It also demonstrates that even though the average score for the dimension overall may rate better than other dimensions, closer scrutiny will reveal the issues which are problematic (not working well) and those that are not as problematic (working better), thus serving to highlight specific issues. Relationships, indicators and role were the dimensions which resulted in the least stress overall.

Relationships

Strained relationships and friction between colleagues were the biggest stressors in this category. Despite this, staff reported receiving support from colleagues more positively. This suggests that staff support each other even though there are issues around relationships at work; the qualitative findings indicate the nature of these issues (see Table 4b). The relationships dimension also includes perceptions on fair treatment; this also emerged as a theme in the qualitative findings (see Table 4)

Indicators

Low morale was seen as the most stressful component in this dimension, followed by pressure at work affecting health. The results of this study for the health and safety dimension showed a marginally greater concern over health than safety. While taking time off due to pressure at work, as well as coming to work when not well enough to work scored high (less stress) these results must be interpreted with caution. These findings suggest a high level of commitment from staff, which is positive for the

organisation, but could be indicative of overcommitment as associated with the ERI model (Siegrist, 1996, 1998). Evidence suggests that the overcommited behaviour of excessive effort results from a distortion in the individuals' perceptions. This can lead them to underestimate the challenge involved, which may be triggered by an underlying motivation to experience approval and esteem (Siegrist, 1996, 1998). Other researchers suggest that people characterised by overcommitment tend to exaggerate their efforts as well as underestimate their rewards (van Vegchel et al. 2001). Results from a Dutch study of ancillary healthcare workers in a nursing home setting (mostly female, 65% of whom were nurses aides and the remainder comprised cleaning, catering and administrative staff) supported the ERI model (van Vegchel et al. 2001).

Role

Lack of information regarding organisational policies and decisions, as well as team decisions rated poorly in this dimension compared to awareness of reporting structures, role clarity, expectations regarding role and above all knowing how to get the job done. The lack of consultation regarding organisational and team decisions has already been noted. Regarding the dimension of role, it is the lack of information regarding organisational and team decisions that is highlighted, such information is vital for staff in order to execute their role effectively and represents poor or a lack of communication. In the recent study of HSE staff over half (53%) agreed with the statement that they are informed of developments within the HSE, however 26% did not agree. A higher percentage (64%) reported that they were kept informed of issues relevant to their specific section or department. Management/administrative and social care grades were more likely than other staff to feel informed of developments (HSE, 2009) therefore support staff were less likely to feel informed, this concurs with the lack of information received by support staff in the current study.

5.3.4 Summary of key aspects of organisational life from Work Positive

Overall conditions at work for this occupational group are characterised by high levels of demand and (workload, poor welfare facilities and poor work-station design) low levels of

control (decision latitude regarding what work to do, how to do it, when to take breaks etc.). Monetary and non-monetary rewards are perceived as inadequate. Lack of consultation and information regarding organisational and team decisions and change, as well as a lack of positive feedback, appear to characterise the working environment for support staff in this setting, these factors more than likely contribute to the low morale and stress reported by respondents. Conversely the findings indicate that support staff know how to go about getting their job done, are clear about their duties/responsibilities and reporting structures. Generally they do not work more than 48hours per week and while bullying/harassment exist it did not rank as a key stressor.

5.4 Bullying

O'Connell & Williams (2002) describe developments in the field of workplace bullying and indicate that, attention has largely focused on measuring the incidence of bullying, with much less attention being paid to the correlates of workplace bullying. Furthermore they indicate that attention has turned to focussing on responses to deal with workplace bullying (organisational responses which aim to prevent and deal with bullying) as well as individual coping strategies (O'Connell & Williams 2002). The current study focused on incidence, source, nature of bullying and seeking support as a coping behaviour. According to the National reports on workplace bullying (O'Connell et al. 2007) the overall incidence of bullying in the workplace is 7.9%. The recent HSE report on staff well being (2009) reported that 14% of staff said their work had been affected by bullying/harassment. The incidence from the current study was 21.2%. This appears high by comparison in particular with the national average. The national surveys however report a number of factors, which contribute to a higher incidence of workplace bullying which could be influential in contributing to the incidence reported in this study. These include: Women being at more risk than men, (60% of the respondents in this study were female) higher incidence in public sector and larger organisations as well as organisations undergoing change, all factors relevant to the work environment of this population of support staff. Interestingly the MHB survey by Wynne et al. et al. (2003) reported a similar incidence (22.3%). However Wynne et al advised caution in

interpreting their result as they suspected an over-interpretation of the definition employed, which could result in an over-reporting of bullying.

