Respect and Engagement by Action Learning ~ REAL ~ A Work Engagement Intervention for Irish Health Services

Declan McCarthy

Royal College of Surgeons in Ireland

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Respect and Engagement by Action Learning

~ REAL ~

A Work Engagement Intervention for Irish Health Services

Declan McCarthy

A Dissertation submitted in part fulfilment of the degree of MSc in Leadership, Institute of Leadership, Royal College of Surgeons in Ireland
2015

Respect and Engagement by Action Learning

~ REAL ~

A Work Engagement Intervention for Irish Health Services

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I would like to express my gratitude to the Director of Mental Health Nursing for South Lee, Cork for supporting me in completing this thesis and MSc. I would like to thank my line manager for their support and my many colleagues who helped along the way.

I would like to thank my partner and family for their support. I would also like to thank the staff at the Institute of Leadership in the RCSI, especially Steve Pitman who gave me much of his time and helped me understand the concept of work engagement. I would like to thank my supervisor Jenny Hogan and all in my action learning group who guided me through this project.

It has not been an easy task, but the learning and experience I have gained as a result of doing this thesis certainly made it all well worth the time and effort.
Abstract

This thesis describes an implementation plan for a work engagement (Schaufeli & Bakker, 2010) intervention designed for the Irish health care arena. The hypothesis is based on the principle that when people are happier and more resourced in their workplace, performance is increased, and a higher quality of care is provided. This thesis argues the need for a work engagement intervention and suggests why services and future leaders would benefit from integrating work engagement as a concept into health care organisations.

This thesis contains a proposal for the intervention, with drivers for the change and possible resistance being identified. The challenges and current organisational context are discussed and explored. The findings are identified through the process of a systematic literature review exploring work engagement interventions from 2002 to 2014. The themes that emerged from the literature review are further discussed. The dissemination process of the themes helped identify core issues which allowed for recommendations for future best practice to be implemented. The Health Service Executive Change Model (2015) was chosen as part of the methodology in order to carry out the implementation of the change initiative. The rationale for choosing this model is explained in the thesis, and each step of the model is discussed. The thesis describes how parts of the initiation and planning stages of the suggested change have already taken place. Further then is a discussion of the process and steps to be yet undertaken to implement fully the change with reference to how a robust evaluation of the change would be achieved. Measurements and expected outcomes are highlighted and identified. In conclusion, a description of strengths and weaknesses of the intervention are identified and discussed and how the practice and theory differ in the implementation of such a change. Recommendations and guidance for future leaders, with a view to implementing work engagement interventions are described, and the author concludes with learning and experiences gained from this work.
1 Work Engagement Proposal

1.1 Introduction to Chapter

This chapter outlines the proposal for a work engagement intervention initiative highlighting drivers for the change and threats to implementation. The aim and objectives of the initiative are explained, and the process of its evaluation is discussed. The chapter further identifies the student’s role in the process and ends with a summary of the benefits of the change initiative for the organisation.

1.2 Title of the project

Respect and Engagement by Action Learning

- Respect
- Engagement
- Action
- Learning

The above title was chosen to reflect a more colloquial acronym that fits with the Irish health care service; the intention was to ensure that it reflected the key constituents of the change being proposed.

1.3 Introduction to Proposed Project

Evidence shows that when staff becomes more engaged with their work the quality of their work and the performance of organisations increase. In studies on staff nurses, for example, “higher levels of work engagement were
associated with higher levels of patient satisfaction… quality of care… and work effectiveness” (Warshawsky et al., 2012, p.418).

This proposal is designed to introduce a work engagement intervention culturally suitable for Ireland. An international example of such an intervention is CREW. CREW is an acronym that stands for Civility, Respect and Engagement at Work. CREW has been widely used in the U.S Veterans Hospitals and the Canadian health care services as well as more recently in Tokyo. It is an evidenced based intervention (Leiter, 2015), which has been shown to enhance relationships in the workplace, improve civility and have a positive influence on people’s mental health and reduce absenteeism and turnover intention.

REAL will draw from the concepts of CREW and will allow for the development of a work engagement project that is specifically geared for the Irish health care arena.

The proposed change will be collaborative, in that a Health Service Executive (HSE) staff member (author) and a Programme Director/Lecturer from the Institute of Leadership of the Royal College of Surgeons (RCSI) will work together with others to deliver the intervention. Consultation and expertise are to be procured from international expert Professor Michael Leiter (Acadia University, Canada), who designed CREW. It will be a multidisciplinary intervention enhanced by interdisciplinary sharing. Kossek et al. (2014) state that “Interdisciplinary work fosters greater synthesis between a psychosocial, disease-oriented focus on preventing workplace influences on stress, and approaches that facilitate or promote lower stress” (p.59-60).

The undertaking of a systematic literature review of contemporary work engagement interventions will ensure that best practice is undertaken for the introduction of this change. The HSE change model will be used to facilitate the change; the model’s methodology will be outlined, discussed and evaluated in more detail in chapter three.
1.4 Objectives and Aims

1.4.1 Aim

The author’s hope and the aim of this change proposal are that a respectful and a more productive work culture will be created. This initiative will lead to an increase in work engagement amongst staff and to improvements in the quality of patient care delivered within one year of its introduction.

1.4.2 Objectives

- That guidelines for the project will be completed and authorised for use in June 2015
- That resource requirements will be agreed and sanctioned by senior management by September 2015
- That funding will be approved by June 2015
- That a number of facilitators will attend train the trainer programmes by October 2015
- That a pilot site will be identified and agreed upon with authorisation from the appropriate personnel within the organisation by May 2015
- That staff will report an increase in work engagement by the end of the project as measured by the Utrecht Work Engagement Scale (UWES)

See Figure 1 (Appendix 1) for a Gannt chart that outlines the timelines for achieving the above criteria.

1.5 Projected Outcomes

- That a more respectful work environment will be created and that there will be a measurable increase in work engagement using UWES
• That staff will be refocussed on compassion, hope, respect and engagement and how these should at all times remain at the forefront of person-centred care
• That respect and support for each colleague’s uniqueness, skill set and opinion in the workplace be recognised
• That there will be a decrease in staff turnover and conflict
• That there will be an improvement in the quality of care provided by the services who undertake the intervention

1.6 Organisational Context

The HSE is currently facing significant challenges in staff retention and recruitment. The demands faced by the moratorium and fiscal adjustments over the past number of years have placed increased demands on HSE staff. Interventions that build resilience and increase engagement will be crucial in sustaining healthy and efficient work environments.

The Health Service Executive is a large organisation consisting of over 100,000 people, with nurses making up approximately 30% of this workforce. The National Leadership and Innovation Centre for Nursing and Midwifery (2015) identify the following four goals for their department.

- Influencing Cultural Change
- Developing Leadership Competencies
- Building Workforce Capacity
- Supporting Innovation

A people strategy is presently being designed by HSE Human Resources Director, and engagement is one of the pillars for inclusion. The recent results of a HSE Employee Engagement Survey in which only a 7.1 response rate was achieved (Have Your Say, 2014) has resulted in the publication of a report. The report outlines that only a 7.1% response rate was
achieved. The report sets out recommendations and guidelines for improving engagement into the future. This is crucial timing in relation to this proposal, in that it provides some solutions for increasing engagement levels within the HSE. With the Minister for Health calling for the recruitment of an extra 500 nurses (Independent, 2015), and with the current introduction of health care assistants into the mental health care areas beginning, the drafting of this proposal could be any more timely.

Workplaces are becoming more complex in terms of the increase in generational age gaps. There are now four generations present in the workplace. “Generational difference in expectations of collegial relationships have significant implications for nursing work environments where both affective and informational support is essential to the well-being of both the nurse and the patient” (Leiter et al., 2010, p.977). The organisation, therefore, will require work engagement interventions as it responds to all of the complexities above. A recent (HSE) Listening Meeting Initiative (McGowan, 2014) re-affirms that service user populations are calling for a more respectful attitude and that better communication from and amongst professionals be practiced. This was a theme identified by approximately 1,400 people who participated in Listening Meetings, which were carried out in Ireland in order to ascertain client’s experiences of engagement with the mental health services. What also emerged from feedback received at the Listening Meetings was that some service users did on occasions not feel listened to, or feel that they were treated with compassion and dignity.

The NHS Mid Staffordshire Report (Francis, 2013) suggests a focus is required on nursing issues such as leadership, education, culture and appraisal. It suggests the implementation of a ‘Duty of Candour’ highlighting openness and transparency as a method of improving the quality of care. In terms of the 6C’s¹ nursing strategy introduced to the NHS compassion and communication are two of the 6C’s that are currently lacking from nursing care

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¹ Care; Compassion; Competence; Communication; Courage; Commitment. Watterson, L. (2013).
(Gillen, 2012). The author believes that a work engagement intervention is an ideal base for supporting such concepts as the 6C’s.

The lack of safe and dignified care being delivered in Ireland was starkly illustrated in a recent media programme (Prime-Time, 2014). The programme, by way of undercover filming, highlighted abusive care and disrespect that was shown to residents of a care home by staff. Commenting on that particular case, a recent Sunday Independent article highlighted a values intervention that prioritised dignity and respect as one solution that is required if we are to ensure this does not happen again (2014, p.4). A work engagement intervention that highlights staff respect and value towards each other, the author maintains is a solid base from which to develop safe caring. Paul et al. (2013) affirms how CREW as an intervention has proved positive in other areas where respect and civility have been an issue, thus affirming that work engagement interventions can change the culture of the caring environment.

The new HSE Corporate Plan 2015-2017 published recently sets out five goals for the health services. There too are values listed under the plan; care, compassion, trust, and learning. These values integrate perfectly with work engagement practice and theory. Two of the five goals of the plan stated below are in keeping with this project’s goal:

1. Foster a culture that is honest, compassionate, transparent and accountable
2. Engage, develop and value our workforce to deliver the best possible care and service to them

(Health Service Executive, 2015 p.5).
1.7 Role of the Student in the Process

The role of the student will be to lead the project. Collaboration with others and by way of shared leadership will be a priority. Drescher et al. (2014) contends that when shared leadership grows, trust also grows within a group. The student will explore potential sites and assess their readiness for accommodate this implementation plan, thus identifying them as probable potential introductory sites. The student will source funding, network, collaborate with and engage stakeholders in order to seek their views. The student will review the literature in relation to best practice. A further role of the student will be to liaise with international experts and arrange for a masterclass in work engagement and CREW to be delivered in Ireland. The student will build a guiding coalition.

This group will consist of:

- Health Service Executive representation
- Representatives from senior management
- Academic representatives
- Work engagement experts

1.8 Organisational Impact and Expected Outcomes

It is expected that as a result of the full implementation of the work engagement intervention there will be:

- An increase in morale and a greater sense of people being valued due to an increase in awareness amongst staff of respect for one another
- A more engaged and empowered workforce
- An increase in self-development and self-awareness amongst staff
- A decrease in complaints, i.e. bullying, harassment and absenteeism
• A more respectful and compassionate healthcare environment
• An increase in job resources (to be decided by the group)
• A culture more focused on feedback, coaching and mutual respect
• A greater sense of trust in the workplace between staff and management

1.8.1 Potential Threats to the Implementation

It is the opinion of this author that one of the major potential threats in recent times to implementing this change initiative is that job demands have increased while resources have lessened. Also, a potential threat to this implementation would be if the author were not to self-regulate and adopt an impulsive and forceful style of leadership. That kind of ethos would annoy and manifest in staff resisting the imposed change. Dixon – Woods et al. (2015, p.6) state that in terms of leadership a “key to success may be ‘quieter’ leadership less about bombastic declarations and more about working to facilitate collaboration”. They also have identified a number of challenges in improving quality in healthcare such as clinicians feeling the problem targeted is not real; the solution being chosen is not the correct one; and talk of transformation being overwhelming, thus alienating stakeholders as they perceive solutions as too ambitious and not practical. In the author’s opinion, the following could be potential threats:

• Staff resistance and fear of the change
• A sense of teams feeling patronised by the initiative
• Senior management not engaging
• Staff not finding the time to be involved
• Soft interpersonal skill sets are more difficult to implement
• Too much change at present being undergone so timing will be crucial
1.9 Proposed Methods of Evaluation

The evaluation of how the intervention benefits patient quality care will be a more challenging aspect of the change. This is as a result of the amount of indeterminate factors that could have affected the quality of patient care during the intervention. To help navigate these challenges an explicit evaluation will be carried out by:

- The implementation of the UWES
- The collection of feedback and evaluation from participants and management
- The administration of a culture change questionnaire
- The measurement of absenteeism and staff turnover

When evaluating any up-skilling or training, the link with the intervention must be made with the organisations goals. Watkins et al. (1998) compared Kirkpatrick’s four level of evaluation with Kaufman’s organisational levels model. These models of evaluation help evaluate the gains for individuals, the organisation, and more importantly the people who attend the service. This can be seen in the table below.

