The reduction of burnout and stress for primary care physiotherapists by proactive stress management.

Marian Mullaney  
Royal College of Surgeons in Ireland
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The reduction of burnout and stress for primary care physiotherapists by proactive stress management

Marian Mullaney

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

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Declaration Form

Declaration:

“I hereby certify that this material, which I now submit for assessment for the Project Dissertation Module on the MSc in Healthcare Management is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

Student’s Signature(s):

Date: 12 May 2016

Student’s Number:
14108704
## Table of Contents

Acknowledgements  
Abstract  
List of tables  
List of figures  

1 Introduction  
1.1 Introduction  
1.2 Organisational Context  
1.2.1 Ethical Approval  
1.3 Rationale  
1.4 Aims and Objectives  
1.4.1 Aim  
1.4.2 Objectives  
1.5 Role of the Student in the Organisational Project  
1.6 Summary and Conclusion  

2 Literature Review  
2.1 Introduction  
2.2 Search Strategy  
2.3 Themes  
2.3.1 Predictors of burnout and stress  
2.3.2 Impact on the Physiotherapists  
2.3.3 Response to burnout and stress  
2.4 Implications for the project  
2.5 Summary and Conclusions  

3 Organisational Development Process  
3.1 Introduction  
3.2 Critical Review of Approaches to Organisational Development  
3.2.1 Change Management  
3.2.2 OD change models  
3.3 Rationale for OD model selected  
3.4 OD Model – Health Service Executive Change Model  
3.4.1 Initiation  
3.4.1.1 Preparing to lead the change  
3.4.2 Planning  
3.4.2.1 Building a Commitment
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‘It always seems impossible until it is done’

Nelson Mandela
Abstract

The purpose of the organisational development project is to reduce burnout and stress for primary care physiotherapists by implementing a proactive stress management system including a stress control programme. This system is designed to eliminate or minimise psychosocial risks in the workplace and is also restorative by equipping the physiotherapists with practical coping skills. Burnout and stress are the number one occupational reasons for absenteeism in Europe. The moratorium on recruitment in the health care service increased personal and financial demands for patients and staff. The existing gap widening between the work requirements and the supports provided for health care workers. The literature findings promote the need for burnout prediction before providing an intervention, directed not only at the individual but the organisation for effective change. The HSE model was chosen to demonstrate the change in a precise way, containing assessment data, focus group themes, evidenced stress management policy and access to a programme devised to upskill the participants in stress regulation. Evaluation of the project was a mixed quantitative and qualitative style, including thematic analysis of the focus group content, Maslach Burnout Inventory, audit and questionnaires. The Kirkpatrick Framework evaluated the training elements of the project. The change project achieved its primary objectives by reducing burnout and stress for the physiotherapist, decreasing absenteeism, decreasing work and patient load, and improving control. There is a new era emerging in Irish healthcare where the care provider’s health requirements merit equal consideration with the health needs of the client.
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Focus group questions</td>
<td>28</td>
</tr>
<tr>
<td>2</td>
<td>Kirkpatrick levels</td>
<td>36</td>
</tr>
<tr>
<td>2</td>
<td>Key objectives and results</td>
<td>39</td>
</tr>
<tr>
<td>3</td>
<td>Kirkpatrick levels and Likert questions (1-6)</td>
<td>39</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1 HSE Change Model 22

Figure 2 Kirkpatrick Model 35

Figure 3 Question one Likert tool 40

Figure 4 Question two, three and four of the Likert tool 40

Figure 5 Absenteeism and non-availability at work 41
1. Introduction

The purpose of this development project is to reduce stress and burnout for Primary care physiotherapists (PT’s) by implementing a proactive stress management system including a stress control programme. A two level approach will achieve this. The first level is prevention, or eliminating psychosocial risks (stressors) in the workplace (Hassard and Cox, 2014). Themes around supports and vitality are identified with a physiotherapy focus group and these inform a local stress management guideline. The second level is ameliorative, equipping the physiotherapists with the knowledge and coping skills, making them more resilient to stressors (Hassard and Cox, 2014). A validated stress control programme will provide this. At present, there are no stress management or ameliorative programmes on offer in the writer’s primary care health area for staff. The organisation’s management will audit the safety and quality aspects, by attributing risk to work related stress, the same as with any other health and safety issue. The future ‘mainstreaming’ of the stress control programmes in primary care will follow evaluation with front line staff offering positive health outcomes to them.

The dissertation is presented in five chapters. This chapter will give the organisational context and rationale for this development project, including the definition of the aim and objectives and a description of the role of the student. In chapter two, three key themes will be gleaned from a literature review that is relevant for justifying the proposed change project. Chapter three contains the methodology and methods employed as part of the organisational development (OD) process. Chapter four will discuss the importance of evaluation in healthcare and of appraising the impact of burnout and stress reduction for physiotherapists. Finally, chapter five provides further details and discussion of the project findings, the impact and their implications, strengths and limitations. This chapter will conclude with recommendations for future improvements and a summation of the results from the completed change project.

1.2 Organisational Context

The Health Service Executive (HSE) provides employment assistance support service (EASS). But the referrals to this service are made only in acute, stressful situations
with clients. The waiting time for EASS is four weeks and one counsellor facilitates one to one intervention for an HSE population of 11,000. The negative effects of burnout are job turnover, decreasing staff morale, absenteeism and personal dysfunction (Maslach et al. 2015). The physiotherapists like other healthcare staff can be negatively impacted by long-term stress, reporting low morale, feeling undervalued and desensitised to people. If the policies and systems are implemented, providing the dialogue, information and supports needed for managing stress then the physiotherapists will engage more with the Health organisation, feel valued and respected and in turn, improve the quality of care to their clients.

1.2.1 Ethical Approval:

The local research ethics committee and Quality Risk and Patient Safety Department reviewed and approved the writer’s application to the research committee, for the use of the Maslach Burnout Inventory MBI (Maslach and Jackson, 1981) or Human Services survey, information leaflet and the consent form.

1.3 Rationale for carrying out the change

The healthcare services in Ireland had to deal with significant challenges in recent years mainly due to a moratorium on recruitment in a time of austerity, (HSE, HR Circular 015/2009). The lack of recruitment led to increased demands both personal and financial for patients and staff. Burnout and stress are the number one occupational reasons for absenteeism in Europe, contributing to 50 - 60% of lost work days (Hassard and Cox, 2014) and reduced productivity of 1.5 billion euros per year in Ireland alone (IBEC, 2013). Work related burnout and stress is caused or made worse when the individual realises the imbalance between the demands of work weighed up with their ability to cope (Ireland. Health and Safety Authority, 2015).

According to Maslach et al. (2015), a gap exists in the Irish healthcare services between the work demands and the supports provided for the healthcare worker. The writer wants to reduce the gap between resource depletion and support. If supports
are not readily available, they need to be identified and sourced. The burnout construct is important in any organisational change, particularly with the current focus of the HSE on staff engagement. Engaging stakeholders at every level of the proposed change is significant. Factors which cause stress for healthcare workers can be role conflict and ambiguity (Ireland. Health and Safety Authority, 2008) along with a heavy workload (Maslach et al., 2015; Nolan and Ryan, 2008). A significant stressor can be their emotional response to dealing with the sick and the dying or compassion fatigue. There are higher levels of burnout and work distress in healthcare workers (Ruotsalainen et al., 2015), but minimal research on the impact of burnout on service recipients (Maslach et al., 2015). The Safety, Health and Welfare Act advise the use of a safety statement, risk assessment and prevention (Ireland. Health and Safety Authority, 2008). Primary care physiotherapists in their supervision sessions with the writer have increasingly reported stress and loss of identity. When the health care worker experiences severe burnout and stress and becomes physically ill, then they cannot provide a high-quality service to the patient. The level of absenteeism has risen in the team to above the national average of 3.5% (Likely and Switzer, 2015).

The Stress Control Programme is six, sixty-minute sessions in a psycho-educational programme by clinical psychologist Jim White (White, 1998). It consists of cognitive behavioural therapy (CBT) focusing on the role played by behaviours, thoughts and the experience of stress (Switzer, 2013) (Appendix 1). The intervention suggests that CBT is useful in decreasing stress (Ketlaar et al., 2013). The desired state opposite to burnout is engagement and vitality (Maslach et al., 2012). Stress management research delivers on the premise that stress management programmes will positively impact on staff health and well-being (Switzer, 2013). Early predictors of burnout are valid for identifying ‘high risk’ people selected for early, preventative interventions. The multi-dimensional MBI (Appendix 2) is such a measure of burnout with potential early indicators (Maslach and Leiter, 2008). The sensitive material collected protected by the use of the HSE data protection policy (HSE, 2003). The writer will ensure all information is anonymised and utilised for the purpose collected. It will be stored securely and retained only for the length of the project. The implementation of this change project will not only create valuable dialogue around burnout and stress, but it
will also provide a local guideline on managing stress to the region and access for physiotherapists to validated supports they need.

1.4 Aims and Objectives

1.4.1 Aim:

The aim of this project is to reduce stress and burnout for Primary care physiotherapists by implementing a local stress management policy including a stress control programme. This will improve safety in the workplace by identifying psychosocial hazards or risks (stressors) and providing both a preventative and a curative approach.