The sources of bullying were predominantly from other staff members (60%) followed by patients/visitors and supervisors at 24% each. This same trend was observed in the MHB study (Wynn, at al. 2003). The national workplace surveys also revealed that colleagues were the primary source of workplace bullying (O'Connell et al. 2007). These findings strengthen the argument for improved awareness and implementation of dignity at work policies. The most common type of bullying reported in the current study was verbal followed by exclusion and physical which were equal. Similar trends were reported in other studies regarding the most common types of bullying (Wynn, 2003; O'Connell et al. 2007) but they differed in the degree of physical abuse reported. The two studies cited above reported very low incidence of physical abuse (less than1% and less than10% respectively). The current study showed that physical abuse was reported by 28% of respondents. It could be suggested that bullying of a physical nature may be more prevalent amongst support staff. This would not be detectable in the national surveys and may not have been detectable in the MHB survey as support staff were mainly represented by home helps whose response rate was low, (4.6% of the total respondents (Wynn, 2003). However the above suggestion needs further investigation in order to determine its' validity.

The majority of respondents (71%) revealed that they looked for support following an incidence of bullying. However there was a difference in where internal and external staff sought support. Internal staff sought support mainly outside of work from partner/spouse/ family and inside of work from workmates, with fewer reporting trade unions as a source of support. These findings show similar patterns to those observed in other studies among teachers, nurses and the staff of the MHB (Wynn et al. 1991, 1992, 2003). Conversely the external group sought support largely from their supervisors and line managers. A number of possible explanations may account for these differences. A greater proportion of internal staff may have easy access to the support offered by family, whereas according to anecdotal reports many of the external staff were non-Irish nationals and may be working away from their families, making such support less

accessible for them. Another factor influencing where support is sought is the extent to which workers trust the different management levels within their organisation to deal with the issue of bullying; only a small percentage of internal staff sought support from management. Fear may influence the level of reporting, as staff may not want to be seen as looking for trouble.

In the case of external staff they may not know how to access a union representative. If family support is not readily available there may be little choice but to seek support from management. This tendency could be due to the serious nature of bullying which would warrant management intervention. Finally, the findings in this study revealed that those who reported being subjected to bullying reported significantly higher levels of stress across eight of the nine dimensions of stress measured. This was not surprising, as the consequences of workplace bullying have been well documented (Quine, 1999; Frank et al.1999; Barker et al, 1999; Kivimaki et al. 2000; Arehart-Treichel, 2006). One author describes bullying as "a particularly noxious form of occupational stress" and suggests that looking for a position in another organisation is often the best solution, because if bullying is tolerated in the person's workplace, then "there is a culture there that supports it," and it is highly unlikely that such a culture can be detoxified (Gold. 2006 cited in Arehart-Treichel, 2006). Bullying is considered to be a significant source of social stress at work (Zapf, 1999; Vartia, 2001 cited in Einarsen et al. nd) and more devastating for employees than all other work-related stresses put together (Wilson, 1991 cited in Einarsen et al. nd).

5.5 Social Support and Coping

Almost three quarters of respondents (74.8%) reported that they seek support in relation to issues at work with workmates and supervisors/line managers being the sources where support is most often sought. These findings are consistent with those from the MHB study (Wynne et al., 2003) and are viewed positively as support from colleagues and management is regarded as the best and most immediate response to staff in need (Wynne et al., 2003). The Whitehall II study of British civil servants (North et al.1996) revealed that support from colleagues and supervisors reduced the chances of poor

mental health and absenteeism. Other studies have shown that when supervisors show concern and sensitivity towards their employees, that staff seemed to tolerate difficult work conditions (Skarlicki & Folger, 1997). Findings from the current study revealed that the key coping strategy to reduce or cope with stress was to 'talk to someone.' Exercise and sleeping were the next most frequently used coping behaviours; this finding is consistent with those from the MHB survey (Wynne et al., 2003). It is encouraging from a health promotion perspective that the majority of respondents report these more positive coping behaviours. Negative coping behaviours such as smoking and drinking were reported by approximately 20% of respondents, while in the region of 10% reported eating more and taking medication as a coping mechanism.