<table>
<thead>
<tr>
<th>Kirkpatrick Model</th>
<th>Kaufman Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td>Contributions to society from the training</td>
</tr>
<tr>
<td>Behaviour</td>
<td>Organisational payoffs</td>
</tr>
<tr>
<td>Learning</td>
<td>Individual or group payoff</td>
</tr>
<tr>
<td>Reaction</td>
<td>Process acceptability and efficiency and resources</td>
</tr>
</tbody>
</table>

Table 1
1.10 Summary and Conclusion

The field of healthcare is very familiar with the integration of disciplines and various schools of thought. There is a multitude of paradigms that exist given the many professional disciplines and training that co-exist. However, healthcare struggles in trying to achieve in practice what is learned in theory. Mindset, therefore, is key to leading organisational quality changes. Skill sets, tool sets and passion are all required to drive quality changes (Covey, 2013). Training and tool sets are not on their own enough. In a presentation entitled Developing Cultures of High-Quality Care (2015), Michael Westin of the King’s Fund asks to what extent the following are carried out by leaders:

- Are staff voices encouraged and heard and acted on by leaders?
- How does intimidating behaviour and poor performance get addressed by leaders?
- How often do leaders display dealing with patients and staff with compassion?
- Do leaders promote engagement?
- Do leaders avoid controlling and dominating behaviours except when in a crisis?
- Do leaders promote autonomy and accountability and quality of care outcomes?

In the area of mental health, which is best known to the author, one of the six pillars of recovery² is hope and inspiring relationships. Inspiring others, promoting engagement and addressing performance all need to be handled well by leaders. Creating hope and optimism amongst staff is key to a healthy working environment.

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² Six Pillars of Recovery are: Leadership; Person Centred and Empowering Care; Access and Inclusion; Hope Inspiring Relationships; Education; Research and Evaluation. (Mental Health Commission, 2008).
Hope and inspiring relationships is an essential pillar of quality improvements in mental health as set out by the Mental Health Commission (2008) in terms of patient care delivery. There is no justifiable reason this should not also apply to a quality improvement in relation to staff.

The author’s main reason for introducing this particular change is on the premise of the belief that; happy teams provide better care. If there is an environment of respect and positivity in the workplace and amongst the staff then this will in turn be reflected in the care given to patients. As the Golden Goose (Jackson, 1999) archetypal story portrays, it is important to remember not to be overly greedy and over expectant of staff to the extent that they are so overworked, that they can no longer perform. Perhaps in attempting to cut back on spending in our health services we are taking away too many resources from where they are most needed. If job demand increase then resources also ought to increase. If people are not happy and engaged and do not enjoy their jobs or do not like coming to work, then a problem exists. A solution also exists; it is this author’s belief that a work engagement intervention is one such solution. The work engagement solution would benefit individuals and the organisation by helping to create more trust, positivity and respect in the workplace. Communities and clients of our healthcare system would also benefit, in that they would receive a more improved quality of care. This quality improvement would be driven by the change in the organisation culture that the work engagement proposal would initiate.
2 Literature Review

2.1 Introduction to Chapter

The following literature review was taken by systematically exploring the literature on work engagement interventions from 2002 to 2014. Academic data basis were used, and the process of how the analysis was undertaken is explained in detail. The themes and learning from the review are then further explored. The chapter concludes with recommendations and implications for evidenced based best practice.

2.2 Origins of Work Engagement

Work engagement is derived from organisational development that has its roots in positive psychology. Seligman (2008) work in the area of psychology centres on positive aspects of emotions and cognitive processes such as happiness and joy, as opposed to sadness and anger. When Seligman and others explored and broke down further the concept of happiness, quantifiable components such as being pleasant and staying engaged emerged. These components are the corners stones of work engagement interventions. Seligman and Csikszentmihalyi (2000) affirm the benefits of being hopeful, happy and optimistic about things, as opposed to perceiving pathology of illness.

Schaufeli (2011) identifies a new paradigm and way to develop; it requires an attitudinal shift in how we approach work. He suggests a more active and healthy way of approaching occupational health psychology. Work is something we can enjoy; it is a place where we can develop and be creative and can experience a sense of well-being. Schaufeli (2011) emphasises how we may have a tendency to look at the negatives side rather than the positive. He presents us with the fact that a ratio of 32:1 studies exists in favour of burnout rather than work engagement. He is highlights that we explore much more the negative constructs of work then we do the positive. Myers (2000)
in another study similarly noted that our negative emotions outweigh our positive emotions by a ratio of 14 to 1.

Wang (2011) points that an article in The *Wall Street Journal* displays the increasing general interest in creating positive workplaces. Mills et al. (2013) argue that organisations previously concerned themselves with the bottom line of just saving money and that for far too long active organisational practices were as a result cast aside. Therefore, this author maintains this current positive swing towards healthy workplaces should be incorporated into health care work environments.

### 2.3 Definition

Work engagement as a term is very new. It is different in concept to terms such as employee engagement and staff engagement. ‘Work engagement’ is defined as having vigour, dedication, and absorption in terms of one’s work (Schaufeli & Bakker, 2010; Schaufeli et al., 2002). While Schaufeli and others see work engagement as a stand-alone concept, Maslach and Leiter (1997) perceive it differently and instead view work engagement as the opposite to burnout. Strengthening Schaufeli and others concept, Bogaert et al. (2013) concluded in a study that involved 357 registered nurses in a psychiatric hospital work environment that “burnout and work engagement are separate, albeit highly interrelated constructs meriting study different measures” (p.1725). Schaufeli et al. (2008) point to the existence of three distinct types of employee well-being: workaholism, burnout, and work engagement.

### 2.4 Search Strategy

This literature review's methodology was informed by a study undertaken by Lucisano and Talbot (2012). Their study gave a clear and comprehensive layout of how to undertake a literature search and guided the below format.
For the purpose of this study when the term ‘work engagement’ was entered as a search in Google in January (2015), 2,780,000 hits were returned. When ‘work engagement and ‘intervention’ were entered as a search term in Google, 1,090,000 hits were returned. This is evidence of the plethora of literature that is available on what can be deemed to be a relatively new subject area, given that the term was first coined in 2002.

To explore the literature further, a search of seven databases was undertaken, via an electronic search using the (RCSI) academic online library facility. The word string used in the search was “work engagement and intervention and Utrecht Work Engagement Scale”. The word string chosen arose following much trial and error, and it was finally derived following conversations and discussions with librarians and academic staff.

The rationale for arriving at the particular word string search was that it was deemed to serve the purpose of investigating the best contemporary work engagement interventions available. This then informs us of best practice in order to apply effective work engagement interventions for teams in healthcare.

The following were the databases chosen for the search: Cumulative Index to Nursing and Allied Health Literature (CINAHL); (January 2002 to November 25th, 2014 via Ebsco); MEDLINE (January 2002 to November 25th, 2014 via Ebsco); PsycINFO (January 2002 to November 25th, 2014 via OVID); Web of Knowledge, (January 2002 to November 25th, 2014); SCOPUS, (January 2002 to November 25th, 2014); Emerald Insight, (January 2002 to November 25th) Health Business Elite, (January 2002 to November 25th).

281 articles were collected following the first search of the below databases. Each database results were then cross-checked for duplication papers. The total of non-duplicate articles was found to be 234 in total.
The numbers of articles found in each database are outlined below are as follows:

- CINAHL = 2
- MEDLINE = 3
- PsychINFO = 167
- Web of Knowledge = 4
- SCOPUS = 10
- Emerald Insight = 68
- Health Business Elite = 0

A visual flow diagram explaining the search can be seen on the next page in Figure 2.
Abstracts and previews of 234 papers screened using following parameters: 1. “Work Engagement” 2. “Intervention” 3. “Utrecht Work Engagement Scale”. Papers had to contain at least two of these three keywords to be included.
Given the purpose, time limits and parameters of this thesis it was decided to scale down the amount of papers for review to a more workable size. To facilitate this, a scale was implemented and agreed with the Course Director. It was agreed that article abstracts (previews in the case of Emerald Insight articles) that did not contain at least two of the following three terms would be eliminated: (1) ‘Work Engagement’ (2) ‘Intervention’ (3) ‘Utrecht Work Engagement Scale’. Following this elimination, which consisted of excluding 188 articles, 46 articles were then for further analysis. Of these 46 articles, 39 were noted as being research-based articles while seven articles were a descriptive review of the literature.

A common thread identified throughout the articles was that only one article was directly related to Ireland and only one related to England. Displayed in Table 2 are the articles broken down in terms of their country of origin. It was noted that one of the articles classed as a review article in the literature identified research carried out in Japan. Therefore, the total amount of numbers in the table adds to 40 and not 39.

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<thead>
<tr>
<th>Country of Origin of Research</th>
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</table>

Table 2
Of note during the review was that only 13 (33%) of the 39 research papers were carried out in health care environments. Of those 13 papers that covered health care, 7 (over 50%) were linked to the discipline of nursing. These figures fit logistically given that the HSE has a 100,000 workforce, with nursing compromising of approximately 30% of this. It is, therefore, imperative that issues such as work engagement should be well explored as nursing retention and recruitment are emerging as challenges in today’s healthcare arena.

2.5 Literature Themes

Themes such as creativity, leadership, and the provision of adequate resources emerged from the literature. The importance of not taking work home was also visible in the literature. The notion of work-life balance was seen as a positive indicator to work engagement levels. Trust, relationships and adequate sleep were also identified. These themes are set out below in Table 3 and will be further discussed.

Themes in Literature

<table>
<thead>
<tr>
<th>Creativity</th>
<th>Provide Resources</th>
<th>Leadership Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Appropriate Tasks</td>
<td>Trust and Relationships</td>
<td>Emotional Intelligence</td>
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<td>Psychological Environments</td>
<td>Work Life–Balance</td>
<td>Sleep</td>
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<td>Job Support</td>
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</table>

Table 3

The themes outlined above are in many ways are quite similar to those of the Productive Ward series recently carried out in the HSE by White et al. (2014).
While these may be identifiable and seem like common themes to most staff in healthcare in healthcare, the challenge for leaders remains: how does one intervene and implement interventions that facilitate the increase of these subjects in the workplace? An answer that emerges from the literature is that work engagement interventions are one solution. Therefore, the challenge now is to develop a culture that embeds these themes permanently in the workplace.