1.4.2. Objectives:
1. To reduce the level of burnout by 10% by 31 March 2016.
2. The physiotherapists will attend 90% of the stress control classes by 31 March 2016.
3. The stress management policy will include 100% of the identified themes from the focus group.
4. The Physiotherapy managers will be 95% compliant with the policy audit by 31 March 2016.
5. To reduce the level of absenteeism by 30% by 31 March 2016.

1.5 Role of the student in the organisation and project

The writer works in an HSE Primary care setting managing an allied health professional team. The manager role includes being responsible and accountable for both staff and patient safety and welfare. This position is underpinned by legislation—the safety, health and welfare at work Act (Ireland. Office of the Attorney General, 2005) and policy, stress management and healthy Ireland (HSE, 2012; HSE 2013)). The project is an expansion of the writer’s role in line with the HSE Corporate Strategy 2015-2017. This strategy advocates engaging, supporting and developing the workforce. Using the HSE Change model (HSE, 2008) the writer will lead and participate at every stage of the implementation of the project, actively engaging and supporting vital stakeholders and getting agreement from senior management. The writer had preliminary negotiations with a psychology colleague. The crucial work including a local focus group, educating the writer around systematic thematic analysis and the provision of a stress control programme to staff. This engagement was vital
not only in understanding how to approach, provide and assess stress management activities but also to psychologically protect any of the team members while providing a safe workplace. The writer is also responsible for evaluating the outcomes and process used in this project (Ovretveit, 1998). To measure the efficacy of stress management activities both the stress control programme and the implementation of a local stress management policy in reducing burnout and stress. To evaluate physiotherapist satisfaction with the stress control programme, their burnout indicators and overall service improvement.

1.6 Summary and conclusion
This project focused on reducing burnout and stress for Primary care physiotherapists. Any changes implemented are underpinned by safety legislation, health policy, the physiotherapist’s voice and the evidence supported by a literature review. To achieve the outcome and process objectives, the writer needed the ‘buy-in’ by the key stakeholders and to demonstrate a strong commitment to this vision of a safer place to work.

2 Literature Review
2.1 Introduction
In this chapter the writer has completed a literature review of the implementation of a system to reduce burnout and stress for Primary care physiotherapists. The purpose of this literature review is to extract and critique key information that is relevant to the proposed change project and highlight any gaps, paradoxes or limitations that may present. In the broad and extensive field that is burnout, three relevant themes emerged:

- Predictors of burnout and stress
- Impact on physiotherapists
- Response to burnout and stress
It is the writer’s opinion that these themes will substantiate the rationale for introducing preventative and supportive measures for burnout and stress to Primary-care Physiotherapists. The conclusion, at the end of the chapter, summarises the main findings in the evidence.

2.2 Search Strategy


2.3 Themes

2.3.1 Predictors of burnout and stress

Predicting future changes has a definite practical benefit to workers. In his major study across eight countries including Ireland, Montgomery et al. (2013) identifies six common predictors of stress with healthcare staff: workload, high numbers of patients, the work environment, lack of resources, poor healthcare management and lack of co-operation between services. The Irish context as with other countries was symptomatic of the impact of austerity. Again in the Irish context, Donnelly (2014), in identifying perceived stressors with nurses in acute hospitals named redeployment to other areas and lack of resources. There is a positive correlation between lack of resources and evidence of burnout in the literature. Bakker and Costa (2014) confirmed the relationship between burnout and job resources as consistently negative. Most of the burnout literature are centred on employees with only mild signs of burnout and has actively ignored the employees who are at risk for burnout. There are confounding
demographic variables, but no consistency, with differing results for age, sex, work experience, type of occupation (Maslach et al., 2001). The level and amount of physical contact the health care professional has with the client, especially when in adverse working conditions can increase their risk of burnout.

In a study group by Nowakowksa-Domagala et al. (2015), the relationships between coping styles and professional burnout were investigated with a cohort of 117 physiotherapists in Poland. The continuous physical contact with patients was considered a significant stressor, evidently having more physical contact with the patient than their nursing or medical colleagues. Shin et al. (2014) used a meta-analytic approach reviewing relationships between coping strategies and burnout symptoms and realistically prolonged physical contact with a client who is sick, in pain and dying is a burnout predictor. Burnout itself is a predictor of subsequent absenteeism, turnover of staff and poorer levels of job satisfaction (Alarcon and Edwards, 2011). Fearon and Nicol (2011) in a literature review on nursing burnout established a relationship between certain personality traits, their coping style and burnout. Certain traits have a better coping style and are less susceptible to burnout. Lazarus and Folkman (1984, p.141) defined coping as ‘constantly changing cognitive and behavioural efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of that person’. Wright (2014) introduced the predictor of burnout showing how the individual is coping and their perceived control over what is happening to them. A person needs to be autonomous and control their work-life to the same extent as their personal lives. Separate entities can influence burnout not only organisational or environment variables.

A Job Strain Index examines job demands, available job resources and control in the working environment. Job demands can be cognitive, physical and emotional demands and job resources can be supervisory support, autonomy and career opportunities. The higher job demands, a reduced job resource and a low level of control indicate a greater risk of burnout (Campo et al., 2009; Santos et al., 2010). Grawitch et al. (2015) report that most of the research treat job demands and resources as separate predictors of stress-related outcomes. But it is the leveraging
of resources to meet needs, the actual stress control tactics that make the difference. Rickard et al. (2012, P. 213) evaluated a cohort of 484 nurses before providing an organisational intervention utilising a Job Demands Resources framework. The author makes the point that we need to look at ‘the cause of the causes of stress’, that system level factors influence these demands and resources. The most common aspect of burnout and stress studied are the ‘stressors’ and linked in turn with work stress outcomes and the interventions offered. Santos et al. (2010), assessed a group of 55 physiotherapists in Portugal to identify job stressors and coping resources. The intervention was a cognitive-transactional approach, looking at the interaction between the personal and the working environment. This approach addressed their individual beliefs and values, their coping strategies and predominantly their personality characteristics. The personality characteristics defined as hardiness, self-efficacy, a locus of control, positive attitudes to the work environment, sense of coherence, commitment to work and perception of work relevance. These are all significant predictors and moderators for all healthcare professionals.

But outside the individual and work environment predictors what outcome tools used in the literature and why? The scales used widely in the literature are the Maslach Burnout Indicator MBI (Maslach and Jackson, 1981), and the Utrecht Work Engagement Scale, (UWES) (Schaufeli et al., 2002). The MBI is the diagnostic or outcome tool that is used in 90% of burnout studies (Maslach et al., 2012). Maslach and Jackson (1981 b) designed this tool to assess different elements of burnout syndrome applied to a broad range of health service professionals. Three subscales emerged—emotional exhaustion, depersonalisation and personal accomplishment supported by psychometric analysis indicating high reliability and validity. Rupert et al. (2015., p. 168) described the MBI as the ‘gold standard’ measure of stress, even in the absence of cut-off scores and distinct criteria for categorising an individual as a burnout sufferer. Korczak et al. (2012) pointed out that even though most of the studies use MBI, there are different cut-off points and therefore questions the validity of it as a diagnostic tool. Ruotsalainen et al. (2015) agreed a better validation of this instrument is required as there is no clinically relevant difference and advises that only one stress measurement tool used, to avoid false-positive results. But even in the absence of clinical cut-off points, its development in the healthcare and social studies
fields, included extensive, in-depth interviews, across cultures and therefore improved clinical applicability (Shin et al., 2014). Much of the empirical evidence is based on these two questionnaires, and they are subjective in nature. Further research is needed to go beyond the restrained picture of isolated predictors to look at the broader range of demands and resources and to understand how they interact to produce burnout.

The Utrecht Work Engagement Scale (UWES) is also a self-reported questionnaire about a work engagement scale with three constructs of vigour, dedication and absorption. Gonzalez-Roma et al. (2006, p.166) define work engagement as a ‘positive, fulfilling, work-related state of mind.’ Maslach and Leiter (1997, p. 217) recast burnout as ‘an erosion of the positive state of mind’ which they characterised as engagement with energy, involvement and efficacy, the opposite of the burnout scale. Schaufeli et al. (2004, p.293) stated ‘positive states are not popular in psychology’ and ‘negative outcomes outnumber positive outcomes by a comparative 15:1 ratio.’

In the burnout literature, 95% of the articles are about negative ill health and only 5% are about positive aspects such as drive and job satisfaction but the newer, more positive psychology on work engagement is taking centre stage. The opposing poles of the same spectrum are questionable as work completed by Russell and Carroll (1999) show positive and negative influences are unconnected, rather than two opposite points of the same bipolar compass. Schaufeli et al. (2004) did not assume work engagement was the opposite of burnout and he suggested independent assessment. The researcher analysed data from a cohort of 1698 people from four independent occupational samples. A model activated, in which engagement and burnout have different predictors and possible results. Work engagement and burnout are variously related, with a 10-25% difference. Burnout refers to turnover and illness, work engagement relates only to turnover. Burnout predicted by job resources and demands, work engagement by job resources alone. There are different patterns, so, therefore, different strategies would need to be adopted in decreasing burnout and increasing work engagement.
Hakanen and Schaufeli (2012) analysed the data from 71% of all Finnish dentists, using the MBI and UWES simultaneously. Over a three-year longitudinal study, he established that burnout and work engagement are not direct opposites, burnout predicts depressive symptoms but not vice versa. Work engagement has particular cumulative impacts on quality of life and depressive symptoms. Roelen et al. (2015) also used both tools simultaneously for 4,921 employees engaged in an occupational health survey. Both could predict mental long-term sickness absence (LTSA) for employees in healthy listed employees but neither were useful for identifying individual employees at high risk.