Those who seek support in relation to work issues reported generally higher levels of stress (lower scores) across all nine-stress dimensions measured, which may explain why they seek support. The differences were statistically significant in relation to three of the dimensions; Demands, Relationships and Role which suggests that those who seek support are more likely to do so because of difficulties associated with high demands, (which was one of the six key stressors identified in this study) relationships or role. While other dimensions contribute to stress, staff may choose other mechanisms to cope other than seeking support. It could be argued in light of social support theory that if those who seek support received adequate support this would result in lower levels of perceived stress. In this study 41.4% of respondents reported that the support they receive is adequate and 14.6% as very adequate. But a high aggregate percentage (44%) reported the support as neutral, inadequate, not at all adequate or did not answer. This could indicate that the type of report received, did not match that which was needed (Saraffino, 2002)

5.6 Study limitations

A number of limitations to the current study are discussed below.

5.6.1 Response rate and sample size

While every effort was made to maximise the response rate, the survey yielded a response of 36.6% from those sampled. While it is an acceptable level and compares favourably with other studies in healthcare settings (Wynn et al. 2003) a higher response would strengthen any conclusions drawn from the study. A higher response, coupled with a larger sample size could yield sufficient numbers in each category of support staff (see 3.6.3) to allow for the detection of possible differences between each category. This micro level of analysis was not possible in the current study. Aust et al. (2007) achieved a very high response rate (89%) in a survey of hospital workers. They ensured that participants had the opportunity to complete the questionnaire during their work time, though the option to complete the questionnaire electronically was also available and 75.9% used this method (Aust et al. 2007). The latter was not an option for the current study as anecdotal evidence suggests that the majority of support staff do not have computer access. While the support of line managers in encouraging staff to complete the survey was actively pursued, negotiating time to complete the questionnaire during work time could be pursued in future studies.

The researcher was aware that this survey might raise the expectations of participants regarding resources in the workplace in relation to health and well-being. Conversely the current climate might lead to the survey being received as a cynical exercise. These factors could affect response rate.

Bowling (2002) suggests that response rate can be improved by personalising the survey; this could include writing the participants name on the cover letter as well as hand writing the addresses on the envelope.

5.6.2 Study design, instrument, methodology and bias

Owing to the cross sectional nature of the study, causality can not be determined (Tsutsumi, 2004) associations can only be inferred. A longitudinal prospective study was outside the scope of this research.

Self-reported work characteristics may be biased by negative affectivity, (Burke, et al. 1993, Stanfield, 1999). The Work Positive instrument has no mental health measure to assess personality orientation (Karasek, 1998), which may affect how participants respond to the questionnaire. Therefore when interpreting data it was not possible to allow for negative orientation. This could be overcome in any future studies by the inclusion of the short version of the General Health Questionnaire (GHQ 12) (Karasek, 1998).

There was a small difference in the way the sample was collected from internal staff compared to external staff. While random sampling was employed for both, conditions of confidentiality and anonymity were assured and the voluntary nature of participation emphasised. It could be construed that external staff may have felt obliged to participate as in their situation the line managers agreed to collect the completed and sealed questionnaires. However the response rate from this group was almost 20% greater than from the internal group, therefore it is possible that having the line manager personally involved could be used as a method of increasing response rate.

Some participants were known to the researcher, this could possibly lead to bias due to social desirability. Conversely it could have led to over-reporting, in the hope of creating a sense of urgency in an attempt to achieve a "quick fix" solution.

Stressors outside of work clearly impact on staff; it would perhaps be worth investigating the nature of these. This could be achieved by including additional questions in the questionnaire. Having a greater understanding of these issues would allow for more appropriate interventions to be considered.