These themes were identified by a systematic and comprehensive review of the chosen literature. To further clarify this process, an example of how the articles in the literature were examined is defined in Table 4 below. This table outlines how each paper was considered in terms of analysis of the outcomes and the results of each piece of research conducted. The layout of the table also assisted the reviewer to identify logically and systematically conclusions and themes from the literature. The table was completed for each of the 46 articles. However, only the first four articles are shown in Table 4 below which is to be viewed as an example. The authors of each paper, the purpose of study, the design, the results and the conclusion of each piece of research are all listed in the following table.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Purpose of Study</th>
<th>Design</th>
<th>Results</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zaniboni, S., Truxillo, D., Fraccaroli, F., McCune, E., &amp; Bertolino, M. (2014). Who benefits from more tasks? Older versus younger workers. 1</td>
<td>To establish age moderation matters in terms of task variety, attitude and satisfaction and engagement</td>
<td>152 self–reported questionnaires</td>
<td>Task variety had a stronger relationship with job satisfaction and engagement for younger workers</td>
<td>Organisations may benefit from challenging different age groups with different tasks</td>
</tr>
<tr>
<td>Beattie, L., &amp; Griffin, B. (2014). Day-level fluctuations in stress and engagement in response to workplace incivility: A diary study. 2</td>
<td>To examine the effect of experiences of incivility at work of stress and engagement</td>
<td>323 participants originally with 130 completing one of eight diary surveys</td>
<td>Verified hypothesis that when people experience incivility higher stress on those days in indicated.</td>
<td>Supervisors are ideally situated and pivotal in decreasing incivility at work and increasing supervisors awareness would prove useful</td>
</tr>
<tr>
<td>Ugwu, F. O., Onyishi, I. E., &amp; Rodríguez-Sánchez, A. M. (2014). Linking organizational trust with employee engagement: the role of psychological empowerment. 3</td>
<td>To examine the relationship between organisational trust and empowerment and employee engagements</td>
<td>715 employees undertook a hierarchical regression analysis</td>
<td>This showed that organisational trust and psychological empowerment were predictors of work engagement</td>
<td>Empowerment interventions and organisational trust are essential in building engagement at work</td>
</tr>
<tr>
<td>Kaiseler, M., QueirdS, C., Passos, F., &amp; Sousa, P. (2014). STRESS APPRAISAL, COPING, AND WORK ENGAGEMENT AMONG POLICE 4</td>
<td>To investigate the influence of stress appraisal and coping on work engagement levels of police officers</td>
<td>387 men between ages 20-33</td>
<td>Work engagement was associated with stressor control, but absorption was better explained</td>
<td>Future applied interventions fostering work engagement with police should reinforce perceptions of control over a stressor as well as coping strategies</td>
</tr>
</tbody>
</table>

Table 4
2.6 Discussion of Themes

2.6.1 Leadership Influences, Emotional Intelligence and Sleep

The first theme explored is the significant role that leadership plays in supporting work engagement interventions. Bakker et al. (2011) propose that transformational leadership will improve people’s work engagement. They highlight supports and resources for staff as well as staff-management relationships as being pivotal. If leaders are to be equipped to help increase work engagement by working collaboratively with staff they will need knowledge and training in the area. When there is a holistic care culture in the workplace higher levels of vigour are noted, and people become less exhausted. Organisations can by way of its leaders create a holistic care culture. Leaders can ensure a framework where the system will respond organisationally in order to promote healthy work environments. A study by Ng et al. (2011) showed that interventions were best at the organisational level in terms of stress reduction as opposed to individual stress interventions. This study was comprehensive in that 992 service workers took part.

There is an awareness and trend visible in the review that simple mechanisms such as sleep hygiene and nutrition programmes (Barber et al., 2013) are proven to help self-regulation of individuals at work. This study identified that people who had inadequate became less engaged.

Goleman et al., (2012) have identified self-regulation as an essential component for leaders. They view empathy and being able to judge and make sense of things to be vital for leaders in workplaces. A necessary shift or indeed a return to fundamental humanistic traits such as civility, respect, and care accentuates the necessity for workplace engagements interventions.
2.6.2 Age Appropriate Tasks and Safe Psychological Environments

Evident in the literature and now a growing school of thought is that organisations benefit by proportioning different age groups with different tasks. Zaniboni et al. (2014) clarified that age moderation matters in terms of engagement, attitude, task variety and satisfaction. They found that younger workers had better job satisfaction and engagement levels from task-orientated work, which allowed them to learn skills. For older workers, however, job complexity was seen as more engaging than task-orientated work. If absorption, which is a part measure of work engagement, is to improve adjustments to the workplaces physical environments are the best type of interventions. Coffeng et al. (2014) noted that task performance is more influenced by a social intervention.

Scanlan and Still (2013) carried out a comprehensive study of 951 occupational therapists and concluded that turnover in organisations is significantly affected by job satisfaction and recognition. When work is found to be rewarding and challenging to the individual, the turnover of staff decreases. Therefore with the right staff doing the right jobs, turnover is inclined to decrease.

Osatuke et al. (2009) have illustrated CREW to be a reliable work engagement intervention. It primarily works as a behavioural intervention that concentrates on creating a foundation of civility and respect in the workplace. Leiter et al., (2011) and Beattie and Griffin (2014) identified that incivility has an adverse effect on people in the workplace. Therefore, it could be concluded that interventions are worthwhile where incivility and disrespect exist in the workplace. Organisations are ideally situated to facilitate managers, leaders, and supervisor’s levels of awareness. The importance of having a safe and comfortable psychological environment is conducive to healthy work environments. A study of over 200 people in schools clarified that a Psychological Safety Climate (PSC) proved to be an efficient mechanism for a work stress intervention. PSC is a cornerstone of Work Stress Theory. When people are empowered and perceive that they have more control over stressors, they perform better. They are hence more empowered in adopting improved coping strategies as detailed in a study of 387 of a police force (Kaiseler et al., 2014).
2.6.3 Job Support

Receiving job support at work recurs time and time again in the literature. Identifying job supports and resources as key elements in increasing work engagement is significantly researched (Biggs et al., 2014; McKeown & Cochrane, 2012; Botma & Jonker, 2012; Moodie & Burke, 2014; Adriaenssens et al., 2011). Job supports are also imperative in strengthening clinician’s work engagement. A study of 123 surgeons identified that job resources have a greater impact on surgeons than job demands (Mache et al., 2014). Mache et al., (2014) describe job resources as the psychological, social, physical and institutional facets of one’s role. They suggest further research would be appropriate in the area of flexible working hours and training programmes as essential predictors of clinician’s work engagement. Narainsamy and Van Der Westhiuzen (2013) found that people’s vigour and dedication is negatively linked to the lack of job resources in place. Therefore, active steps to provide interventions and supports and increase people’s positive energy in the workplace make logistical sense.

Simpson (2010) identifies physical comfort as important in sustaining healthy environments at work. A study of 155 nursing staff explored how physical resources had a most significant correlation with positive work engagement. Materials such as chairs and rest spaces and their availability were linked to the positive well-being of staff. Access to equipment and having regular breaks was also shown to be beneficial for work engagement levels in the study. Job supports can also be the facilitation of time away from the caring environment for people to reflect and re-energise. Bishop (2013) carried out a study in which 19 nurses attended an offsite retreat during which they had time to talk and discuss the spirit of caring. This study showed this time was beneficial, and it re-ignited a spirit of caring that increased work engagement. This fact augments the hypothesis that time away from the work environment allowing adequate space and time for reflection recharges the energy of carers rather than on site reflection.
2.6.4 Trust and Relationships

The literature emphasises that trust and empowerment are significant in predicting work engagement levels (Ugwu et al., 2014). Albrecht and Andreetta (2011) carried out a study of 139 employees of a community health service that showed that empowerment was proven to be a mediator in influencing leadership on engagement. CREW emphasises how better relationships and specific interventions can enhance staff management rapports in the workplace. Laschinger et al. (2012) also highlighted the increase of trust in a healthcare environment following a work engagement intervention. By undertaking the work engagement intervention CREW, it was found that “by improving collegial relationships, nurses may have increased their support base for their ideas for improvements in their work settings” (p.322). Ugwu et al. (2014) found “that organizational trust… and psychological empowerment…are positively related to work engagement” (p.390). The study implies that people “should indulge in a give and take form of relationship. These behaviours not only help both parties feel confident, but also create a positive work environment that enhances work performance” (p.392).

2.6.5 Work- Life Balance

Simbula (2010) explored daily fluctuations in 61 teacher’s well-being. This was testing the validity of the concept of the Job-Demands, Resource Model (JD-R) as devised by Demerouti et al. (2001). The study portrayed that the pursuit of work activities at home resulted in an adverse impact on the individual’s wellbeing.

Workaholism often leads to burn-out and becoming over involved in one’s work has a negative effect on the person and their family. This strongly suggests that a balance is required and that being over consumed by one’s work and employment is not healthy. A further investigation that also involved the JD-R model consisted of 224 school principals being researched. Results from this identified that variables personally affected the health of the individual and their motivation (Guglielmi et al., 2012).
People also are seen to benefit from receiving tuition and guidance at work (more so than from home). A study was undertaken by Van Berkel van et al. (2013) in which 257 people took part in a mindfulness program ascertained that people rather and benefit more from practical interventions from the facilitator. This was in contrast to where the attendees of the programme did not have a good uptake of compliance with home working and e-coaching. Bringing work home interferes with one’s quality of life; relationships and family is not healthy it blurs boundaries and a sense of time and confuses an individual’s sense of time and self-management.

2.6.6 Creativity

What is clear from the literature is that creativity and group work as evaluated by Sodani et al. (2011) enhances work engagement. In the study they undertook concerning a welfare organisation, a group based creativity intervention was used. The result was that they found people were more engaged, active and focused in their jobs by taking part in creative learning. Creativity aids empowerment and promotes self-efficacy and allows subjective control to be enhanced. Park et al. (2013) identified that innovative behaviour in the workplace is significantly proportional to people’s level of engagement in their work. The study involved 326 people and showed that a learning organisation alone does not directly influence the innovation thinking; it needs to be practically linked, and collaborative in nature.

2.7 Measuring Work Engagement

The Utrecht Work Engagement Scale is a validated tool that has been designed to measure work engagement (Seppälä et al., 2009). It measures the three components of work engagement: vigour, absorption and dedication and consists of 17 questions. A shortened version consisting of only nine questions can also be used (UWES-9) (Schaufeli et al., 2006). Measures are taken two months before the intervention, and then again after the intervention is finished (which is usually six
months in duration). A cross-national study incorporating ten countries was undertaken in relation to the UWES as a measuring tool, and 14,521 people were involved. It was concluded that the UWES-9 could indeed be validated as a psychometric tool.

2.8 Critical Analysis

The literature was plentiful on work engagement, but not enough proven studies from healthcare were noted. It is also a very new area, and there are two schools of thought as discussed previously. Should we view burnout the antithesis of engagement or should treat work engagement as an independent construct. There was no evidence of a significant study having been undertaken in mental health, and there is difficulty in accessing robust literature that directly links work engagement to an increase in care quality. However, Sakai et al. (2012) demonstrated that increases in nurses work engagement did increase the quality of care delivered and organisational efficiency. The author believes that we should at least carry out a study in Ireland regarding work engagement levels and use the study to inform practice.

We now are perhaps entering a world of work where there is an increase in transactional engagement. By that, the author is suggesting that young nurses are now staying in areas for short periods and not looking for long terms employment in any one setting. This is due to world changes such as travel, technology and emerging trends in generational thinking. Generations being defined as ‘X’, ‘Y’ and ‘Baby Boomers’ are being identified as all having different needs in the workplace (Ng et al., 2010). Specialist centres of excellence are also encouraging a more dynamic and well-informed health care professional to emerge, thereby producing a transactional workforce rather than a transformational one. Young people now move internationally more readily and gain expertise before moving on. Thus, the challenge in recruiting and retaining staff is a primary concern within contemporary health systems. People are less likely, however, to leave work environments that provide definite scope for development and wellbeing. Organisations still tend to
focus on cost-cutting instead of establishing the workforce as its best asset, despite the fact that investing money in developing staff has been proven to pay dividends. While there now is a focus on work and staff engagement in HSE services, no plan or study of a work engagement intervention has of yet been initiated. Future changes to alternate models of working practices prove to be challenging as turnover of younger people in the workplace increases. Transport and technology have enabled people to transfer, travel and up-skill in different parts of the. This has resulted in a more transient workforce and consequently more unpredictable workplace which make it extremely difficult to implement successful cultural changes.

2.9 Recommendations

A collection of interventions in the area of work engagement should be identified and established. A work engagement focus group could be set in Ireland whereby people could swap knowledge and compare and contrast best practice. New studies are required in the UK and Ireland so as to facilitate a culturally suitable work engagement intervention. The setting up of a symposium or conference on the topic would be an inviting arena for interested stakeholders in the subject. Insights as to the importance of home/work-life balance needs to be explored further as does flexible working arrangements. The discipline of not bringing work home, which should be encouraged by the organisation, may prove to increase and maintain work engagement levels. It is clear from a study of 349 nurses in Australia carried out by Opie et al. (2011), some of which worked in a remote area and some of which worked in urban busy hospital settings, that interventions that increase job resources are beneficial. If the demands grow where people work, then it is reasonable to conclude that so too should the resources. As leaders and managers, there is a duty to ensure that staff can access the necessary resources they need in order to carry out their jobs effectively. Allowing creativity and encouraging a sense of empowerment in the workplace will prove beneficial. Healthcare should concentrate somewhat on minding the caregivers: if we do not embrace this the myth of the
goose that laid the golden egg will apply: what is working well will be overworked and, as a result, will end up exhausted and overburdened leading to burnout.