2.3.2 Impact on Physiotherapists

There is no Irish or UK study looking at burnout prediction or prevention with physiotherapists. It is a stressful profession with a high degree of attrition early on in their careers in the Australian context McPhail and Waite (2014) or the UK context Park et al. (2003). The first physiotherapy study on burnout by Donohue et al. (1993) based in the United States, and the majority of stress/burnout studies related to physiotherapy conducted after the year 2010. There are very few studies for physiotherapists in the burnout field which is dominated by nursing. The twenty physiotherapy related studies reviewed (see Appendices 3 and 4) are predominantly target predictors and use questionnaires. Thirteen out of the twenty use the MBI and only one study (Saganha et al., 2012) mention an intervention, that is qigong and it had positive outcomes for physiotherapists.

Lindsay et al. (2008) defined stressors as increased workload, increased caseload, complexity of clients and cross cover, with up to 11% taking leave due to stress. The resource issue is a common theme in all the studies. Du Plessis et al. (2014) states public physiotherapists are more frustrated than private practitioners with increased job challenges, less flexibility and less autonomy. Physiotherapists take a long time seeking help for burnout as it is less accepted than the physical symptoms, which they are busy treating in their professional capacity (Putnik et al., 2010). The evidence extracted for age and work experience is not consistent. Al Imam and Al-Saboyel (2014) states less experienced and younger staff become more stressed, whereas
Sliwinski et al. (2014b) reports physiotherapists with five to fifteen years’ experience report better job satisfaction and interactions. Nowakowska-Domagala et al. (2015), state higher rates of burnout for the short serving (2-4 years) and the long-serving (15 years plus). Fischer (2013) found no difference in the years served. Research on stress and burnout in the general population in Sweden by Norlund et al. (2010) indicate the younger age and females have higher burnout risk. It could be argued paradoxically the longer serving are better at coping and have less strain but that with years working there is a greater vulnerability contributing to more strain.

Donohue et al. (1993) established the fact early that physiotherapists are prime candidates for burnout because of their close physical contact with patients and they spend a significant proportion of their work time deeply engaged with patients. Nowakowska-Domagala et al. (2015) in assessing the relationships of coping styles and burnout in a cohort of 117 Polish physiotherapists supports this notion that their physical contact is often higher than that of nurses or doctors. Fischer et al. (2013) in assessing a cohort of 132 physiotherapists in Italy for burnout, stated the close physical contact may create a desire for more distance. But if a physical distance is not possible then the therapists may distance themselves emotionally. How is their empathy affected? In a Polish study of a group of 665 healthcare workers by Wilczek-Ruzyczka (2011) she stated that the level of empathy correlates with burnout level negatively, so the hypothesis is when understanding developed professional burnout can be prevented.

The inter-personal communication and ability to portray compassion is a concern for the physiotherapy discipline. In a study by Włoszczak-Szubda and Jarosz (2013, p.194), she investigated the adequacy of communication between physiotherapists and their patients. The results of her studies indicated developing communication skills among physiotherapy students is poor. Not only that, any competencies acquired during the undergraduate education, will regress with clinical practice. Due to work related stress, the interpersonal communication skills are replaced by ‘undesirable defence mechanisms’ such as resistance and withdrawal. Brattig et al. (2014) in discussing physiotherapist’s communication with GP’s and doctors, only 8% said it
was sufficient. Again a paradox in some of the studies that medics expect the physiotherapists to act autonomously to the point of being entirely independent or else they lack autonomy around decision making.

Du Plessis et al. (2014) reiterates the point that most burnout studies concentrate on nursing, mainly in public health and acute and state nursing are the most stressed healthcare discipline. There are few comparative studies evaluating burnout levels for nursing and other healthcare disciplines. Out of the twenty studies reviewed, Fiabane et al. (2013) is the only study to do this, assessing a cohort of 110 healthcare workers, physiotherapy, nursing and medical, although occupational therapy is missing. The research was carried out at four long stay hospitals providing neurological rehabilitation and palliative care. This study indicated physiotherapists are the profession most vulnerable to burnout and disengagement from work. It could be due to the physiotherapists lacking the same autonomy, support or resources as their nursing colleagues.

There is a high level of interaction and responsibility, the physiotherapist is directly linked to the process of the patient's recovery or rehabilitation and their vulnerability to stress (Lindsay et al., 2008). Wilski et al. (2015) report stress increases with the time spent with patients and the intensity of the emotional demands. If the physiotherapist adopts active coping (problem focused) strategy, as opposed to emotion-focussed strategy, they feel more in control. This active coping is a process in planning work systematically and transparently and creates an internal locus of control at work. Stress control programmes incorporated these active coping strategies (Van Daele et al., 2013) and discussed in the next theme on ‘responses.’ Campo et al. (2009), looked at job demands and job control in a national sample of 882 physiotherapists in the US. If there are moderate to high levels of demand but the practitioner has exceptional levels of control, stress reduced. If there are significant levels of demands but low levels of control, there is a likelier prospect of work-related pain and turnover. Santos et al. (2010) discuss physiotherapists engaged in effective stress resolution strategies who perceived lower levels of stress, possibly due to engagement as opposed to having a less demanding work context.
2.3.3

Response to burnout and stress

A comprehensive systematic review carried out by Ruotsalainen et al. (2015) on work stress in healthcare workers evaluated the effectiveness of individually directed interventions and organisational interventions compared to none or different ones. The studies suggest that organisational change such as organising support, introducing special care models or improving the work environment had no apparent benefit. Changing work schedules had some benefit. But this is based on only one or two studies each. A relative paucity of studies focusing on organisational change may be sufficient but not demonstrated in the literature. Biron and Karanika-Murray (2014) when looking at the process evaluation for organisational stress and well-being writes that there is inadequate empirical evidence to draw any conclusion on the effectiveness of organisational level interventions. The studies look at process issues in their implementation stage but do not link their data with outcomes and therefore not underpinning their research in sound theoretical models. The interventions at an organisational level are considerably costlier and complicated than the individual responses.

Awa et al. (2010) carried out another systematic review of twenty-five intervention programmes for burnout prevention; two were organisational, seventeen individual and the remaining six, combining both. Even though the author did not carry out a meta-analysis of the studies, 80% of the studies showed a reduction in burnout. The organisational interventions highlighted changes in task re-organisation, work processes and evaluation, supervision and involving the workers in decision making. Ruotsalainen et al. (2015) stated the improved theoretical underpinning required in organisational change could lead to an individual stress reduction, and this begs the question ‘why is this not evaluated”? Both of these reviews presented the evidence for the effectiveness of cognitive behavioural training (13% improvement) and mental and physical relaxation individual interventions (23% improvement) but that any intervention should be designed with the ‘stressors’ or predictors in mind as discussed in 2.3.1.
As Rickard et al. (2012) observes the gap in systems at any organisational level can be ignoring the stressor. Ironically the stressor can be the organisation. His study with nurses suggests targeted organisational interventions should be as follows; decrease the workload, to roster and increase the number of nursing personnel. Silva and Alchieri (2014) and Putnik et al. (2010) support the idea that individual stress is down to lack of organisational backing in healthcare and it is not a singular issue. The work environment has failed the individual. In studies, the organisational and personal factors are linked with work engagement and their recommendation is that interventions focus on job satisfaction, workload and personal expectations (Fiabane et al., 2013; Wright 2014). The organisational interventions provided over a period, in an ongoing process that mimics the unfolding, ongoing process that is burnout syndrome. They address the situational context, the job demands, the job resources and control (Bakker and Costa, 2014). Maslach et al. (2001) suggest customising responses, so they function like an organisational checklist. However, actual interventions over an extended period are impractical. Uchiyama et al. (2013) in his study assessed participatory interventions for nurses in the form of unit based meetings, producing actions to improve their work environment over a six-month period. The intervention was effective in improving psychosocial outcomes but costly in time and resources. Overall in the literature, there was scanty evidence for the effectiveness of participatory interventions.

Leadership is pivotal to the success of an organisational response to stress and burnout (Maslach et al., 2012). Leaders can directly influence work engagement, as well as optimise the environment for workers, channelling work challenges such as job demands and resources (Tuckey et al., 2013). According to Putnik et al. (2010, p.5) supervisors and leaders ‘appear to have an important gate-keeping role in the process of help seeking’ as in healthcare professionals. The professional has replaced the idea of good enough in work with the ideal worker. The perfect image internalised and in all honesty, unachievable. There is a need to point the way for the individual, the team and in doing so, use a multi-level approach (Maslach et al., 2012). Wilski et al., (2015) suggests concentrating on the individual by looking at separate characteristics with burnout, helps active coping or practical problem focused or stress control strategies. The employee with increased levels of burnout requires help to strategically and
structurally change their working conditions and health status (Bakker and Costa, 2014).

Anderson et al. (2015) reiterate one could focus on the team particularly if merging with new teams or other services as this can improve work engagement and inadvertently reduce work-related burnout. But if the team member over-extends themselves to meet the needs of their client and satisfy their organisation’s goals and the organisation fails to respond and deal competently with the employee problems, this is a one-sided deal (Putnik et al., 2010). The gap bridged for the individual and organisation’s needs by encapsulating the individual within their team, within their organisation, within their locus of control, suggests the support of leaders as the ‘gatekeepers’ to the positive change. Maslach and Leiter (2001) recommends combining changes in management practice with education and individual interventions, include cognitive behavioural therapy and mental/physical relaxation methods as mentioned. If done in an integrated fashion, this will build on work engagement. It is simpler and cheaper to develop individual interventions than organisational. As previously stated the key is giving the worker as much control and autonomy in their work-life as in their personal life. Considering the evidence in the literature – is the stress control programme an appropriate response to burnout and stress?