Finally, conducting focus groups with the different categories of support staff would give greater clarity and understanding on stressors, which may be specific to each category and help generate group specific solutions. For example the researcher knows from

personal experience that a key stressor for porters is a lack of wheelchairs, while for laundry staff a key stressor would be the risk of infection from soiled laundry due to non-compliance with waste management and infection control procedures. Breaches of these procedures include laundry soiled with biological fluids not being placed in alginate bags or leaving a needle in a white coat pocket, such practices constitute considerable risks for laundry staff. Focus groups would help enlighten the contexts within which different groups of support staff operates, enabling deeper understanding and more appropriate solutions.

5.7 Conclusions

In general the findings of the research were similar to the findings of other Irish healthcare studies where the Work-Positive questionnaire was used. (Wynn, 2003; Janas &Harrington, 2003; Falvey & O' Donnell, 2007). The key stressors identified were similar, indicating that support staff are broadly reflective of the population of healthcare workers. Where findings differed from other studies (HSE, 2009; O'Connell & Williams, 2007) (primarily in the incidence of workplace bullying and in the level of physical abuse reported), further research is indicated.

The main aim of this study was to identify the key workplace stressors for support staff in an acute hospital setting. The method used was appropriate in achieving this, given the limitations outlined above. Findings suggested that the work environment for support staff in this setting is not exceedingly stressful, key areas where stress could be reduced are identified. These relate mainly to issues of management style regarding consultation and inclusion in decision-making, as well as increasing employee decision latitude and promoting greater feedback and communication.

5.8   Key Recommendations

The following recommendations were informed by the findings of this study and are suggested, within the context of current health service policy and evidence-based health promotion practice. Care was taken to ensure that recommendations are; realistic, defensible, targeted, simple, specific and timely as recommended by Hendricks &

Papagianis (1990), Sonnichen (1994), Hendricks (1994), cited in Grembowski, 2001. Many are cost neutral, an important criterion in a climate dominated by recession and cutbacks, particularly in healthcare. Some recommendations are generic in nature while others have implications for specific groups e.g. management, staff, unions, those with responsibility for policy implementation, health promotion within the hospital and researchers. These will now be presented.

Management/Staff /Unions

i.   Management, support staff and unions, through the existing Support Service (union-management) Partnership Forum, would consider the findings of this research and agree a plan to implement its recommendations.

Management

ii.   Would implement a plan to reduce the levels of stress found among support staff, particularly in those dimensions that were found to be the biggest stressors i.e. Control, Health and Safety and Reward/Contribution.

iii.   Would work to address the finding of the high incidence of peer bullying among support staff.

iv.   Would promote the awareness of the support services (e.g. HSE Dignity at Work Policy, Dignity at Work information sessions, Designated Support Contact Persons and Employee Support service) that are available for staff, so that those who have or are experiencing bullying in the workplace know where to seek support.

v.   Would provide training for line managers of the support staff to enable them to consult with staff on issues that affect their work such as choice of work.

vi.   Would develop peer-support groups for the support staff.

vii.   Would ensure fairer distribution of workload and rotation of staff between different areas. This would serve to improve working atmosphere and alleviate the boredom and monotony associated with repetitive tasks. In line with the qualitative findings from this study.

viii.   Would improve welfare facilities for support staff as well as workstation design (through consultation with staff).

ix.   Would promote among staff the support and services provided by unions representing the interests of the external group.

The findings suggest that in general a more inclusive and participative management style is recommended. In particular regarding the introduction of change and in relation to information and consultation concerning organisational and team decisions. This may well be happening and functioning well within the hospital for other occupational groups, since the introduction of Partnership working, but is not evident for support staff. It is accepted that monetary benefits cannot be addressed in the current climate, even though staff indicated that they are not happy with pay (Reward/contribution dimension). However lack of positive feedback also featured as an issue for staff. Such practices have no monetary implications and would boost staff morale and confidence. A prospective Swedish study of four different healthcare organisations revealed that performance feedback and participatory management could serve as predictors of healthy workplaces (Arnetz & Blomkvist, 2007).