Leaders need to ensure teams are not overburdened. Leaders need to concentrate on generational gaps. Different generations have different value systems in the workplace. The young may prefer task-orientated work so as they can learn skills. They may value time off more, and they have a preference for much leisure time.

2.10 Limitations

This study was limited in that a particular word string was used in order to narrow the amount of literature. Also, it was not feasible to cover all the grey literature that exists in the area. There is much information out there, as can be seen from the amount of hits on Google described earlier so therefore a considerable quantity of that information has not been explored. The time limit for the research was short, and a more comprehensible search could be undertaken over a longer period. One of the articles was in Japanese and not available in English and others would require time-consuming intra-library loans. An intervention or a study on work engagement in Ireland or the UK has not as yet been measured. Only 30% of the articles reviewed were directly linked with healthcare environments.

2.11 Summary and Conclusion

The challenges from the data collected are many, but they are not complex. Much of work engagement interventions can be cost neutral after an initial cost of training the trainer or completing a supervised CREW intervention that is estimated at approximately €17,000 (Appendix 7). We can conclude that ways forward involve exploring interventions that support and encourage creativity. We need to ensure to meet the demands of the workplace that there is an adequate amount of resources. Again these are not costly, but would necessitate a shift in our attitudes, beliefs and culture. By building trust and interpersonal relationships at work, communication is enhanced, and the literature shows that respect for others will increase. Enhanced
communication and respect for others decreases conflict, allowing a better sense of trust to develop between management and staff. Evidence in the literature suggests that collaborative working is the best environment for work engagement initiatives to grow. Group work, as opposed to individuals working in a silo environment, is seen as more productive. We need to work inter-disciplinary and share each others knowledge.

It is also evident that a proper value system and transformational leadership provides inspiration and opportunities for shared leadership within organisations. Time away from the work environment for teambuilding gives time to re-energise and reflect, which has been shown to be an endeavour for re-energising staff and reaffirming their caring spirit.

2.12 Implications for Practice

Unlike the implementation of many new initiatives, we can see from the available literature that the cost of work engagement interventions is not a major challenge. It is the challenge of encouraging senior management to adopt such interventions that will be the real challenge. The task then is to influence key stakeholders of the many positives and benefits to be obtained. Leadership, and especially leading by example in terms of being trustworthy and reliable, is vital if people are to grow and flourish in work environments.

Another implication from the literature is that an exploration and discussion of how resources can be increased is valuable. Ensuring that people are supported, and an emphasis on soft skill sets are also worthwhile despite the fact that these were often perceived as time wasting endeavours. However, the value of psychological healthy and safe places is now evident and it is becoming clear that healthcare staff need to take the time to discuss and build such environments if they wish to create mutually beneficial workplace conditions.

The project will need to be well communicated, and power distributed to the group undertaking the intervention as it is they who will be local champions and leaders in
their sites. We need then to train and educate a group of people in Ireland who can deliver the interventions following training guided by experts in the area. These relationships have been built, and the parties on the other side of the Atlantic (Canada) are willing and able.

We now need to find the courage and readiness in our environments to embrace and facilitate what can be a lasting cultural change. Team building and time away from the units/wards may be a challenge given resources are at present not plentiful. However, the likely result of not addressing the need for change is that we risk a climate of burnout, apathy, and negativity.
3 Methodology

3.1 Introduction to Chapter

This chapter begins with a discussion of contemporary views on organisational development, change models and strategic tools. A rationale is outlined in this chapter outlined as to why the HSE Change Model (2015) was chosen as a tool for the implementation of this change initiative. Each step of the process and change model such as *Initiation, Planning, Implementation and Mainstreaming* is discussed in detail. It proved extremely beneficial and supportive to have a change model so as each step could carefully and chronologically be followed. This helped process the change implementation process and allowed for a more in-depth analysis of how to proceed with each part of the initiative. Although this thesis is set out as an implementation plan for the future, in this chapter it becomes evident that some of the processes for initiating and planning the change has already taken place. Implementation and mainstreaming are discussed in future terms and have yet to be undertaken.

3.2 Organisational Development Models

Senior and Swailes (2010) in their model of organisational change put emphasis on the current presentation of the environment or work situation and assessing same. They identify the vision, commitment, action needed and the implementation part of the change or development. They highlight that reinforcing the change is crucial to maintaining it. The HSE (2015) Change Model identifies, initiating, planning, implementation and mainstreaming as the steps required in bringing about change within the organisation. Coghlan and Brannick (2014) in their Organisational Development Model emphasise actions such as constructing, planning, action and evaluating. Visible in each model is assessing and starting a change. Implementing is common to each as is maintaining and reinforcing the change.
It is worth noting here that key to implementing change no matter what models are used are trust, relationships, and concepts such as social and professional capital (Jones & Harris, 2014). Glisson and Williams (2015) in a review of social contexts from a mental health services point that the Organisational Social Context (OSC) of a mental health service is critical when introducing successful implementations. Culture and work climate can be assessed using a tool that measures the climate of the work environment at a particular time using a specific measurement tool (Ehrhart et al., 2014). The benefits here are that one gets a sense of how an intervention to practice may be received at the particular time in the particular environment. Therefore, while a model or guide to implementing the change is a priority, it cannot be underestimated the importance of whether the climate is at the time ready and conducive to embracing the change. For change to be implemented it must be agreed as beneficial and be perceived as an improvement not only in patient care but also to the professionals way of working.

Smith (2011) while exploring organisational quality and change suggests that they go hand in hand. A comparison of Kotter’s model of change with Doppelt’s wheel of change model provokes thoughts worth considering maintains Smith. With Doppelt’s model, there is no particular sequence in the seven-point model of change. This is different to Kotter’s chronological eight step model. Doppelts model is informative in that positive affirmations one may hear from staff are highlighted as green lights and negative affirmations are deemed red lights. Shah and Shah (2009) show that peer relations are determinants of readiness in an environment. This sits well with the concept of the work engagement intervention CREW, in that civility and respect towards peers, and other workers are a cornerstone in healthy work environments.
3.3 Rationale for Using the HSE Change Model

While undertaking lectures in the RCSI – a lecture on how to use the HSE change model was given by Blunden, (2015). The reasons for using it are many and logistically it is by far the most pragmatic model to follow given its particularly adapted for the organisation. It is also culturally sensitive to the Irish health service. It promotes consistency as a model and allows for good governance.

The model encourages the inclusion of all stakeholders prioritising consistent communication with the people who are involved in the change. It is evidenced based, and it incorporates project management skills and agreed partnership approaches to change.

The model has been agreed upon by the HSE leadership team and by the Joint Information and Consultation Forum (JICF). It is stipulated as the model for change in the Public Service Stability Agreement better known as Haddington Road. The model has clear guidelines, and it provides the ethos of putting the patient at the centre of care while emphasising changes in culture and identifying the need to mainstream same. For this project, it fits well in that it supports a change in hearts and minds of people, not just policies, procedures, and protocols.

3.4 Change Agent Suitability

Readiness and timing of interventions are crucial in terms of their effectiveness (Armenia’s et al., 1993). Before going into the initiation phase of the HSE change model, it is worth exploring where the author sits in relation to the change and why this change for them at this time, and why implement a collaborative approach? In exploring same the author views themselves as relatively experienced and qualified in the area of interpersonal work being an accredited psychotherapist and a mental health nurse. They have an awareness of the required skill set needed to implement the change and are currently undertaking a leadership MSc, so they have the required support and guidance needed to help them design an implementation plan.
The author views himself as passionate in the area of working with like-minded people who have an interest in changing culture in relation to respect and civility at work.

The author having an Extrovert, Intuitive, Feeling, and Perceptive (ENFP) type personality (Briggs & Myers, 1988) is aware aware of others that have opposite profiles and is constantly learning and planning about how best to work with others in order to have a collaboration of different views and different skill sets. The intervention being implemented here fits well with the authors vision and with the organisations. The emphasis here is that staff support each other and that effective teamwork is pivotal and that all staff are aligned and understand the mission and vision of the organisation. The change agents will require good self-regulation skills and patience and influencing techniques will be required.

3.5 HSE Change Model

3.5.1 Initiation

Turning now to initiation, the first step in the process of the HSE change model we explore here is initiation. The different types of input and co-operation, in order to get the process started, is discussed below. With this initiative being collaborative, both organisations the RCSI and the HSE will benefit. Both are clear about their roles and ownership of the project as this was discussed in terms of academic ownership of data and results of the intervention and in terms of who leads the project. The data will belong to the HSE, and the author will be the lead on the project. A discussion was had with the CREW experts from Canada also, and this discussion needs revisiting in terms of their views on ownership of the data and leadership roles in rolling out the intervention.

It was pivotal also to identify locally and nationally what was on the national agenda for the organisational and what was best practice in healthcare nationally. Recruitment, morale, retention of staff and poor quality of care have been in the press and media and recently locally and internationally. In preparing to lead the
change it is vital to have a good team and guiding coalition. The author began building a rapport with a lecturer in the RCSI who had more expertise and knowledge in the area of work engagement. Many useful discussions took place, and links and networks arose from the many conversations. A joined up vision was reached between and it was agreed to start networking with an international expert. A consultant in Canada and a world leader in work engagement was written to by the author following a prompt from the RCSI lecturer. As a result, the plan began to grow. Someone at a senior level in organisational development was asked for guidance and input, and they kindly obliged. Links and an intention of the design project are being communicated to senior management at the national level in the organisation so as to gain support. A good elevator pitch and presentation are being put together for future meetings with senior management in the HSE.

In this initiation stage, others motivation to change is being explored. The author is beginning to ask colleagues about the present culture and if respect and a work engagement intervention would be of interest. It was at this point that influencing techniques were becoming visibly useful and learnable (Cialdini, 1994). Cialdini's six persuasion techniques will be getting much practice over the next year. How was the author going to influence people? what relationships and examples had they already set previous in the organisation? Burke and Zapped (2006) discuss Aristotle’s views on how to appeal to someone that you are trying to influence. “One may appeal to reason, to the emotions, or in terms of character (logos, pathos, ethos) hence Aristotle offers topics reviewing these resources including ways of transforming an opponent’s argument for your purposes” (p.334).

Knowledge of change and it is the effect on people was necessary at this stage. It was vital to know how and in what way change affects people so that provisions could be made of how to support people best during the process.

A guiding coalition was needed and identification of which people with authority would best to be approached was considered? What are the local service needs and who benefits most? What teams, networks, groups have an input and
influence? Locally the collaborators began to think about unions, senior management and the wider multidisciplinary team and how it worked interdisciplinarily.

The collaborators identified that the mission of the HSE and its values and public ethos being that which understands that values drive behaviors, and culture then drives employee fulfillment, tied well with a work engagement intervention. Fulfilled employees then drive mission assurances which gives customer satisfaction or not depending on culture.

The collaborators had to plan how the intervention would be measured and evaluated, and this needed to be communicated as it gave the intervention a robust frame. A measurement scale known as the UWES would be taken six months before and after the intervention. What would be the savings and the cost to the organisation? What would be win-win for the service and clients? A meeting was set up with the Area Director of Nursing and the Operations Manager. The collaborators met with them to identify and promote why now the change initiative was needed. A briefing document was put together by the collaborators of the project with a note of local changes and drivers considered so as to help progress the initiative to a more formal costing and progression route. For an example and copy of the briefing document see (Appendix 2).

Local needs of service were discussed. From this meeting, a business case (Appendix 6) was put together. As a presentation was suggested, a formal presentation to the Area Management Team by way of Prezi was constructed. Meanwhile, liaison continued with experts internationally who were prepared to bring the project to Ireland and is still presently underway. The collaborators are due to meet soon with a guiding coalition in the HSE South to discuss implementation of the project.
3.5.2 Planning

Good leadership needs good communication and example is one of the best ways to lead. Likewise, the history of the change agent and the credibility they had in the organisation in bringing previous change about would be of importance. The author had previously been a part of favorable changes locally (Connolly et al., 2010; McCarthy et al., 2012), and senior management were aware of the initiatives. Such changes had been published and indeed the author had been complimented on their collaborative abilities for this previous work by senior management publicly. This proved influential as this helped build trust and was an assurance of the competency of the author in implementing change. The inclusion of RCSI staff supported the change initiative and showed credibility and displayed commitment by a willing and well-known institution. It was also decided that sites and costing would need to be identified and procured for the implementation part of the change to work. Discussions are already ongoing with a number of HSE departments, and scoping has begun to identify the most appropriate sites/areas in which to launch the initiative.