Stress Control is an intervention developed by White (2000), within the Cognitive Behavioural therapy school which was originally designed to reduce anxiety-six, sixty-minute sessions of a psycho-educational programme. Evidence from the literature suggests that even though the programme has proven useful for an eclectic diagnostic mix of people of varying ages and backgrounds, there is a clear need to evaluate the effectiveness of the intervention. For the mental health clients, the programme had a positive impact on their anxiety and depression levels. The process brought them closer to the mean of the ‘normal’ population and strengthened their resilience in dealing with daily stressors and ultimately taking charge of their mental health (Joice and Mercer, 2010).
Van Daele et al. (2012) carried out a meta-analytic review of stress reduction through psychoeducation, 19 studies from 1990 to 2010. The hypothesis is following the Cochrane review by Ruotsalainen et al. (2015) the relevance of the Cognitive behaviour and relaxation strands should have a positive effect in stress reduction, which they do. Shorter interventions produced better results as they were transferring a skill set. Another study by Van Daele et al. (2012a), the participants were from primary mental health care. The primary focus was to preserve the member’s mental health as opposed to restoring it, initially through the phenomenon of stress reduction than on anxiety. There were 80% of the 52 participants who were women, 70% of all the participants agreed the programme was useful, and 91% indicated they would recommend it to a friend. The researcher then tried the stress control programme in the general community (Van Daele et al., 2013a), the cohort consists of 47 in an intervention group and 47 in a control group. There was a clinically significant and definite change in 30% of the participants with a decline in symptoms for all the intervention group and this remained stable after six months. There was no such development for the control cohort. The results of this study would suggest carrying out further research on large groups of community dwellers to determine the effectiveness of stress control. Identifying the worker who is disengaging is crucial.

Cross et al. (2012) discovered that increased disengagement is related to overload. Across a variety of firms and community groups the theme persists, the least engaged employee is also the most heavily sought out for help or overloaded. Their colleagues needed this access to them to function in their roles. Anderson et al. (2015) considered the relationship between perceived stress and emotional exhaustion or burnout, the strategies known to reduce stress may also be helpful in reducing burnout.

2.4 Implications for the Project

The literature review provides an informed and detailed overview of burnout and stress in this vast field. The writer finds the research convincing in the area of predicting stress. The investigation of responses and prevention of stress is of some value to all the healthcare professions including physiotherapy. Of all the healthcare disciplines, physiotherapists are as likely to have significant burnout as their nursing and medical
colleagues, if not higher. Early warning signs of burnout predicted by the MBI, which is used in the change project so that preventative interventions could be applied more effectively. If there is a higher score in the emotional exhaustion or depersonalisation subscales of the MBI, then this should be looked on as an early warning sign. The MBI is now over thirty years old and in light of the modern healthcare environment there is a need to evolve and develop a new ‘gold standard’, to incorporate modern psychometric methods and definitions of burnout. The discrepancies between the individual, their job and the organisation and the wide-ranging evidence will be taken into account when implementing this change project and ensure its credibility.

2.5 Summary and Conclusions

The writer carried out a literature review of burnout and stress in healthcare, with a focus on physiotherapists, this review resulted in three main themes, predictors of burnout and stress, impact on physiotherapists and responses to stress and burnout. The findings from the literature promote the need for prediction of burnout before providing an intervention. The intervention should link with the stressors and direct not only at the individual but the organisation for effective change. The literature addressed process issues in their implementation stage but did not link their data with outcomes. Sound theoretical models do not underpin their research. The review has helped to highlight that predictors of burnout and stress used with the physiotherapists, in the Irish context should match the interventions. The writer plans to evaluate the data from inputs, process and outcomes. The following Chapter is concerned with the methodology used for this study.

3 Organisational Development Process

3.1 Introduction

The organisational change project is about implementing a system to reduce burnout and stress for Primary care physiotherapists. In this chapter, the writer will critically review some change models and provide an overview of the methods used in the change project. The original aims and objectives are aligned to the four stages of the Health Service Executive (HSE) model of change: initiation, planning, implementation
3.2 Critical Review of Approaches to Organisational Development

3.2.1 Change Management

Change management is a process where an organisation continually adapt and change their orientation, structure and experiences to the ever changing requirements of the external and internal client. (Moran and Brightman, 2001; Pollack, 2015). Change Research and academic literature depict a plethora of approaches to change management, many differing in focus and priority, rooted primarily in the social sciences (The NHS Service Delivery and Organisation, 2000). For the past thirty years the academics, consultants and managers have explored in depth this difficult subject. Change demands leadership, cultural awareness, participation top down and bottom up and people involvement be they change agents or working groups. Kotter (1996 p.57) described these groups of influential people as a ‘guiding coalition’. If this team could move collectively towards the vision of an organisation who is the leader? Senior and Swailes (2010), note leading change is itself complex and the skill is in knowing not always to be a transformational leader, but knowing how to choose one style of leadership over another. Graetz (2000) reiterates the blend of instrumental and charismatic dimensions of leadership, integrating the operational knowledge with well-developed interpersonal and captivating skills. But then leadership is irrelevant if not connected to a collective purpose (Young 2009). The leader, the change agent and the change recipient or participant linked to this collective goal.

The fact is 70% of change initiatives fail (Beer and Nohria, 2011) and 50 % fail in the initial phase (Kotter 1995). Leeman et al. (2007) mention that the poor success rate of the change initiatives is partially due to the lack of a change model. Kotter (2008) implies the absence of a valid framework and change model or a one size fits all approach leads to failure. Al Haddad and Kotnour (2015. P. 254) discusses the notion that planning for change increases the probability of success in adopting ‘a structured
methodological process for achieving desired outcomes’. Senior and Swailes (2010) reiterates the focal points of change, that is, continuous improvement, aligning activities in achieving organisational goals and involving all the stakeholders.

The stakeholders can resist change if they are not ready for it if the change conflicts with their existing values and expectations and even when the actual change is consistent with their best interests (Burnes, 2015). Members who ignore the change readiness and culture of an organisation contribute to its failure. In the Irish context, these cultural influences include shared beliefs and values, excellence in care and delivery, professionalism, ethical values, strategic thinking and cost of health (Carney, 2011). The change approach needs to match the cultural context, at the time of the alteration (Ford et al., 2008). Change happens at such a fast pace in healthcare that it is unreasonable to expect any stability. The designers of organisational change can apply ‘non-linear’ models to modify and use a feedback system, but equilibrium remains unlikely (McAuliffe and Van Vaerenbergh, 2006). Implementing change using a validated change model with a clear focus makes sense and makes success more likely.

3.2.2 OD change models

To date, various OD models have been developed and introduced to manage change. Lewin (1947) is one of the original fathers of change, providing the three steps design of unfreeze, change and refreeze which developed from his three fundamental theories of group dynamics, field theory and action research (McAuliffe and Van Vaerenbergh, 2006). Group dynamics is where the organisational change emphasis is through teams rather than the individual. The person cannot change and is confined by the group pressures to conform. The assumption developed further into the concept of field theory. Certain forces and modifications maintain the status quo and can affect group integrity and individual actions (Burnes, 2000). Action research is a phrase coined by Lewin. An action research model is a democratic approach, data gathering and discussion among the organisations senior management, the subjects of change and the change agent. The research is in action rather than about action, a sequence of events and problem solving (Coughlan and Brannick, 2014; Burnes 2000). Again
action research as with group dynamics uses teamwork and participants to solve issues. His combined work promotes the idea; there may be constancy in identifiable behaviours but a group is never going to be in a state of equilibrium (Burnes 2000). Swanson and Creed (2014) argues the original, sophisticated Lewin model reduced to only three steps instead of a full analysis of forces in the field of change which is apparent in the literature.

Kotter (1996, p.22) expanded on the work of Lewis by developing an eight step flow or ‘increase urgency. Build the guiding team, get the vision right, communicate for buy-in, empower action, create short-term wins, don’t let up and make it stick’. Appelbaum et al. (2012) report this model derives its success more from its intuitive, usable format rather than from sound academic reasoning. Hughes (2015) reiterates the point; the practitioners are Kotter’s target audience. It is rigid in sequence and the onus is to follow all the steps sequentially as overlapping can contribute to failure. If this model proves too rigid and prescriptive and opposes the organisation’s cultural ethos, then it is bound to fail. The literature does not corroborate the implementation of this sequence of steps with successful outcomes (Appelbaum et al., 2012). Pollack and Pollack (2015) applied the Kotter model to a practical example in a finance sector. In practice, there were some instances in the process where the sense of urgency created by a leadership team moved to a group empowered to lead change. Lewin and Kotter are looked on as soft systems model but should not be downgraded as comprehending and responding to the needs of other human beings involve some of the hardest work of all (Waytz 2014).

The model from Senior and Swailes (2010), is a comprehensive one, operating at all levels of the organisation including the individual and the group level. Change is ongoing, iterative and cyclical meeting the client’s and stakeholders needs with a strong emphasis on strategy, technology and structure. The concerns with this model are its applicability in the public service where financial support and funding is decided on by top management. The OD objectives may conflict with senior and often multi-level civil service decision-making but more significantly the bureaucratic systems and culture may impede change. The change agent is the central focus of this design.
The writer believes the change agent be it an individual or a team should not be in the centre. The change agent positions in the cyclical process when they are required to assess a problem, provide and implement a solution (Patton and McCalman, 2008).