Staff

   x.   To become proactive in relation to managing stressors in their workplace. Staff also have a duty of care under Health & Safety legislation to safeguard their own health. This does not only apply to physical but also psychosocial factors.

   xi.   To treat each other with respect.

   xii.   To support each other when demands escalate.

   xiii.   To engage with supports provided by management.

   xiv.   To put forward suggestions for improvement in work-stations.

Policy

   xv.   Address the health & safety concerns given that this was second highest dimension causing stress and as per the statutory obligations to do so.

   xvi.   Develop and disseminate a workplace stress policy.

Research

   xvii.   Support staff are a very diverse group of workers and would benefit from a larger study where each category within this diverse occupational group could be studied. The present study did not have sufficient numbers in all categories to allow for statistical analysis of each. Other researchers also stress the importance of conducting studies with occupation-based samples (Kristensen, 1996).

   xviii.   While the current study included a qualitative dimension this aspect could be expanded in future studies, other researchers also suggest that considerable improvements could be made in job-stress with increased use of triangulation (Kristensen, 1996; Hurrell, 1998).

   xix.   Greater use of objective measures in relation to the investigation of job stress along with consideration of the appropriateness of existing constructs to capture the demands of

the contemporary work would also result in improvements in the area of work related stress (Hurrell, 1998).

xx.   Ascertain why the levels of bullying found in this study are higher than those in national and European studies.

xxi.   Ascertain why internal and external staff seek support from different sources.

xxii.   Repeat the survey after the recommendations of this report have been implemented to assess their impact.

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Appendices

Appendix 1: Letter to Participants

Dear Colleague,

I am employed as Project Officer on the Staff Meetings Project. My work has given me the opportunity to gain considerable insight into the issues and concerns of different groups of staff working in the Hospital. I work closely with many of the Support Services Staff and this has highlighted the need to address the issues, which affect the quality of working life for this group. As a first step it is important to identify what exactly these issues are, this is where your help is important.

Our Hospital has over 900 support staff. I am conducting a survey with a sample of these, a computer programme has generated a random list and your name was selected. I kindly ask for your help in supporting me carry to out this survey. I have enclosed a questionnaire for you to fill out; it should take between 10-20 minutes. When you have finished please fold and place the completed questionnaire in the envelope provided and I would **really appreciate** if you could send it back by return post (through the internal mail) or before May 20th.   *"Many Thanks"*

Participation in this survey is voluntary; your support is greatly appreciated. All information is anonymous, please do not write your name anywhere on the questionnaire. The results of the survey will help to identify the key issues as seen by staff and recommendations will be made regarding how to address these. A Summary of the results will be presented to both Staff and Management with a view to making improvements where possible. I am seeking your cooperation in conducting this survey.

With kind regards,

Hospital Logo

<u>Survey of Support Staff</u>

Purpose:

This survey is being carried out in order to find out what the sources of stress are for you at work and how this might affect your health and well being. It forms the basis of research being conducted as part of a Masters Degree in the National University of Ireland. The results will be used to highlight the working conditions of support staff with a view to making necessary changes, with the assistance of both management and staff within the hospital.

How long will it take to fill it out?

It should take about 15 minutes, but I would really appreciate this time from you.

Remember;

- All information is confidential

- All questionnaires are anonymous

- Completed questionnaires will be accessible only to the researcher and will be destroyed as soon as the information is entered

- The findings will be presented to both staff and management

Please:

- Read each question carefully and give your first natural answer by placing a tick ✓ in one of the boxes

- There are no right or wrong answers, please answer accurately

- Answer all questions

- If you make a mistake cross it out **X** and tick ✓ your new answer

- Do not put your name anywhere on the questionnaire.

Thank you very much for your help.

<u>PART 1:</u>

This part asks some general questions about you:

A. Please state what your current job title is ------------------------

Please ✓as appropriate

B. Do you currently work   Part time☐ **or** Full time☐

C. Are you?   Male☐   **or** Female☐

 D. Which age group do you belong to?

☐   ☐   ☐   ☐   ☐   ☐

Under 20   20-29   30-39   40-49   50-59   60 or over

E. What level of Education have you reached?

 1st level ☐   2nd level☐   3rd level☐

(National School)   (Secondary/Vocational School)   (College)

Please go to <u>PART 2</u> which follows on the next page

<u>PART 2:</u> This part asks about the support available to you.