Smollan (2013) discusses how staff view changes as hopeful and that they might expect the changes to be positive. They perceive management and the leadership to have taken their views into account. This magnifies the importance of trust and integrity and relationships in the workplace. The collaborators are aware of the significance of this, began to forge honest and open dialogue with others that would be influential in the change process. To help inform the collaborators more comprehensive of this strategic tools that help introducing change initiatives were used.

3.5.3 Strategic Tools

Jarzabkowski and Kaplan (2014) argue “Strategy tools are intended to be useful in coping with the uncertainties associated with strategy making” (p.2).
A PESTLE (Khatri, 2014) was completed and this gave a sense of the political and social landscape as well as informing the authors of legal and economic factors that would influence the change (Appendix 3). PESTLE is an acronym that stands for Political, Economic, Sociological, Technological, Legal and Environmental factors. Kralj et al. (2013, p. 72) state that “PESTLE analysis is a useful tool for understanding the industry situation as a whole and is often used in conjunction with a SWOT analysis to assess the situation of an individual business.” A Stakeholders Analysis (Appendix 4) (Hollenssen, 2015) was used to understand who the key stakeholders were and what needed to be done in terms of influencing them. A Forcefield Analysis (Appendix 5) was also completed, and these strategic tools gave insight into where the power and influences were greatest in relation to the project. It is worth noting that these are subjective and originate from the authors construct. Other may complete the tools and view the power and influence and political landscape differently. This is, of course, what makes changes and large organisations more complex in nature.

It was decided that the collaborators of the initiative to go away and work on a presentation and begin to put together what it would look like and how that picture would then be communicated. Documents were given to senior management (Appendix 2) outlining the local needs for the change and also in the report were identified the proposed outcomes. Resources and costs needed to be identified to progress to implementation, and, therefore, a costing and a business case have been completed (Appendix 6).

Key to any change is also networking, and relationship building and links were established via e-mail and teleconference with Dr Michael Leiter (Acadia University, 2015). E-mails and telecalls were had over a six-month period whereby the focus and objectives of the collaborative process began to grow.

Locally people who were perceived as having an influence or were seen as stakeholders were communicated with, and Administration and Nursing management were asked for supports and a meeting to discuss how best to plan for the initiative. Communicating the plan happened at informal and formal meetings. It was
discussed with possible champions of the change and with people who may be pivotal such as research and development staff of a nursing union.

Scoping out what the new initiative may resemble was evidenced by previous research and results that the CREW intervention had previously achieved. Research of best practice internationally was undertaken as evidenced here in the literature review.

Taken into account and discussed by the guiding coalition was what was the readiness and capacity for the change? Were there any similar projects to the date of engagement undertaken. The poor results of a national employee engagement initiative are interesting. This could prove beneficial or detrimental to this project, so thoughts on how to use this result wisely were strategised.

Planning is more than simply identifying steps; it also is about communicating and targetting the correct audience with the right amount of information. If an area management team are to be convinced to support and fund the initiative, then clarity as regards to what supports and funding were needed had to be calculated. This was achieved by discussion and identification of what they perceived their needs were. These were then integrated with the change agents perceived needs. We then began to engage with other stakeholders and began to listen and understand their view of the needs of the service. A meeting with a trade union representative was undertaken, and insights regarding their construct of the change was gathered. A meeting was then arranged with the Area Manager for Performance and Development. This meeting was extremely beneficial as it became evident that this initiative could indeed be a win-win for all involved (Covey, 2013).

A constructive query that arose during the above meetings was that there were industrial relations issues taking place at present in a proposed site where the initiative was due to commence. The high media discussion that was happening in relation to the proposed site was worth considering carefully. The timing and readiness for the launch of the change carefully had to be re-considered. Management and union bodies and the Labour Court Recommendation body were
presently involved in negotiations. Therefore, it was worth brainstorming what other sites the work engagement intervention could be piloted in. No decision has been definitively made as of yet as this project is an implementation proposal and therefore not tied rigidly to a strict time deadline.

Perhaps instead of going straight to implementing the full change initiative, the introduction of the initiative by having a one-day master class by the CREW experts was the way to go? What was agreed is that rather than risk failure and get caught up in being impulsive about rolling out a change; it was important to check and re-check the information and data of where it may work rather than risk a failure or make a mistake by not taking all the heuristics into account (Kahneman, 2011).

It was becoming more evident as time passed that this project was very much in sync with organisational strategies. A new corporate people strategy by human resources was to have a particular focus on engagement. The structure of the organisation and senior management were viewed to be pivotal and would thus need to be very involved in the implementation stage. Therefore, with their buy-in being so imperative, an explanation of how this could benefit them was consistently communicated.

Resistance would be part of this change initiative as it is with other changes. Very often as Bedeian (1980) explains there can be four common causes for resistance to change. He identifies these as parochial self-interest, misunderstanding and lack of trust, contradictory assessment, and having little tolerance for change. Kotter and Schlesinger (1979) describe ways of overcoming resistance and argues that agreement, facilitation, negotiation and commitment are crucial for unblocking resistance. Bovey and Hede (2010) would say that humour and exploration of the human side of change prove more beneficial when working with resistance than focussing just on the technical side. The project lead, in this case, is an accredited psychotherapist and understands the process of unconscious defence mechanisms. Therefore, they are in a position to navigate better, understand and empathise with projections individuals resistances. Also, the other primary collaborator on the
project has a psychology and organisational development background so the particular change resistance dynamics can be thoroughly examined.

3.5.3 Implementation

Following the successful bid for funding and with the support of line and senior management agreement on commencement dates, roles and actions of who will do what, where and when will be agreed.

A proposal will be forwarded to management and a time for a presentation to the area management team will be arranged. To help with this proposal, there is already completed a CREW implementation plan (Appendix 8).

Who will manage the risks and who will monitor the implementation will need to be agreed. It was agreed however that the team would meet as often as necessary to monitor the impact of changes. This was to be decided by the project lead, although if others requested such a meeting, then this too could be facilitated.

How to best support people during the process would be decided and acknowledged by the project team and the view that would take responsibility for the process. Coaching, mentoring, and leadership, as well as the encouragement and development of others, would occur in an informal and formal process. Engaged leadership was seen to be vital in keeping the change occurring. Celebrating small wins was going to be significant, and small behaviour changes were to be affirmed and encouraged during the implementation.

3.5.4 Mainstreaming

The new ways of working would be highlighted by the suggested evaluation process as seen in the next chapter. If new skills and practices have developed, then they would need to be embraced and encouraged continuously. Mechanisms to support these changes long term would need to be provided. As emphasised throughout the
literature in terms of work engagement, job resources are imperative to successful working, and these would need to be provided. Having regularly scheduled review meetings or discussions whereby the changes would be noted and identified would need to be undertaken. Writing up the change, publishing it, and presenting it at conferences would all be useful in mainstreaming the change. Flagging and constantly communicating any progress as regards the initiative would all be deemed helpful to mainstreaming the change. The importance of keeping and maintaining a change is reflected in Lewin’s change model (Van den Heuvel et al., 2013) in the third step whereby freezing the change after it is made is referred to.
4 Evaluation

4.1 Introduction to Chapter

This chapter outlines how the project will be evaluated. It discusses measurement tools and how the results will be disseminated. The chapter discusses how the changes are perceived to change and improve the quality of care delivered by the organisation.

4.2 Evaluation and Healthcare

An integral part of any change implementation initiative is evaluating its effect. This particular project uses an objective scale (UWES) as described previously. This is very specific and measurable and is not ambiguous or can not be deemed fluffy or not scientifically valid to some. Hultell and Gustavsson (2010) however would argue with this scale, proposing it depends on whether one’s construct is viewing work engagement as a state or trait. They go on to conclude that: “Hence, in contrast to the claim of Schaufeli and Baker that work engagement is a cognitive –affective state, it is found after examining both the definition and the items of the UWES that the operationalisation of work engagement is closer to a trait then a state” (p.264).

Before we look at the nuances of evaluating this particular implementation package further, let us turn to evaluation and healthcare in general.

Evaluation is an essential pillar of the nursing process. Assess, Plan, Implement and Evaluate is the nursing mantra. The Gibbs Cycle is part of the daily process reminding constant vigilance and exploration of how things can be improved. This is no doubt in other healthcare professional training and thinking. Critical thinking and attitudes are paramount in assessing lenses of different groups and stakeholders (Raza & Standing, 2011). This encourages the development of collaborative strategies for change and facilitates progressive solutions. If changes and efficiencies in systems are going to be made, they will be futile if they do not improve patient quality. Vogelgesang et al. (2013) found that there is a link between
work engagement and performance. Therefore, if as they purport “follower engagement is positively related to follower performance” (p.408) then logically the more engaged staff are, the better the service they are likely to deliver. This theory supports the link between work engagement improvements and the quality of care improvements.

4.3 Evaluation

4.3.1 Aims

The aim presented in the proposal was, ‘that a respectful and a more efficient work culture will be created leading to an increase in work engagement amongst staff. This will lead to improvements in the quality of patient care delivered within one year’. Although this proposal set out to be an implementation plan, it has already begun to be embraced. By simply discussing and engaging with stakeholders in the organisation, there should now be a better understanding of what work engagement is. Outlining and proposing the intervention has in itself created dialogue and a better understanding of the concept. People are now becoming more aware of interventions that increase civility and respect in workplaces. Colleagues agree with the principle and energy is developing whereby people are becoming more aware of such an intervention. Funding has been agreed to an extent whereby Performance and Development (HSE, South) have agreed to fund 50% of a master class on the subject. Senior management is open to the idea and has asked for a proposal and presentation. Because this is a project design, then there is no deadline, and the degree of urgency is steadily developing as awareness increases. These points made above certainly validate that the idea already is having a positive effect in that work engagement is now being discussed and talked about. Measuring robustly the change itself when it happens is discussed further below.
4.3.2 Methods and Measures

On initiation and completion of the change initiative, the UWES will be used so as a rigorous objective test will have been used. The HSE change model will be being used in the projects implementation. The objectives of the proposal such as identifying sites and resources and funding are currently being agreed and look probable rather than possible. Feedback and evaluation from participants and management using Kirkpatrick and Kaufman models as templates will be utilised. Therefore, a culture change questionnaire could be implanted to measure the learning before and after. Measures can often be very subjective based, and this is a criticism worth noting in any measures. Whether collecting qualitative or quantitative data or auditing an environment we must be aware of how and why we use the particular measures we do. Approaching human resources and administration and collecting data on sickness and absenteeism levels before the implementation of the initiative is crucial.

4.3.4 Results

Results are of course as of yet unknown and will not be conclusive until the project is initiated in full. The learning and changes in behaviour would need to be recorded and monitored following the intervention. These would show the difference in the before and after stages of the work engagement initiative. Also, a comparison of sick and absenteeism levels would produce information in terms of staff attendance. A cultural assessment questionnaire would validate any significant changes in culture. Ultimately the real change and the preferred result will be if patients receive a better quality of care.
4.3.5 Dissemination Plan

Blunden, (2015) raises many valid questions in the evaluation of projects. What was the goal, what went well, what didn’t work so well and what is it needs tweaking. Did each group involved get their perceived benefits? How will the learning be translated into feedback? Following the collection and analysis of the data, a plan as to its dissemination will be implemented. This will involve discussion with senior management. The data would be communicated to all stakeholders equally and with transparency, after the logistics of doing same has been agreed and identified. It is important that an example be set, and all stakeholders and data be treated equally and respectfully, so as to show effective leadership and communication skills. It is important that the change would be logged and when completed that any steering group or external contracts be closed. Plans for terminating the budget or transferring to new sites would also need to be made. Finally, the nomination of who is responsible for the ongoing monitoring and reporting mechanisms around same would need to be clarified? It is envisaged that this role would be undertaken by the author of this thesis.

4.4 Summary and Conclusion

A good way of understanding and concluding the evaluation is to use the Watkins et al. (1998) exercise mentioned in the proposal introduction of this thesis. Kirkpatrick’s four levels of evaluation are compared with Kaufman’s organisational evaluation model.