3.3 Rationale for OD model selected

The HSE change model (HSE, 2008) figure one, describes the transformation journey that allows people to move from an organisation’s current state to the desired future state. The easily comprehended four stages of initiation, planning, implementation and mainstreaming positioned on the four points of the project management wheel (McAuliffe and Van Varenbergh, 2006). This model has some attractive features. It is an Irish healthcare model and there is credibility in applying this local model to a public sector organisational change. The researchers of the design carried out a literature review on best practice. Utilising this model will promote a universal focus on the implementation of change initiatives across the Irish Healthcare system and build on the supporting literature for its use, which is currently lacking. The HSE model is the best model for this OD implementation as non-linear with an easily comprehended four stages. It is user-friendly and adaptable. The type purports to people changing and supporting what they help create. The writer’s change project is around systematically changing the way we manage and behave with stress, so the aims and objectives aligned with the model.

When looking at the components in the model, it becomes clear that the compilers have taken the stronger more credible elements from the other OD models and added their own. Lewin’s advocacy for balance and stability, his comprehensive overview in employing a multi-level approach for the individual, team and organisation. Kotter’s sense of urgency and the importance of communicating. Senior and Swailes promoted the commitment to resources both the people, skills, technology and infrastructure. The HSE model ‘adds in’ the cultural context and the importance of services users, stakeholders and partnerships. The design creates an information flow internally and externally or dialogue feedback loops. The HSE model delivers a continuous and adaptive process with all the essential ingredients as evidenced by research. The
challenge for the writer with this model is completing each phase in a narrow time-frame, especially in the cross-over from implementation to mainstreaming. The learning and evaluation should be evident, ‘making it the way we do our business’ but the dissemination piece could take longer. This model of change is ‘situational’, aligning strategic objectives to the changing environment, resulting in an ‘optimum fit’ (Burnes 2000, p.277).

3.4 HSE Change Model

3.4.1 Initiation

3.4.1.1 Preparing to lead the change

During the initiation stage, there was significant scoping of the change project concepts including dialogue with the stakeholders. The writer wanted to investigate the merit or pitfalls of this change but also to extrapolate the richness and credibility the subject matter deserved. The first stage in the change cycle is the initiation stage and the writer employed some practical analytical tools, SWOT (Appendix 5), PESTLE (Appendix 6), Force field analysis (Appendix 7), stakeholder analysis (Appendix 8) and
cultural analysis in the format of the Organisational Culture Assessment Instrument (OCAI) or competing values framework (CVF) (Appendix 9).

A SWOT is an efficient and practical grid used to list the strengths, weaknesses, opportunities and threats of an organisation. This tool was developed for strategic analysis and used in the healthcare sector. The external developments contest the internal competencies'. External events are looked on as either the opportunities or weak points of the organisation and the internal skills are described as strong or low points (Van Wijngaarden et al., 2010). Align the chosen strategy with the objectives of the decision makers. It is only a listing, or an incomplete examination of the external and internal factors if it does not materialise in the decision-making process (Kajunus et al., 2012). Jacobs et al. (2013, p. 780) define 'fit' as this alignment of the an organisation's internal features with those of the external environment, to improve performance. Inferior performance produces a ‘misfit’. The organisational change triggers include the subjective perception of ‘misfit’, the objective outcomes of SWOT analysis together with control-restoring aims and managerial power. These are all compelling change drivers. The writer used the SWOT objectives to inform decision-making and actions. The key strengths identified were the strong messages in both the literature and legislatively to manage staff health and the positive ‘buy in’ from management. The main identified weakness was the time to take part now or in any future developments.

The strategic management body of evidence recommends the PESTLE approach as an organising grid to monitor the external opportunities and threats (Johnson et al., 2005). The network merges the analysis of political, economic, social, technological, legal and environmental, pitting them against the internal strengths and weaknesses of the organisation. The resulting framework outlines the additional active change drivers. The increased demands on a reduced health resource accelerated stress levels for people and are costly concerning health outcomes and financially due to absenteeism and reduced productivity. The introduction of a system to proactively manage stress is a chance to impact both humanly and economically. The stakeholder analysis is another critical grid to determine the people and groups who will influence
the outcome of the change project. In this early stage, the dialogue started with the great importance and high influence stakeholders to gain their commitment.

The writer had selected the Organisational Culture Assessment Instrument (OCAI) based on competing values framework and used extensively in many organisations, primarily as a diagnostic and development tool with particular attention to cultural differences (Cameron and Quinn, 2011). The ‘now’ culture is predominantly Market at 85/100 (compete) and only 15/100 in the clan (collaborate) focus. But the ‘preferred’ culture is the clan culture. It is not surprising, as the secure ‘stability/control element could be a result of years of resource and HSE budgetary constraints, a results-oriented workplace. The OCAI lets the writer visualise the ‘misfit’ between the actual and desired state. There was a consensual view on our current cultural situation and the steps needed to get to the desired collaborative state.

The force-field analysis reviews the dynamic forces for change and the constraining forces against change. These forces move from the current situation towards the required state, reducing the problem and realising a goal (Baulcomb, 2003). Burnes (2000) outlines the concept of Lewin’s field theory and the potency of forces under personal and group dynamics. The emphasis on the benefits will minimise the adverse effects of personal and collective interactions. The one negative effect could negate health and well-being, legislative, safety and economic considerations, that is, non-participation by physiotherapists and their managers. The planning phase was primarily focusing on their involvement and that it would be meaningful to them. If there is resistance or anxiety attributed to change, then it is important to understand the exact cause and so understand the individual factors (Bovey and Hede, 2001). Burnes (2015) reports that resistance to change is not wholly attributed to the individual but also to the context, match the transition to the setting and allow for participative decision-making. It is imperative that the writer tries to understand the context and engage everyone in a participative decision-making process.
3.4.2 Planning

3.4.2.1 Building Commitment

The planning stage of the project is meeting with the high importance and great influence stakeholders, the physiotherapists, the physiotherapy managers, Psychology manager and senior management presenting the concept as a business case. In all of these interactions, the writer submitted information from the analysis tools, evidence-based literature and legislation to support the initiative. A well-conceived vision comprises of two significant components first the core ideology and second is a picture of the future which is simple to communicate. The core ideology consists of core values (caring and client focused) and a core purpose (make people well). The picture of the future consists of ambitious goals vividly described, engaging, and understood (Collins and Porras, 1996). The HSE vision for change is accessibility, instilling public confidence and staff pride (McAuliffe and Van Vaerenbergh 2006). The vision for this project is to restore staff pride, instilling public trust in their care providers and giving the patient better access to happy staff.

The writer described the innovative change in a meaningful way- the positivity of a proactive stress management system, the provision of a local policy formulated by the key stakeholders and access to stress control psycho-educational classes. There is an assigned leadership role based on the writer’s role as manager but emergent leadership is required. The leadership style emerges over a period through communication. ‘being verbally involved, being informed, seeking others’ opinions, initiating new ideas and being firm but not rigid’ (Northouse, 2012 p. 8). How many of the group are early adopters, the opinion leaders in the community? Or are there later adopters, seeing how others get on before they adopt. The leader as a change agent should ensure the ‘new’ system is compatible with the existing value systems of the change recipients and understood by them. The results of this innovation ascertained by other adopters (Gillam and Siriwardena, 2013). The change is innovative and promotes a person’s well-being. These drivers will encourage the team to adopt the change and the dialogue will gauge resistance. The Psychology Manager offered places to the physiotherapists for existing stress control classes. He informed me of a key driver. The evaluation of a primary care cohort of therapists on the programme.
would strengthen any business plan to mainstream the intervention into Primary care with the provision of the requisite resources. The writer did not encounter any significant resistance in building commitment but posed some interesting questions which guided the remaining piece. Primarily the format of the policy, should a physiotherapy focus group inform the policy objectives? How would the stress control programme be delivered and the expertise, cost, venue and time needed to secure this for the physiotherapists? In effect, the key stakeholders included in the design and delivery of the change project to ensure *grassroots support* and the commitment necessary to mainstream the changes (Kotter, 2008). The writer needed to provide the change initiators, that is, the early adopters did not become the resisters. An enabling driving force can have the opposite effect of impeding change but equally, the resistive forces can inversely lead a person or team to a higher level of motivation to overcome any obstacle. The shared purpose is towards a shared vision (Swanson and Creed, 2014).

### 3.4.2.2. Determining the detail of the change

Ascertaining the detail of the change proved to be the most challenging aspect of the OD project, the writer was generating energy while simultaneously deciding on the specifics. The deductions informed the next stage, creating mini Plan-Do-Study-Act, PDSA (Best and Neuhauser, 2006) cycles in this time-frame. This work was carried out when assessing the current situation against the future vision for change and not only providing feedback to the key stakeholders but allowing the work to evolve naturally. The process for gathering information included a focus group, dialogue with the key stakeholders, information gathering at an HSE stress management seminar, the MBI assessment and data collection from team members to judge if burnout was a concern.