A. Do you look for support in relation to work issues?

Yes ☐ No ☐

B. Who would you ask for support? (Tick ✓ as many as apply)

☐   ☐   ☐   ☐   ☐   ☐

Spouse   Work mate   Supervisor   Line   Senior   Union rep.
Partner   Manager   Manager
Family
Friends

                 ☐   ☐

                 Employee Assistance   Services of a Professional
                 Service at work   outside of work

C. In general how adequate is the amount of support you receive?

☐   ☐   ☐   ☐   ☐

Not at all adequate   Inadequate   Neutral   Adequate   Very adequate

Please go to <u>PART 3</u> which follows on the next page

PART 3: This part asks questions about your workplace and working conditions (Please ✓ as appropriate)

A. Which category of support staff **best** describes your role?

☐	☐	☐	☐	☐	☐	☐
Assistant	Catering	Healthcare	Laundry	Maintenance	Porter	Other:
to therapist	Chef,	Assistant	Worker	Grounds		Security
Lab aide	Domestic					Cleaner
HSSD-	Cashier					Driver
Operative						

B. Are you?   Temporary ☐   Permanent ☐

Below is a list of statements. Please ✓ **one box** only for **each** statement.

Do not write any words in the boxes

No.	Statement	Never	Seldom	Sometimes	Often	Always
1	I am clear what is expected of me at work					
2	I can decide when to take a break					
3	Different groups at work demand things from me that are hard to combine					
4	I know how to go about getting my job done					
5	I am subject to personal harassment in the form of unkind words or behaviour					
6	I have unachievable deadlines					
7	If work gets difficult, my colleagues will help me					

No.	Statement	Never	Seldom	Sometimes	Often	Always
8	I am given supportive feedback on the work I do					
9	I have to work very intensively					
10	I have a say in my own work speed					
11	I am clear what my duties and responsibilities are					
12	I have to neglect some tasks because I have too much to do					
13	I am clear about the goals and objectives for my department					
14	There is friction or anger between colleagues					
15	I have a choice in deciding how I do my work					
16	I am unable to take sufficient breaks					
17	I understand how my work fits into the overall aim of the organisation					
18	I am pressured to work long hours					
19	I have a choice in deciding what I do at work					
20	I have to work very fast					
21	I am subject to bullying at work					
22	I have unrealistic time pressures					
23	I can rely on my line manager to help me out with a work problem					

Please answer the following by placing a ✓ in the   box you agree **most** with:

No.	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
24	I get the help and support I need from colleagues					
25	I have some say over the way I work					
26	I have sufficient opportunities to question managers about change at work					
27	I receive the respect at work I deserve from my colleagues					
28	Staff are always consulted about change at work					
29	I can talk to my line manager about something that has upset or annoyed me at work					
30	My working time can be flexible					
31	My colleagues are willing to listen to my work-related problems					
32	When changes are made at work, I am clear how they will work out in practice					
33	I am supported through emotionally demanding work					
34	Relationships at work are strained					
35	My line manager encourages me at work					
36	My work patterns/arrangements (e.g. hours, shifts) suit me					
37	I feel my job is secure					

No.	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
38	I feel I am fairly paid for the work I do					
39	The pace of change (whether too fast or too slow) is a source of pressure for me					
40	I am happy with the non-pay benefits I receive (e.g. pension, social events, annual leave)					
41	I feel that my contribution is valued					
42	The work environment is comfortable					
43	The equipment I use is adequate to do my job					
44	My work area is well designed and laid out for the job I do					
45	I am clear who I report to					
46	Recent incidents at work have been a source of pressure (e.g. threat of redundancy, death of a colleague, violence at work)					
47	I receive positive feedback when I do a job well					
48	I lack the skills I need to do my job					
49	I am concerned about my safety at work					
50	I am concerned about my health at work					
51	The welfare facilities are adequate (e.g. toilets, wash facilities etc)					
52	I receive the training I need to do my job					

No.	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
53	I am involved in decisions made by my team / function					

Please ✓ the box which **agrees best** with your opinion.