- What are the results? Whose behaviour has changed? Identifying whether it was the individuals who benefited or the organisation as a whole.
- Was it society who benefited in terms of are the clients better off as a result of the changes in behaviour by the staff. How did the group and organisation respond to the change and the process?
• Is it an efficient process and are there adequate resources to carry it out again.
• The project’s cost effectiveness would need to be evaluated. Were there changes in absenteeism rates?
• Has the quality of patient care been improved following the change? The objectives as laid out in 1.3.2 of this proposal would need to be compared and contrasted before and after the project.
5 Discussion & Conclusions

5.1 Introduction to Chapter

This chapter outlines the key learning experienced in terms of designing and researching a work engagement initiative. The nuances as regards the practice and theory are discussed. The strengths of the project are highlighted and are many. The chapter begins with an outline of the personal learning experienced by the author.

Much learning and development of the self, as well as knowledge of the organisation, has been experienced by the author of this change initiative. The author having arrived on an MSc course in Leadership having never heard of the term *work engagement*, has in one year worked with others to prepare this implementation plan. The author had always been driven about how to inspire others and bring hope to work environments. The learning in this MSc has helped refine and process that thinking. This has then evolved by way of them identifying work engagement interventions that are contemporary and aligned with the organisational themes.

Work engagement is as highlighted by the research in this thesis a growing concept. Simpson (2010) states in a review of the literature on work engagement that; “Key findings suggest organizational factors versus individual contributors significantly impact engagement at work” (p.1012). This supports the argument that the organisation has a role in setting up procedures and protocol in order for staff to increase their levels of work engagement. It is not just an individual’s responsibility. It is this author’s opinion that future leaders are responsible for ensuring that a vision foresight, skills, knowledge and passion for work engagement interventions be embedded in the organisational culture and strategy so as to play a part in the organisations future.
5.2 Project Impact

5.2.1 Stakeholders

The stakeholders analysis (Appendix 4) displays the level of perceived power and influence each group had as regards the project. What is identified along the journey is that the key to implementing change is to have the people whom the change affects the most on your side and in favour of the change itself. Having those people in favour of a sense of wanting more of the change is pivotal. If demands increase in the work place, then resources need to increase to facilitate the avoidance of burnout and turnover in staff. Discussing the intervention with different stakeholders was enlightening and helpful. It allowed a viewing of the initiative from a multiple of perspectives. Hester and Adams (2014) present a six-step model of how to manage and work with stakeholders: brainstorm, classify, evaluate attitudes, determine engagement priority of the groups, develop a plan and then manage the stakeholders groups. Stakeholder resistance can at times be very challenging, and it can be expressed in subliminal ways. It is important to note that all stakeholders have different constructs and what may be viewed as a good change for some may not be perceived as good for others. Spending time listening and understanding key stakeholders needs can not be underestimated in significance if a change is to successfully be implemented.

5.2.2 Practice

Cited in (Silva et al, 2014) we see the following quote; “Leonardo da Vinci once said, “He who loves practice without theory is like the sailor who boards ship without a rudder and compass and never knows where he may cast”(p.171). Theory and practice are separate, and not all theory translates smoothly into workplace environments. Change is not always easy, and culture can often hinder and disrupt new organisational models (Johannson, 2014). Following a plan and a change model can often help the change become practice.
5.2.3 Theory

Extensively written about and reviewed is the complicated nature and challenges that change implementations and initiatives bring. We are told in the theory about the curves and the resistances to change. It is emphasised just how the natural human response is fear when change comes. Leaders are described in the literature as agents of change. The experience learned is that it is in the doing that the learning occurs, and that introducing change takes much effort and skill. If we peel away the layers and nuances and knowledge of work engagement theory, we see that introducing a change of any level reverts to leadership skills. Learning from the last 24 months have thought the author that ranking highest in the introduction of change are themes such as communication, collaboration, vision, people skills, inspiring hope, self-regulation, action and resilience. Having the ability to listen and hear what people think not just what is being said is key. The different views and constructs of people need to be understood as previously mentioned as people view things according to their own constructs of the world. People coming from different backgrounds and different professions have different paradigms and therefore different needs and different understandings. The current theme of emotional intelligence (EI) in leadership skills, as argued by Goleman et al. (2013), should not be underestimated. Goleman highlights relationships and self-awareness and self-regulation as being indicative of good working environments for leaders. The (NHS) identifies teamwork and engagement and quality improvements as priorities in leadership (Story & Holti, 2013) and these have been the lived experience of the author during the past year.

5.3 Strengths of the project

The strengths of the project are that it is evidenced based, progressive, and it lends itself to improving working conditions. As a result, it delivers on the improved quality of care for the client. It is measurable, and the results are easily quantified with specific measures such as the UWES in situ for such interventions. It saves money and creates and environment of less conflict. It improves respect and civility and creates a sense of positive mental health in the environments where it has been
introduced. It aligns itself with the HSE mission and value system, and now the recent release of the 2015-2017 HSE Corporate Service Plan scaffolds the initiative even stronger. A further strength of the project is that it is collaborative. The projects values align with the organisations need to deliver care with compassion and further engage staff. It is a project that influences and improves the quality of care we deliver to the public. It is flexible and transferable in nature to most sites in mental health if not all healthcare environments. The project has in its favour the fact that it works interdisciplinary and is not hierarchical in nature. It promotes health, fairness and transparency in the workplace. It takes into account the fact that each group can own the project themselves and set their chosen boundaries and goals.

5.4 Limitations of the project

It can only take place where there is a commitment to it by the team. It is new and unfamiliar in Ireland and the UK. There are no experts in the area yet, on these islands. The project takes a timeline of eight months to complete from start to finish. It requires funding to be initially undertaken. It requires people to have trained in how to facilitate and carry out the intervention, so it therefore must have small and humble beginnings.

5.5 Recommendations

When registering absenteeism organizations Schaufeli et al. (2009) maintain that they should differentiate between duration and frequency. When targeting a reduction in sickness duration levels, burnout (i.e., employee unwell-being) should be decreased by reducing job demands and increasing job resources. When targeting a reduction in sickness absence frequency, levels of engagement (i.e., employee well-being) should be promoted by providing additional job resources. This work engagement initiative can be used as solutions to the above. This project and other work engagement interventions need to be piloted and measured within sites in the HSE. That way evidenced based practice can be informed and built upon. Themes from the literature review such as creativity, work-life-balance, trust and
relationships, emotional intelligence and age appropriate task should be in the minds of future leaders and managers in order to help engage staff in their work and organisation. Job supports and resources and leadership as an influence are key to having healthy workplaces. It's a strong view of the author's that investing in staff development and finding the right job for the right person in the organisation is extremely beneficial.

5.6 Learning about Organisational Development

A learning thread during the process of writing this implementation plan has been the significance and supportive role that ‘Performance and Development’ (P&D) of the HSE South has been. The project fits very well with much of the work they undertake. During a discussion with the author and the General Manager of the P&D the author became aware that “staff personal effectiveness, improving service user experience, team development, systemic team coaching, coaching skills and action learning sets” are possible alignment possibilities with this work engagement initiative being proposed here. Links have now been made, and P&D are keen in supporting the author’s change initiative. Meetings have already taken place and another meeting has been arranged to take place in the near future with staff from the mental health services to be included so as to design a collaborative plan and share a joined vision.

Much learning has been undergone in terms of experiencing the challenges and requirements needed to bring about changes in the area of organisational development. It is clear that organisational models and progress is not directly linear or stepwise. It can be quite chaotic and can slip back before it goes forward. It is interesting as out of chaos emerges change. Innovative thinking and the growth of outside quality standards as well as the increase in media technology validate the statement made by (Sujan, & Furniss, 2015) which is that “patient and staff activism can be more easily operationalised through social media and blogs”9 (p.4).
The HSE is an organization that employees approximately over 100,000 people. This makes it a complex organisation in terms of communication and logistics. Strategies are abundant, and each department can operate differently with its own culture. This leads to a challenge in that alignment of goals and developments in each department can need working on. It is reasonable to say that communicating effectively a joined up vision is a more complex task in a larger organisation more than communicating within a smaller organisation. Taking into account all the different people, attitudes, mindsets and priorities it takes considerable effort and expertise to co-ordinate change effectively.

Work engagement the author believes is a way of at least levelling the playing field in terms of respect and civility within the organisation. It hits at the core of a system; values and beliefs. If management and leadership set emphasis on providing a space where people can grow, this will lead to a focus on creating a healthier organization.

5.7 Summary and Conclusion

Bogaert et al. (2013) found “work engagement is a likely direct consequence of practice environments that may ultimately have impacts on both staff and patient outcomes” (p. 1717). It is safe to conclude that how a team performs will have a direct result on how the patient is treated. Work engagement is an effective intervention on introducing respect and absorption and dedication to one’s daily work. There is a need for much further research in the area. The learning in understanding how complex organisations function and how different cultures exist in various departments was striking.

In relation to nursing Laschinger and Leiter (2006) conclude that “patient safety outcomes are related to the quality of the nursing practice work environment and nursing leadership’s role in changing the work environment to decrease nurse burnout ”(p. 259).
Different generations have different ways of doing things and the skill mix and age gaps make for challenging workplaces. Leaders, therefore, have much to prepare for (Piper, 2014). The above learning’s coincided with undertaking an MSc of which included modules such as knowledge of self, organisation leadership, quality and governance. These subject areas were more challenging than was previously perceived by the author. Personal potential flaws of the change agent such as impulsiveness, over networking, and not being pragmatic arose as possible blocks for implementing the change.

Particular individuals are better skilled for different change initiatives. The particular proposal being implemented here fits well with the guiding coalition in terms of their knowledge and focus on the particular change area. Deep-smart knowledge of an area and people skills are vital for the proposed change. However, on reflection having little or no knowledge of an area or its politics and culture allows for no prior judgement and this too can be crucial in particular places at particular times of change.

It is timely that the 2015-2017 (HSE) corporate plan has just been published. Much of its framework, goals and mission has exactly to do with the memes and themes that work engagement initiatives attend too. From understanding and following a process in terms of change within a large and complex environment it was noted that the finishing goal can often change, and flexibility is needed. Having and sticking to a change model was invaluable, and a great support as were strategic tool such as stakeholder’s analysis. The timing cannot be better in terms of this proposal in that the recent release of the HSE Employee Engagement Survey referred to in the proposal highlights that there is a definite need and benefit in engaging people in the workplace.

This implementation plan is now prepared plan of work; it can be followed and used as a guide to implementing the said change. It may need to be adapted, but its strength is its flexibility that too is the fundamental strength of its author. Much awareness and emphasis has now increased in the area where the author works, and the term work engagement has become more familiar to people.
Different departments in the HSE locally are now interested, and the project is developing quickly in terms of funding and probable pilots sites. Learning has been established by the change agents by way of understanding more clearly how the organisation works and that joining resources and collaborating allows potential initiatives room to develop.
6 References


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7 Appendices

Appendix 1 Gantt Chart

Figure 1   Gantt Chart
Collaborative Working

The Introduction of a Work Engagement Intervention in the Cork Mental Health Services

By way of the HSE Change Model
Introduction

The HSE is currently facing significant challenges in staff retention and recruitment. The demands faced by the moratorium and fiscal adjustments over the past number of years have placed increased demands on HSE staff. This creates extra demands on the workforce. Interventions that build resilience and increase engagement of staff are crucial to build and sustain a healthy and effective work environment.

Work Engagement interventions have grown in the last decade evolving from positive organisational behaviour. A successful example is the CREW intervention that is evidenced based and widely used nationally, in the U.S Veterans Hospitals and in the Canadian health care services.

This briefing document outlines a rationale for the introduction of a Work Engagement intervention in the cork mental health services. This document is informed by work undertaken as part of an MSc in Leadership (RCSI) funded by the HSE.

CREW is an acronym that stands for Civility, Respect and Engagement at Work. It is an intervention program that will improve civility and has a positive influence on mental health; it reduces absenteeism and turnover intention. It is evidenced based.

How will this improve our service in Cork?