**Maslach Burnout Inventory MBI:**

The MBI measure is a valid and an outcome tool (Maslach and Jackson, 1981). This test is not labelled *burnout* but called ‘Human Services Survey’ to reduce bias and presented as a job-related attitudes survey (Maslach et al., 2015, p.7). The MBI used
in 90% of burnout studies and it was piloted with three Occupational therapists before the physiotherapists (Maslach et al., 2012). Following their written consent and assurance of anonymity, an external facilitator conducted the survey pre and post intervention. An ID number identified each physiotherapist and I had no access to the key which identified the names of the participants.

Stress Control:

The information gathering started with phone calls to Employee Support but no health and well-being programme existed. The deciphering of what would be the best plan for the team, how to provide this and the cost and resource implications. The Jim White Stress Control programme provided in other Irish areas with growing evidence to support its effectiveness (White 1998). I had agreement from the other physiotherapy managers that an education account could finance the preliminary stress control programme in Primary care if required. Eventually, through negotiation with the Psychology Manager, places on a local stress control course were secured for any of our physiotherapists who wished to access it. So there was no direct financial cost to our service, an agreement of places, provision of evaluation and access to future classes for any non-participant. A flyer explaining the stress control programme and consent to attend provided to the physiotherapists.

Focus group:

The central aim of this focus group for physiotherapists is to gather themes around supports and vitality and use them to inform a stress management policy. This piece of work approached with the sensitivity it deserved. The writer contacted a colleague, a clinical psychologist about facilitating this group. Several meetings were held before the focus group to formulate the questions (table 1) and to ensure anonymity for the group.
Table 1 - Focus group questions

- Do you have vitality at work?
- If you do have vitality, what gives you vitality at work?
- Do you know what supports you at work?
- Do you know where to go for help?
- What stops you going for help?
- What encourages you to go for help?

The focus group was recorded and transcribed by a neutral transcriber resulting in 17,000 plus words. The writer set up supervision with a psychology academic who had expertise in a thematic analysis. The correct foundations were in place; adequate teaching and monitoring from an expert who acted as a sounding board for the duration of this piece of work. The final focus group report (Appendix 10) was produced by the writer resulting in three main themes-relationships, need for respect and coping mechanisms.

Local policy on Stress Management (Appendix 11):

A practical local stress management policy was necessary. The existing stress management policy (Health Service Executive 2012) while informative was not ‘user-friendly’ for staff. A gap which required bridging and then a eureka moment on 19th October 2015. The HSE started promoting ‘Healthy workplaces managing stress as part of the European Health and Safety week’ (HSE, 2015) and informative emails circulated to HSE personnel. Seminars held and the writer attended one. This seminar provided networking opportunities that informed the change project. The White programme advocated for healthcare staff in other Irish regions (Likely and Switzer, 2015). The local policy contains the existing stress management policy as a reference point, new evidence and guidelines from the European Agency Safety and Work campaign (2014-2015), the focus group themes, ‘a workplace stress risk management’ and the audit tool. In discussing the draft policy with the physiotherapy managers, it was rewritten ‘within the locus of control of physiotherapy manager and based on the
exigencies of the service’. Equally managing the therapist’s expectations and including only the reasonable deliverables as opposed to aspirations.

3.4.2.3 Developing the implementation plan

The final step in the planning stage is the detailed blueprint of the social and organisational changes that will help to realise the vision. The HSE model divides the layout into four parts: the design of the particular future state, assess its impact, outline and agree with and complete the project plan. The purpose of the implemented policy on stress management will guide the Physiotherapists and the Physiotherapy Managers on how to identify, prevent, support and monitor stress in the workplace. There is a new focus on risk assessment, the identification of stressors and providing supports as required in the local context. The intervention cohort commenced their stress control programme on 27 January 2016 and evaluated with MBI, data and feedback questionnaires. The advantage of a three-month proactive stress management period is the collaboration with the stakeholders, ensuring their ‘buy in’. There is a focused and controlled evaluation of the vital subject of stress. The team had a burnout score which could be improved. With the consent of the group, the writer presented some of the change project data, together with productivity and capacity statistics in a pitch to senior management for additional resources.

3.4.3 Implementation

3.4.3.1 Implementing change:

This stage is the application and monitoring aspect of the project plan where actions are agreed and the leaders must actively engage in leading the group to the vision (HSE, 2008). This transitory phase is the most stressful as it is a new phase in a new context (Smollan, 2015). At this stage, the physiotherapists need to believe change is beneficial binding the individual to this course of action (Appelbaum et al., 2015). If the physiotherapists perceive their manager plays an active role in implementing this change, this could contribute to the success of the implementation outcomes (Nielsen and Randall, 2009).
Commencement dates are clarified and any issues are resolved. An environmental scan shows the ‘old way’ of doing things is clearing a path for the ‘new way’. There is agreement on the stress control programmes attendees, the time required to travel and attend and the cross cover provided in each network by their colleagues. There is agreement with the physiotherapy managers on the master policy, education and one to one discussion on applying the Workplace Stress Risk Assessment. The writer is the principal resource for all the physiotherapists and managers to support the new behaviours in a changed environment. Actively check in with the staff, seeing if the other teams are indeed receptive to the idea of the policy. Monitoring the attendance of staff at the stress control or if there are significant barriers in their working day to them attending. Change takes time, change is ‘neither quick or straightforward but has to be more flexible and very well planned’ (Al Haddad and Kotnour, 2015, p. 251). Keep an awareness of the ripple effect to clients and other PCT members and how they may perceive this positive change.

3.4.3.2 Sustain Momentum:

The first phase of implementation around agreed actions completed. The process has led to more dialogue and alliances. Build on the energy and vitality of the interactions, facilitate local opportunities for staff to guide and lead on aspects of the implementation. Do the non-participants see a benefit in their colleagues that may encourage, them to participate in the future? As a leader, assist in the reactions to the change both the positive and negative, stay in open communication and raise any concerns in supervision. The learning from the change project will be shared at future team meetings, make it an annual item on the physiotherapy groups agenda coinciding with the policy review. But there should be a sensitivity to any unmet needs and understand the psychological concerns for every individual and the team as a whole.

The focus of the change project has been around work engagement for the physiotherapists, support systems with their peers and psycho-education to empower them as individuals. It is a positive and powerful context but the change implementer needs to be vigilant of the ‘deleterious effects of stress from organisational change’. (Smollan, 2015, p.301). Is the introduction of a proactive system for reducing stress
and burnout a contributor of stress to others? Ensure there are clarity and guidance on roles and workload, reducing ambiguity, increasing self-esteem for each person and fairness on the team.

3.4.4 Mainstreaming:

3.4.4.1 ‘The way we do business’

The final stage of the HSE change model is focusing on the change project successes and achievements, embedding these new changes and formulating governance and feedback loops to sustain to maintain the change (HSE, 2008). Staff engagement is essential, as Kotter (1997, p. 21) advises us to ‘generate short-term wins’, that is, plan for the visible change, acknowledge and reward people who made these victories possible. Even though these short-term wins are essential to keep the participants engaged, Appelbaum et al. (2012), reports these short-term gains should be utilised to align any system with the strategic objectives. As a change agent and manager, the writer is sensitive to balancing the needs of the staff with the organisation. The new way of working should not negate existing staff roles (Stonehouse, 2013). Do not assume because the initiative is positive that all the change associated with it, is positive. Staff engagement goes much deeper. The organisational change aligned with the corporate identity and the individuals shared beliefs and values. The personal and organisation identity merged into a combined sense of self (Jacobs et al., 2013).

The proactive stress management system is not just another policy to follow but a living system of continuous change and empowering staff. After the three-month pilot, the writer met with the key stakeholders to communicate the feedback and evaluation. The intention is to advocate for the system to be embedded throughout Primary care. The function is that any short term time and resource challenge (facilitator, travel and location) offset by the long-term gains in productivity, attendance, staff morale and client outcomes. Improvement in the staff health can only add worth to the patient journey. The writer believes the system will embed seamlessly and the results will sell the system. There are clear lines of governance and accountability in the new regime. The roles and responsibilities all the staff clearly outlined in the policy. The policy built
into our existing organisational process with an audit and a ‘work related stress risk assessment’. The WRS managed on the risk registrar in line with the health and safety recommendations.

### 3.4.4.2 Evaluating and Learning

At this final stage, the writer views the change process as a continuous cycle, where the unpredictable turning points created learning along the way. Evaluation according to the HSE change model (HSE 2008) is manufacturing a system to enhance and continuously advance, learn from the change activities and the created turning points, support best practice in this new framework of systems, structures and roles. Constant two-way communication and active engagement with the stakeholders throughout the change project is essential to uphold the evaluative principles.

The continuous monitoring and double feedback loop for all the stakeholders are built into the best practice with re-evaluation and re-framing of goals and values. The framework of identifying and preventing stress in the service implemented through policy and the risk managed on the risk registrar. The change project aligned with the organisation’s strategic objectives includes improving staff health and well-being, ensuring a flexible and healthy workforce. A healthy workforce can, in turn, deliver a person-centred, high quality and sustainable health care grounded in the values of care, compassion, trust and learning (HSE, 2016).

### 3.5 Summary and Conclusion

The focus of this change project is to reduce stress and burnout for primary care physiotherapists by implementing a proactive burnout and stress management system. The writer compared and contrasted some change models before deciding on the HSE change model. This model created within the Irish healthcare context, is easily understood, yet dynamic, focusing on the strengths of the other OD models emphasising stability, communication and resources. But the ‘add-on’ of cultural context, engaging with all the stakeholders and forming partnerships creates a more
person-focused perspective. The next chapter will address the important evaluation aspect which will authenticate the reasons to change the old ways.