No.	Statement	Never	Seldom	Sometimes	Often	Always
54	The type of work I do is emotionally distressing					
55	I find the work I do repetitive and boring					
56	Senior managers are supportive of employees					
57	I am unfairly treated					
58	I am consulted about organisational policies and decisions					
59	I am informed of organisational policy and decisions					
60	I am informed of decisions within my team or function					
61	I work more than 48 hours per week					
62	Pressure at work causes me to come to work when I am not well enough to work					
63	Pressure at work causes me to do my job less well					
64	I have taken time off due to pressure at work					
65	I have considered leaving this organisation due to pressure at work					

No.	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
66	Pressure at work has affected my health whilst working in this organisation					
67	Morale is low in this organisation					

68	It is important to establish the main issues and also to **identify anything that is not covered** in the questions above. In order to do this, please indicate below the **three main sources** of pressure at work for you.
	1
	2
	3
69	What are the **three most important things** that could be done to **help reduce pressure** in you job?
	1
	2
	3
70	**What percentage of the Total Stress in your life comes from your Job?** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
71	**In what ways do you try to reduce and cope with stress? (✓ tick as many as apply to you)** ☐ ☐ ☐ ☐ ☐ Have a few drinks Smoke Exercise Eat more Take Tablets Go to Doctor ☐ Sleep☐ Talk to someone ☐

Part 4: This part asks about bullying at work.

Definition

"Bullying is defined by the Health & Safety Authority (Ireland) as **repeated inappropriate behaviour**, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could reasonably be regarded as **undermining** the individual's rights of dignity at work".

Please Note:

A 'once off' incident which is inappropriate, which may offend the persons' dignity is not considered bullying.

A. Have you been subjected to bullying during the past six months?   **Yes▢ No ▢**

PLEASE BE SURE YOU ANSWER EITHER YES or NO for this question

If No, "*Thank you very much for taking the time to fill out this questionnaire*"

If Yes,   Please answer the five additional questions on the next page

PART 4: Bullying

This section is to be answered only if you answered 'Yes' to the last question on the previous page

1. Where did the source of the bullying come from?   (✓as many boxes as apply)

☐   ☐   ☐   ☐   ☐

Patient/Visitor   Senior Manager   Line Manager   Supervisor   Other staff member

2. Is the bullying currently taking place?   Yes☐   No ☐

3. Which of the following would best describe the form of bullying you experienced?

Verbal abuse ☐   Exclusion☐   Sexual harassment☐   Physical abuse☐ Other ---------

4. Did you look for support following an incident of bullying?   Yes☐ No ☐

5. Where/Who did you go to for support?

☐   ☐   ☐   ☐   ☐

Senior Manager   Line Manager   Supervisor   Work mate   Union rep.

Staff Counselling Service ☐   Family/Spouse/Partner ☐   Other------------------------

(**Please specify**)

"***Thank you very much for your help".***

PLEASE NOTE:

If you have mislaid the return envelope, the address to return the questionnaire to is as follows:

Researchers details here.

Please use the Internal Mail System, there is no need for a stamp.

Appendix 3: letter of Acknowledgement/Reminder

Hospital Logo

I wish to say a sincere *"Thank you"* to everybody who filled out

the recent survey of support staff in the Hospital,

(the yellow questionnaire!). Your support is greatly appreciated.

If you did not fill in <u>your</u> questionnaire yet, I kindly ask you to do

so and return to me immediately, (or by Wednesday June 17th at the

latest) in the enclosed envelope. If you require another questionnaire

 please let me know (Ext. number). I really need your support with this.

It should take between 10-20 minutes to complete. There is no need for

a stamp, you can use the internal mail.

All information is anonymous; please do not write your name anywhere

on the questionnaire. The results of the survey will help to identify

 the key issues as seen by staff and recommendations will be made

regarding how to address these. A Summary of the results will be

presented to both Staff and Management with a view to making

improvements where possible.

Again I ask for your cooperation in completing this survey.

Researcher name.