Cork Mental Health Services have transitioned into 10 CMHT Teams. How can we improve the teams and make them more efficient? A Work Engagement Initiative will:

- build strong teams- enhance resilience- foster positivity - inspire respect
- increase team and individual performance
- reduce conflict
- improve communication
- increases morale and motivates people
- encourages a change in organisational culture
- promotes the delivery of quality care to service users
- support change (for staff)
- decrease cynicism
- increase trust
As per Vision for Change and National Strategy emphasis is targeted at cultural and value changes within the system. The Cork Initiative (Changing Hearts and Minds) is aligned with these principles - a work engagement intervention supports the goals of:

- Interdisciplinary team working
- Integration and partnership
- Community orientated services and teams
- Provide best practice leading to increased quality of care

**Particular issues in Cork**

Huge Changes have taken place and are currently being undertaken

Structural:

Reconfiguration of services and resources
New disciplines- team members have been introduced
New roles (merging and emerging)
New services being initiated and introduced
Movement towards team based networks
Changes in practice

Human Resources:

Supporting staff responses to change
Enhancing our human resources
Providing, maintaining and creating effective work environments

Challenges Ahead:

Securing Funding
Releasing resources
Commitment
Restructuring
Constant change
Fatigue/ Apathy
Lack of trust
Resistance to change

Drivers for the change:
Current appetite for a change in culture
Consultancy and expertise available and ready
Nationally transferable
Leaders in the field
Generation X, Y – Baby Boomers
Skill mix

Methodology

(A) Secure support and funding
(B) Identify sites

Diagnostics…………………… Stakeholder - analysis
Team Data
Measurement by Utrecht Work Engagement Scale
Local changes and demographics
International best practice

Plan..................... Work with teams and management on implementation plan
Build a guiding coalition

Taking Action ........... Train facilitators
Six-month intervention
Evaluation ............ Measurement by way of UWES

Team working
Feedback – Report
Turnover
Absenteeism
## Appendix 3 Pestle

### PESTLE

| Political | Recent media exposure of the area where the change is to take place  
Management in discussion with unions – IR  
15 million has been spent – unit needs to be now functioning  
Minister for state set on opening unit  
More staff needed and promised by Minister for health |
|---|---|
| Economical | Recession, Value for money needed  
Salaries decreased which affected morale - Staff now looking for increase  
Only limited budget locally  
Need to stay within budget |
| Sociological | Partnership – Collaboration is direction from Healthy Ireland (HI)  
Deinstitutionalisation - Community focus taking precedent so now only very acute as in inpatient  
Demographics of areas can increase and decrease admissions  
Unions and partnership are current ethos |
| Technological | Accessibility – new system installed which staffs need to learn  
New alarm system and staff safety a priority – training needed  
New infrastructure – state of the art  
Tele calls now more used as modern ways of communicating develop |
| Legal | 2001 Mental Health Act  
Mental Health Commission; Regulatory Body for Approved Centres  
Codes of Practice NMBI  
The Employees (Provision of Information and Consultation) Act 2006  
Working Conditions – Health and Safety Act 2005  
Trade Union and Labour Recommendation Court (LRC) involved |
| Environmental | Buildings –new development currently underway  
Issues with how best to use beds – i.e. Six bedded high obs unit  
Location – challenges with integration with rest of hospital as site is detached  
Comfort – staff rooms and changing facilities much improved  
Developmental ethos of constant learning  
Interdisciplinary and multidisciplinary working  
Security now on unit 24 hours 7 days a week |

### Table 3
### Appendix 4 Stakeholders Analysis

**Figure 2. Stakeholders Analysis**

<table>
<thead>
<tr>
<th>High Importance/ Low Influence</th>
<th>High Importance / High Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CREW Team</td>
<td>- Operations Manager</td>
</tr>
<tr>
<td>- Project Team</td>
<td>- Area Director of Nursing</td>
</tr>
<tr>
<td>- Service Users</td>
<td>- Director of Nursing</td>
</tr>
<tr>
<td>- Human Resources</td>
<td>- Assistant Director of Nursing</td>
</tr>
<tr>
<td>- RCSI</td>
<td>- CNM III, CNM II, Staff</td>
</tr>
<tr>
<td></td>
<td>- Trade Unions</td>
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<table>
<thead>
<tr>
<th>Low Importance/Low Influence</th>
<th>Low Importance/High Influence</th>
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<tbody>
<tr>
<td>- Administration</td>
<td>- Clinical Director</td>
</tr>
<tr>
<td>- Organisational Development</td>
<td>- Consultants</td>
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<td></td>
<td>- Professor</td>
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Appendix 5 Force Field Analysis

Figure 3. Force Field Analysis

<table>
<thead>
<tr>
<th>Forces for change</th>
<th>Forces against change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of disrespect</td>
<td>Too much change</td>
</tr>
<tr>
<td>Appetite for change</td>
<td>Apathy</td>
</tr>
<tr>
<td>New move taking</td>
<td>Seen as not necessary</td>
</tr>
<tr>
<td>New team will</td>
<td>Funding</td>
</tr>
<tr>
<td>Experts available</td>
<td>Resources</td>
</tr>
</tbody>
</table>

81 39 31
Location:
Cork Mental Health Services

Project Name:
A Work Engagement Intervention

Document prepared by:

Document approved by:

Please note in some of the appendices, names, addresses, emails and phone numbers have been blacked-out for the purpose of confidentiality.
The Business Case draws together the essential information that should be available within the project.

Using Getting Started - Questions for Consideration will assist in populating your Business Case Document. The Business Case is a live document and should be updated and reviewed at each stage of the Project.

1. **Project Title**

   The Introduction of a Work Engagement Intervention in the Cork Mental Health Services.

   This is a project which will increase vigour, dedication and people's absorption in their work. It will increase positive attitudes in the workplace and increase collaborative working.

2. **Project Proposer**

<table>
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<tr>
<th>Name</th>
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<td>E-mail</td>
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3. **Sponsor**
**4. Reason for Project**

The reason for the project is to build resilience and increase the engagement levels of staff and teams leading to a more effective and quality improved service being delivered. It will support and build stronger multi-disciplinary working with interdisciplinary sharing being its priority.

The aim is that a respectful and a more effective work culture will be created leading to an increase in work engagement amongst staff. This will lead to improvements in the quality of patient care delivered within one year.

Locally many changes are happening:

**Structural:**

- Reconfiguration of services and resources
- New team members arriving, different age groups arriving with different values
- New roles (merging and emerging)
- New services being initiated and introduced
- Movement now towards team based networks
## Changes in practice such as recovery ethos ongoing

New Environments, buildings evolving

### Drivers for the change:

- Current appetite for a change in culture
- Engagement is part of organisational national strategy
- Nationally transferable as a solution
- Improvements in quality care needed
- Service users call for attitudinal shifts
- Retention of staff now key for services

### 5. Description of Project

The project will be a six-month intervention which will concentrate on engagement and respect and co-working. See a full implementation guideline attached with this proposal.

It is a series of meetings in which groups of staff meet to discuss issues that affect their work.

The group identify the issues, then focus on these and sets goals so as they are met. Each group is supported by a CREW facilitator who is provided with the toolkit to assist them. Crew combines elements of awareness, personal responsibility and accountability from all.

See attached programme implementation guide.

### 6. What is the Scope of the Project?

*Indicate clearly what is:*
- **Functional scope** – the service areas and processes to be affected
- **Organisation Scope** – what units of the organisation are affected
- **Define main element that are OUT OF SCOPE**

The scope of the project will be that teams and individuals in the service and their processes, attitudes of the way they work will be enhanced. The scope will introduce a culture change in how we do business. This project is initially aimed to begin in the Cork Mental Health Services.

Members of the HSE will be trained as facilitators of a work engagement intervention allowing a rolling and transferability of the project to other areas within the organisation in the future.

Out of scope is Industrial Relations (IR) NB: this project is not to be confused with any IR mechanism.

### 7. Project Timeframe

Please indicate the expected timeframe

<table>
<thead>
<tr>
<th>Stage</th>
<th>Expected Commencement</th>
<th>Expected Completion</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation</td>
<td>On-Going</td>
<td>May 2015</td>
<td>Guiding coalition and commitment being built</td>
</tr>
<tr>
<td>Planning</td>
<td>24&lt;sup&gt;th&lt;/sup&gt; February</td>
<td>June 2015</td>
<td>Constantly being worked on</td>
</tr>
<tr>
<td>Implementation</td>
<td>September 2015</td>
<td>February 2016</td>
<td>May vary a little depending on logistics</td>
</tr>
<tr>
<td>Mainstreaming/ Sustainability Support</td>
<td>February 2016</td>
<td>Ongoing</td>
<td>A change in how we do business and culture shift will be on-going</td>
</tr>
</tbody>
</table>

### 8. Stakeholder Management

Stakeholders should be identified together with the level of interest and impact they have on the project.

<table>
<thead>
<tr>
<th>Stakeholder / Group</th>
<th>Level of Interest</th>
<th>Assessment of Impact</th>
<th>Process / Strategy to gain support / reassure/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder</td>
<td>Engagement</td>
<td>Support</td>
<td>Note</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------</td>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Senior Management</td>
<td>High</td>
<td>High</td>
<td>Their support is vital and they are positive thus far and supportive - continue to lobby and collaborate</td>
</tr>
<tr>
<td>RCSI</td>
<td>High</td>
<td>High</td>
<td>Continue collaboration - research element vital</td>
</tr>
<tr>
<td>Trade Unions</td>
<td>Medium</td>
<td>High</td>
<td>Important this intervention not seen as IR tool. Build alliances with unions reps. Build alliance and involve - discuss and work on influencing attitudes to change</td>
</tr>
<tr>
<td>Staff</td>
<td>High</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Performance and Development (HSE South)</td>
<td>High</td>
<td>High</td>
<td>Build alliance and collaborate - get guidance - funding support</td>
</tr>
<tr>
<td>CREW Experts</td>
<td>High</td>
<td>High</td>
<td>Continue building rapport and keep informed of developments</td>
</tr>
</tbody>
</table>

### 9. Benefit Assessment

Identify the main benefits including enhanced access, quality, service, professional development, efficiency, cost savings, etc.

It will improve teams and make them more efficient. It will enhance staff resiliency-
foster positivity and inspire respect. It will deliver on a better quality of care for service users. Evidence has shown that following a CREW intervention:

- team and individual performance increases
- conflict is reduced
- communication improves
- morale motivation are increased
- it encourages a change in organisational culture
- promotes the delivery of quality care to service users
- it supports staff in change
- trust is increased as are working relationships
- staff retention is increased
- positive mental health is increased

10. Human Resources Assessment

HR resources need to be identified from 2 perspectives as follows:

1. Project Team – Staff required for the Project Team for the duration of the Project Term
2. Services – Increased staff required to run the changed service Services – Reduced staff requirement following the changes

The project team will be made up of staff from the HSE and RCSI - This project can mostly be undertaken without creating new posts although a Project Lead would be advisable so as to concentrate fully on implementation. It will otherwise require people as part of their overall posts to work together to bring the project to fruition over an 8-month period.

N.B - In relation to the below cost, it is purposely tiered into steps so as to invest the least amount first and then progress if it is proving a success. That way initial risk of losing money is decreased significantly and only if senior members of organisation are happy will full investment of 30,000 be required.

11. Cost of Project

| Step 1                                      | Initial outlay of 1200 euro for an international visit to explore workings of | 1,200 |
### Step 2

**Approx 7,000 Euro for Master Class day for staff and senior management to attend - Performance and Development willing to pay 50% so 3,500 euro needed**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
<td>3,500</td>
</tr>
</tbody>
</table>

**Total 34,200**

### Step 3

**A total investment of 30,000 Euro would be required for the project implementation for 8-month duration.**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td>30,000</td>
</tr>
</tbody>
</table>

### 11. What Performance Measures will be used to measure the outcome of the changes

*Identify what Performance Measure(s) will be used to track the outcome of the project (ie. What will indicate if the project has been a success)*

- Utrecht work Engagement Scale
- Absenteeism
- Staff evaluation
- Quality Service Measure
- Service users experience of care pathway to be assessed

### 12. Key Dependencies

*Identify any key dependencies that may impact on the project. Indicate how these dependencies will be managed.*

<table>
<thead>
<tr>
<th>What is the Dependency?</th>
<th>Identify any proposed actions to manage the dependency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CREW – Dr Michael Leiter as expert in the intervention</strong></td>
<td>Ongoing discussion and the setting up of a local and national group explore this is being undertaken</td>
</tr>
</tbody>
</table>
### 13. Key Assumptions

List the main assumptions that underpin the project appraisal.