4. Evaluation
4.1 Introduction
Evaluation according to Ovretveit (1998, p. 9) is ‘attributing value to the intervention’, by collecting data in a systematic and rigorous manner, with the aim of making comparisons and informed decisions. Lazenbatt (2002) described evaluation as a means of measuring the degree to which an action or actions achieves its stated objectives. The principal purpose of evaluating this change project is achieving a desired outcome, whether it depicts an improvement, if it served the interests of the participants and whether it is sustainable. As described in Chapter three, this progressive endeavour was implemented in one profession, in one region, but could be considered for a full primary care roll out if fruitful and allocation of additional resources. This chapter will discuss the essential importance of evaluation in healthcare and of appraising the impact of burnout and stress reduction for physiotherapists. The chapter aligned with the five objectives outlined in Chapter one of this project.

4.2 Significance of Healthcare Evaluation
Evaluation should be used by healthcare professionals to improve purposefully people’s health, to appraise their practice and to advance health services where they work. It has become an important focus in Healthcare activity. However, many improvement projects do not refer to evaluative models in everyday practice, and there is an eclectic mix of approaches by people who do evaluate (Stockmann, 2011). Portela et al. (2015) agrees there is a low number of empirical studies in healthcare, and the majority reported as narrative or editorials. Change is emergent, planning and reporting should happen in the entire process, both the successes and the failures, keeping a focus on the outcomes by linking them with the objectives and using the learning in future decision making (HSE, 2008). Whereas it is recommended the information collected from monitoring a performance should be used to improve the quality and safety of services with continuous assessment embedded into a routine
and preventative health care, this does not happen in practice (HSE, 2008; Health Information Quality Authority, 2012). Parry et al. (2013) states there is poor alignment between the aims of improvement initiatives and the evaluation design. Theory drives evaluation, yet many practitioners are alienated and confounded by theory or giving reasons and do not understand the components of the quality initiative, the problem they intended to solve and the methods for assessing the resultant outcomes, both intended and unintended (Davidoff et al., 2015).

4.3 Evaluation
Evaluation has to be specifically designed to address the questions asked and the nature of the intervention being evaluated-telling us why the intervention worked, but also how and why (Ovretveit and Gustafson, 2002). The process should be used to capture insights that may be lost with time, generate new knowledge that is beneficial to people. The Health Foundation (2015, p.2) advise conducting in the ‘spirit of discovery’ rather than monitoring or managing the improvement. But even the best interventions require a model to communicate a change into practice and identify those that work well before they replicate across a range of contexts (Cohen, 2005). The writer reviewed some evaluation tools before deciding on the most applicable.

Evaluation Models:
The evaluation model used should be well aligned with the distinguishing features of the change project and assess the challenges posed. Stufflebeam developed the CIPP (Context, Input, Process, and Product, with ‘core values’ at the centre) in 1971 (Stufflebeam and Shinkfield, 2007). It is used in multiple settings, is non-linear and therefore not hampered by the possible restrictions of linearity. CIPP is a developmental evaluation type, and the model provides information to the evaluator by operationalising the problem step by step. The reviewer furnishes information to decision makers that may influence funding considerations (Frye and Hemmer, 2012; Zhang et al., 2011). The model does, however, require time to use and understand with repeated collections of data.

The evaluation logic model has been used since the 1980’s (McLaughlin and Jordan, 1999) and has an assumed linearity of ‘logical flow’ (Frye and Hemmer, 2012, p.290). It is useful in the planning phase and focuses on the change process with a detailed
visual form, unlike the other models (Kellog, 2004). Healthcare by its nature holds complex and diverse systems so if evaluating with a logic model, do not ignore the contributory parts and the context. As it is strongly linear, this may lead the evaluator in following a mapped out direction and miss the unintended eventualities and outcomes (Frye and Hemmer, 2012).

The Kirkpatrick evaluation model (Kirkpatrick and Kirkpatrick, 2006) figure 2 was developed in the education system to decide the effectiveness of a training programme but is used by an array of professions including healthcare. This evaluation model has a clarity of programme outcomes beyond simply ‘learner satisfaction’, assuming linearity between objectives and the results (Frye and Hemmer, 2012). The more reductionist an evaluation, the clearer the results but perhaps also, the less applicable they are (Yardley and Dornan, 2011). The Kirkpatrick four-level model is clear, understandable and modifiable in the context of this initiative (table 2). The writer believes this is the most appropriate model to evaluate this change project, reducing a phenomenon to its parts but keeping the applicability.
<table>
<thead>
<tr>
<th>Level</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reaction</td>
<td>The participant’s response, to stress control should be favourable, or they are not motivated to learn</td>
</tr>
<tr>
<td>2 Learning</td>
<td>The learning objectives measure knowledge or skills of stress improving or attitudes changing</td>
</tr>
<tr>
<td>3 Behaviour &amp; Attitudes</td>
<td>Is the learning applied back on the job or at home?</td>
</tr>
<tr>
<td>4 Results</td>
<td>Can we link the targeted outcome of reducing absenteeism as a consequence of intervention as opposed to any other factors and what is their reward (Clark et al., 2014)?</td>
</tr>
</tbody>
</table>

**Table 2- Kirkpatrick levels**

### 4.3.1 Aims
As identified in Chapter one the aim of the project is to reduce the level of burnout and stress for primary care physiotherapists by implementing a proactive stress management system, including a stress control programme. The evaluation methods are to verify whether the results successfully correlated with the objectives in Chapter one. The success criteria increased efficiency, effectiveness, acceptance of change by the stakeholders, value for money and overall sustainability. Bryman and Bell (2015) reports that an evaluation entails a comparison. This project is a comparison of the burnout level, before and after the intervention and between a control group with an intervention group. If the healthcare improvement worked, how and in what context had it worked or can it be modified to work? Parry et al. (2013)

### 4.3.2 Methods and Measures
The SMART objectives were developed at the outset and were adapted as the initiative developed.

**Objective 1 To evaluate if burnout and stress for primary care physiotherapists reduced by 10%.

The initial purpose to establish if the team was experiencing burnout or stress at work. Nineteen physiotherapists completed the initial MBI assessment. The average score
per subscale and the team pre-intervention scores are in Appendix 12 and physiotherapy data in Appendix 13. Some work related questions also put to the physiotherapists, as work overload is a contributor to burnout in Appendix 14 (Likely and Switzer, 2015). The initial MBI scores indicated the team had a moderate burnout risk. The benchmark of a 10% reduction set, as other studies suggested an 8% burnout reduction with similar interventions (Ruotsalainen et al., 2015).

Objective 2 To assess if the physiotherapists attended 90% of stress control classes
The aim is to determine if the physiotherapists attended a significant number of the stress control classes and as result evaluate their engagement, learning and behaviour change from their participation. A Likert feedback tool was distributed anonymously to the participants after the programme to assess the effectiveness of stress control. This tool is very useful as it measures both the direction and the force of attitudes (Quinlan, 2011). It is widely used and therefore it is likely to produce a reliable result (Boynton, 2004). The evaluation is not about the training programme content or delivery which is well-validated (Likely and Switzer, 2015) but the impact on the physiotherapists.

Objective 3 To evaluate if the stress management policy includes 100% of the identified themes from the focus group.
The central aim of the focus group is to gather themes around supports and vitality and use them to inform a stress management policy (Appendix 15). The group was facilitated by a senior clinical psychologist using a semi-structured interview style. The writer used thematic analysis - inductive and exploratory method (Braun and Clark, 2006) in evaluating the data.

Objective 4 To calculate if the Physiotherapy Managers are 95% compliant with implementing the stress management policy.
The purpose of the local stress management policy is to guide the physiotherapy staff, on how to identify, prevent, support and monitor stress in the workplace, with a focus
on risk assessment, identification of stressors and providing supports as defined in a local context. An audit tool with twenty questions, including thirteen yes or no compliance questions, investigates if the physiotherapy service is in line with benchmarked standards and to see if improvements can be made (The Health Foundation, 2015). An audit may not directly assess the effectiveness of the implementation, but it is a quick and low-cost means of evaluating if the managers are carrying out agreed procedures and gauging their reaction to and how they felt about the policy.

Objective 5 To assess if the level of absenteeism at work decreases by 40%.
The effect on the organisation by improved attendance is assessed with level four of the evaluation framework. There are links between levels of absenteeism and work-related burnout and stress (Hassard and Cox, 2014). The MBI identifies employees at work with the risk of long-term sick leave for mental health and psychological reasons (Consiglio et al., 2013). The writer gathered data for the first quarter of 2014, 2015 and 2016. The data collected was the number of days they were out from active work, excluding annual leave but including time to attend the stress control programme, and the number of days they were out on sick leave only. The absenteeism level for the Health area in 2014 was 3.98%, and the present target is 3.5% (Likely and Switzer, 2015). The absenteeism average for the physiotherapy service rose from 1.4% in 2014 to 5.9% in 2015.