<table>
<thead>
<tr>
<th>Assumptions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope - This is not an IR tool</td>
<td>Team-willing Coalition needed</td>
</tr>
<tr>
<td>Policy - Local policies and best practice will be adhered to</td>
<td>Expertise and commitment</td>
</tr>
<tr>
<td>Resource - Crew and local expertise utilised as well as RCSI support</td>
<td>UWES scale</td>
</tr>
<tr>
<td>Technology - current mechanisms used no need for new IT</td>
<td></td>
</tr>
<tr>
<td>Business Case</td>
<td></td>
</tr>
<tr>
<td>Other Staff Commitment</td>
<td></td>
</tr>
</tbody>
</table>

### 13. Key Risks

Identify any key Risks for the project. Indicate how these risks will be managed.

<table>
<thead>
<tr>
<th>What is the Risk?</th>
<th>Identify any proposed actions to manage the Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of the areas to consider are:</td>
<td></td>
</tr>
<tr>
<td>• Other Functions</td>
<td></td>
</tr>
<tr>
<td>• Other programmes</td>
<td></td>
</tr>
<tr>
<td>• ICT</td>
<td></td>
</tr>
<tr>
<td>• Human Resources/Industrial Relations</td>
<td></td>
</tr>
<tr>
<td>• Cultural/Behavioural</td>
<td></td>
</tr>
<tr>
<td>That this will be seen to interfere with IR mechanisms</td>
<td>To clearly communicate that this is not and will not ever be the case</td>
</tr>
<tr>
<td>Resistance</td>
<td>Discuss with IR representatives</td>
</tr>
<tr>
<td></td>
<td>Collaborate – create readiness</td>
</tr>
<tr>
<td></td>
<td>Build support –</td>
</tr>
<tr>
<td></td>
<td>Freeze the change when made</td>
</tr>
</tbody>
</table>
14. Other Relevant Information

*Indicate any other relevant details that will be useful for consideration of the proposal*

<table>
<thead>
<tr>
<th>Other Relevant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a new concept and courage and commitment to change will be needed – It is evidenced based and it has many proven results. It is and will be a contemporary area of focus for healthcare organisations and we should not miss opportunity to embrace work engagement as it will become more part of organisational goals in the near future. It is initially a small outlay of capital so no huge risk entailed financially.</td>
</tr>
</tbody>
</table>
Appendix 7 Costing of CREW Intervention

Cost Information on CREW

The following costs are estimates to give a general guideline on financial commitments. Specific contract details would influence costs in an actual contract. The CREW process also involves responsibilities and obligations, including employee time, devoted to the project. These responsibilities are outlined in the accompanying materials.

Single CREW Process

A single CREW contract covers the process from introducing the concept to the organization, through training and coaching facilitators, to presenting a summary report. This process generally takes 8 months. It is described in detail in the accompanying materials.

The cost for a single CREW contract is $20,000 US. For an engagement in Ireland, we would add a charge to cover the additional travel between Nova Scotia and Ireland.

Larger Scale CREW

An alternative scenario would implement CREW at multiple sites in Ireland. We will use 10 sites for an example. In the first wave of CREW, the organization implements the process on one or two work units; a larger implementation may occur on subsequent waves of CREW. The beginning of subsequent waves may overlap with the previous wave such that we would initiative CREW every six months.

We would consolidate the training and midterm meetings by offering these events at one central location. This format would have the benefits of containing the costs of the training and it would also build the community of people working on improving civility across Irish health care facilities. The participants would participate in CREW community calls that would occur monthly throughout the CREW process.

The costs for implementing CREW at 10 sites following this format would be $50,000 - $60,000 US for each wave depending upon the scale and complexity of the project. Under a contract for multiple waves, the COR&D trainers will develop people fulfilling facilitator or coordinator roles to serve as CREW Companions in subsequent CREW initiatives.

A survey is an integral part of the CREW process. The survey occurs prior to commencing CREW and towards the end of the CREW process. Ideally, the survey would include units not doing CREW or
perhaps on a waiting list to do CREW during a subsequent wave as a contrast group. We can discuss the possibility of surveying the entire staff of a participating facility, but doing so and providing detail reports would require a price adjustment.

In some cases, the survey provides indications that the unit manager would benefit from individual coaching in addition to participating in the CREW process. That coaching would be an additional component beyond the CREW process.

CREW Workshop

We recommend offering a workshop or a series of workshops led by Dr. Leiter and a member of the CREW staff prior to initiating CREW. The workshop would be designed for healthcare leaders and individuals who are potential coordinators or facilitators in the CREW process. The workshop would include didactic elements, relating the relevant research on workplace civility, emphasizing its role in preventing job burnout and enhancing work engagement. The workshop will draw upon Dr. Leiter’s research with the Centre for Organizational Research & Development and with the Veterans Health Administration. The workshop will include participation exercises encouraging participants to reflect upon their experiences with incivility at work and initiatives to promote civility and respect.

The cost of this workshop is $7500 US for the day plus travel expenses. This workshop could occur on one occasion for participants across the country. It could also be repeated in various regions of Ireland to permit participation from a larger number of hospital employees.

Research Issues

The evaluation of CREW relies upon the surveys conducted before and after the process. These surveys use high quality research surveys that allow them to provide a valid perspective on CREW’s impact.

Implementing CREW, especially on a larger scale, provides an opportunity for generating significant research outcomes. A formal research project would require some refinements of the CREW process and the active participation of healthcare leaders in Ireland. There would be cost implications for pursuing a research format that would require discussion.
March 9, 2015
Good afternoon,

Please find enclosed our recommended proposal for a CREW implementation.

The proposal has the following content:

Implementation Proposal .................................................................................................... 2
Workshop: Civility at Work................................................................................................ 4
Cost Breakdown .............................................................................................................. 5
Roles & Responsibilities .................................................................................................... 6
CREW Coordinator Expectations ................................................................................. 6
CREW Facilitator Expectations .................................................................................... 7
CREW Participant Expectations .................................................................................... 7
CREW Workgroup Manager/Supervisor ................................................................. 7
Organizational Senior Leader/Director ................................................................. 8

We have framed this proposal as a one-time two unit pilot, over an 8 month period.

We look forward to discussing the proposal with you.

Implementation Proposal

1. One Wave, Two-Workgroup Implementation:
   a. 2 workgroups participate in CREW
   b. 2-4 trained CREW facilitators
   c. 1 trained CREW coordinator

   Each CREW wave consists of similar activities: Preparation; Assessment; Orientation Training and Mid-Point.

1. Initial Promotion and Preparation Phase
a. CREW Preparation Workshop. A one-day (1) active workshop, delivered by Dr. Michael Leiter to the organization’s key stakeholders (leadership team, union representatives, HR, workgroup managers, employees, etc).

b. Teleconference with CREW Representatives. Discussions with the organization’s CREW stakeholders and CREW facilitators & coordinator(s). Introduction of the CREW Companion

c. Determine groups participating and whether control groups will be used for evaluation purposes

d. Discussion of CREW Roles and Responsibilities

e. Survey preparation and discussions.

2. CREW Implementation. Each wave consists of:

a. Pre & Post CREW survey for evaluation purposes. Profiles of each workgroup will be provided.

b. Initial on-site CREW training conducted by CREW Companions

c. Mid-Point on-site CREW session conducted by CREW Companions.

d. Regular (bi-weekly and ad-hoc) on-going support (CREW Companion mentoring)

e. Monthly CREW Community Calls. All facilitators/coordinators participate in the existing community of Facilitators/Coordinators from CREW projects at other settings.

3 | P a g e

Activities

Preparation

1. CREW Introduction

a. Dr. Leiter delivers a one-day civility workshop

b. Senior leadership endorses CREW process

c. CREW Companions (ML&A) supports CREW preparation and implementation

i. Explanations, business case, survey preparation, help choosing Facilitators etc

a. Organization chooses members to fulfil main CREW roles:

a. CREW Coordinator,

b. CREW Facilitators (2 for each CREW group),

c. CREW Champions.

2. CREW Assessment: Initial CREW Pre-Survey

a. Establish baseline with Wave I CREW groups.

b. Compile and distribute workgroup profiles
3. CREW Companions travel to conduct orientation/training session with Coordinator, Facilitators, Unit Managers, Champions, Senior Leaders and interested stakeholders.

CREW Meetings

1. CREW Wave I groups begin meetings

2. CREW Companions provide direct ongoing support to Coordinator and Facilitators, in the form of bi-weekly teleconferences and ad-hoc email/phone support.

3. CREW Facilitators/Coordinators join the monthly CREW Community calls with other participating organizations.

Midpoint

1. CREW Companions conduct site visit for Wave I CREW Midpoint Meeting
   a. Midpoint is attended by Wave I Facilitators, Coordinator, Managers, Champions

CREW Meetings

1. Wave I CREW groups continue meeting

2. CREW Companions provide direct ongoing support to Coordinator and Facilitators, in the form of weekly teleconferences and ad-hoc email/phone support.

3. CREW Facilitators/Coordinators participate in the monthly CREW Community calls with other participating organizations.

4. Wave I CREW groups determine how to end, if preferred, the formal CREW process.

Wrap-Up

1. Formally, Wave I CREW groups end, if desired.

2. Conduct post-CREW survey with Wave I participants.
   a. Survey results compiled.

Workshop: Civility at Work

Great work comes from great teamwork.

Belonging to a great team makes work enjoyable and effective. But belonging to a dull workgroup or, much worse, a nasty workgroup makes worklife unbearable.

This workshop develops strategies for turning things around. There’s a lot you can do as an individual. There’s a lot you can do as a leader. Join others who share a mission to improve the quality of working relationships.

Learning Objectives

- Identify factors that influence a team’s level of civility and respect
- Identify the causes and consequences of civility and incivility at work.
- Practice specific strategies for inspiring more positive interactions with colleagues.
Practice specific strategies for responding to unpleasant encounters.

Write your plan for promoting civility at work.

A Plan for Civility

Vision: What Is Our Ideal Community?

Values: What are Qualities of Excellent Working Relationships?

Objectives: How Do We Measure Progress?

Pathway: What are Effective Strategies?

Priorities: Who’s Doing What to Get There?

CREW: A Focused Civility Intervention

What is CREW?

What Sorts of Situations Call for a CREW Interventions?

CREW Readiness

Who Should Attend?

Employees intending to improve collegiality at their work

First line managers intending to lead their workgroups to greater teamwork

Senior managers and executives intending to deepen their organizations’ culture of respect

His approach addresses factors contributing to job burnout and strengthens employees’ capacity to experience engagement at work. A major initiative is Civility, Respect, and Engagement at Work (CREW) that leads groups to experience supportive relationships. His approach builds on solid ideas, sophisticated analysis, and a capacity to communicate with diverse audiences. He has brought this approach to organizations across North America and overseas. He is widely published in academic journals and trade publications on burnout and work engagement.

Cost Breakdown

Costs

Civility Workshop

$5,000

CREW Program

$20,000
Travel Surcharge
$10,000
Total
$35,000
Please note all amounts are reflected in US currency and are inclusive of appropriate taxes.

Roles & Responsibilities

CREW Coordinator Expectations

1) Initial Conversations
   a) Raise awareness of the importance of civility and respect among co-workers, customers/clients
   b) Instil commitment to the common goal of enhancing CREW behaviour.

2) Meet with Directors and Senior Leadership
   a) Outline CREW plan
   b) Educate and elicit support for CREW
   c) Seek and allocate necessary resources to accomplish CREW objectives
   d) Suggest avenues for sharing CREW information
   e) Ongoing CREW updates

3) Meet with front line managers in participating unit(s)
   a) Discuss roll-out plan
      i) Outline meeting expectations
      ii) Discuss toolkit options
   b) Serve as a liaison/Point of Contact between Organizational leadership, Facilitators and perhaps the workgroups.

4) Champion in other facility venues as appropriate: newsletters, staff meetings, and any other routes as deemed necessary.

5) Coordinate, champion and support the CREW activities for your site
   a) Monthly meetings with Facilitators
   b) Meetings with managers for ongoing evaluation
   c) Selecting of site CREW Facilitator(s)
   d) Assist in identifying the CREW workgroups
e) Ensure that the workgroups complete their pre-and post-assessments
f) Ensure that the workgroups hold CREW meetings on a regular basis
g) Serve as CREW Facilitator if needed
h) Expect effort near the beginning of a CREW Wave to be more labour intensive.

6) Report on progress
   a) Participate at monthly CREW Community Call