4.3.3 Results
The following tables and bar charts represent the qualitative and quantitative data collected post intervention. The cohort of physiotherapists is nineteen and the physiotherapy managers are four. The three key criteria for evaluation are validity, reliability and replication. The validity is the integrity and accuracy of the data (Bryman and Bell, 2015). The reliability aspect is whether the results are repeatable and consistent. The writer believes the credible findings from this small cohort in its innovative stage shows it could work and be replicated in several settings or on a larger scale.
Appendix 16 - MBI data
Appendix 17 - The mean MBI scores for the team and stress control group
Appendix 18 - Compliance with the stress management policy.
Appendix 19 - Question 5 ‘Top three things’ Likert feedback
Appendix 20 - Question 6 ‘Three things that didn’t work’ Likert feedback.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Reduce burnout by 10%</td>
<td>Reduced burnout by 17% for the team and by 30% for stress control participants</td>
</tr>
<tr>
<td>2) PT to attend 90% of stress control classes</td>
<td>PT attended 95% of classes</td>
</tr>
<tr>
<td>3) 100% focus group themes</td>
<td>100% of focus group themes used</td>
</tr>
<tr>
<td>4) PT managers 95% compliant</td>
<td>PT managers 98% compliant</td>
</tr>
<tr>
<td>5) Reduce absenteeism by 40%</td>
<td>Reduced absenteeism by 84%</td>
</tr>
</tbody>
</table>

Table 3- Key objectives and results

<table>
<thead>
<tr>
<th>Kirkpatrick Level</th>
<th>Q. no</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>1</td>
<td>How many classes did you attend?</td>
</tr>
<tr>
<td>One</td>
<td>2</td>
<td>Did the Stress Control programme meet your expectations?</td>
</tr>
<tr>
<td>One</td>
<td>3</td>
<td>Would you recommend the stress control programme to your colleagues?</td>
</tr>
<tr>
<td>Two</td>
<td>4</td>
<td>Did your learning from the Stress Control programme help in understanding and managing your stressors both at work and at home?</td>
</tr>
<tr>
<td>Two and Three</td>
<td>5</td>
<td>What are the top three things that worked well for you on the stress control programme?</td>
</tr>
<tr>
<td>Two and Three</td>
<td>6</td>
<td>What are the three things that did not work so well on the stress control programme?</td>
</tr>
<tr>
<td>Four</td>
<td></td>
<td>Did the Stress Management system reduce absenteeism?</td>
</tr>
</tbody>
</table>

Table 4- Kirkpatrick levels and Likert questions (1-6)
Figure 3 - Question 1 the Likert feedback tool

Figure 4 - Question 2, 3 and 4 the Likert feedback tool
4.3.4 Dissemination plan

About the implementation, the mixed method evaluation proved the proactive stress management approach was successful with the team. The data evaluated showed a reduction in team burnout from a moderate to a low level, with a more significant decrease for the stress control cohort. The physiotherapists reported a reduction in excessive workload and patient load, both indicators of burnout risk. The majority of the stress control participants agreed or strongly agreed that learning from this programme helped them to manage stressors at work and home.

The dissemination of the project includes a continuous re-evaluating and re-framing the monitoring methods and best practice built into the system. The framework of identifying and preventing stress in the regional physiotherapy service implemented through policy and the risk managed on each team’s risk registrar. The successful evaluative aspect is at the heart of this project, which will authenticate the reasons to change from the old to the new way. It the physiotherapy managers and stress control participants become change champions, and there is a higher likelihood of project sustainability. The writer intends on presenting the evaluation findings at regional physiotherapy team meetings, to senior management and the Psychology service in

Figure 5- Absenteeism and non-availability at work
September 2016. The positive impact and the continuous cycle of improvement can only be beneficial to the physiotherapists, other clinicians, managers and ultimately the patients.

### 4.4 Summary and Conclusion

The aim of the initiative was to reduce burnout and stress in Primary care physiotherapists by introducing proactive stress management systems including stress control. This goal was subdivided into the objectives including attendance at and feedback from stress control classes, using themes from the focus group for the local stress management policy, the introduction of the policy and reducing absenteeism at work. Theory drove the evaluation. The evaluation methods aligned with the objectives. All aspects of learning, improvement, behaviour and organisational performance were confirmed by evaluating with the Kirkpatrick framework. The writer used a complete range of quantitative and qualitative methods, starting the project with an assessment, using thematic analysis with the focus group content, continuing with a validated and reliable outcome, the MBI and data analysis including an audit and Likert. The writer is satisfied the evaluation achieved the agreed objectives. The burnout level did decrease for the team, the stress control programme had a positive impact on the participants, and the stress management policy implemented. The final chapter will discuss the findings and complete this dissertation.

### 5 Discussion and Conclusion

#### 5.1 Introduction

The primary aim of this project was achieved successfully by completing the change cycle and addressing the objectives congruently. The writer by implementing a proactive stress management system reduced the level of burnout, absenteeism, the reported levels of overwork and the patient overload at work. The next chapter provides further details and discussion of these project findings, the impact and their implications, strengths and limitations. It also outlines recommendations for future improvements and knowledge mobilisation.
5.2 Project Impact

The change has a real and positive impact on the physiotherapist’s health and well-being. The ‘day to day’ work of a physiotherapist in Primary care is demanding. There are multiple interactions with their clients and other team members, attempts to resolve their client’s health and social problems, very often in a void where key professionals or information are unavailable to them. The therapists have an increased sensitivity to their own and other people’s stress and they were enabled to prioritise ‘self’ over aspects of their work and personal life. A resonating message from this process is giving the worker as much control and autonomy in their working life as in their private life. The results from this project have the potential to be a compelling component of any future staff management initiative, reducing absenteeism and supporting an improved organisational culture around staff health and well-being.

5.2.1 Stakeholders

The change project was successful due to the engagement and participation of all the physiotherapists and physiotherapy managers. The ‘buy in’ was there from the start and the novel change was communicated to all in a clear way to achieve this. The planning phase was highly participative and energising. This authentic, self-managing process empowered the therapists not only to plan and participate but influence the design and its completion. There was a sense of achievement for all supported by positive feedback from the stress control attendees. The interactions, networking possibilities and partnerships with our physiotherapy and psychology colleagues were limitless. The project was a collaboration, the psychologists facilitated how we shaped the focus group analysis and our understanding of and access to the stress control programme. The positive evaluative results will help our psychology colleagues in their plans to disseminate the training throughout the local primary care service. The marginal costs of an educator, venue and the release of staff tempered by the significant gains in staff health and indirectly in patient outcomes. Stress control is currently in use in other Health Services (Likely and Switzer, 2015) and this is an endorsement of the programme’s expansion.
The aims and ideologies of the senior management and decision makers aligned with the project goals, putting staff at the centre, taking care of them as well as we take care of our patients. The management had played an active role in the implementation by agreeing to the release of staff for stress control. The project has a dominant focus and context in facilitating work engagement, providing support systems for peers and psycho-educational learning to empower staff. The health and patient care benefits, the safety aspects and adherence to legislation and health policy, as well as the financial benefits, are visible to all, including the decision-makers. The 'sense of urgency' advocated by Kotter (1996) is to reduce work-related stress and tackle the human and economic cost of absenteeism and decreased productivity. This change increased operational and management effectiveness by doing just that.

5.2.2 Practice
The central objective of implementing the proactive stress management system was to reduce the level of burnout. Initially, this was done by identifying and eliminating stressors in the workplace. Secondly, burnout was reduced by offering supports, equipping the physiotherapists with practical knowledge and increasing their resilience and energy. Maslach et al. (2012) reported work engagement as the desired objective in any burnout intervention, promoting dedication to work and a sense of 'job satisfaction'. The change matched the environment we inhabited. Our cultural fit was cynical and results driven, but our aim as a team is optimistic, to move towards a more person-focused culture (Cameron and Quinn, 2011). The drivers for change were the negative impact of burnout resulting in abject staff morale and absenteeism. The absenteeism rate was reduced to 1% this year from 5.9% last year. The reports of overwhelming workload reduced by 11%, of overwhelming patient-load, reduced by 26% following the intervention. As expected with this profession, physical activity is part of our DNA and 89% of the physiotherapists exercise regularly. Lindwall et al. (2014) in a study looking at physical activity in Swedish healthcare workers, reported a positive correlation between exercise and reducing burnout, anxiety and depression.

The physiotherapists focus group reflected their low morale, the sense of being undervalued as a profession and at times desensitised to people. The HSE
moratorium led to a recruitment stagnation, heavier workloads, role ambiguity and an increasing gap between the demands of the service and the supports offered. The change project encouraged a valuable dialogue, creating a living policy, underpinned by safety legislation, health policy and it gave the physiotherapists a voice. The ‘top three’ feedback showed the participants learnt about the biological, behavioural and cognitive aspects of stress. They were using the techniques with their clients and spoke of the beneficial carry-over to their personal lives, in understanding and managing their stress. The positive learning and behavioural aspects far outweigh any negative reports.

5.2.3 Theory
The information gathered from the literature helped inform the writer’s thinking, in particular, the change methodologies in chapter three. The misfit triggers mentioned in that section, the widening gap between healthcare demands and resources, and the massive need for restoring control and support to the services. There are correlations between outcomes of this change and other findings in literature which favour this hypothesis. Are burnout interventions recommended for physiotherapists and in what way are they delivered? There is an efficient use of evidence and legislation underpinning both the change approach and the project design. These are ideal circumstances for a small cohort, from a single profession, undertaking post-graduate research in a narrow time frame. The change agent is the service manager. The idea and theory behind the proactive stress management, the change evolution and the evaluation supported the core ideology of caring and the core purpose of ‘make people well’.

5.2.3.1 Impact on Physiotherapists
The primary aim of this project was to reduce burnout for physiotherapists by implementing a burnout and stress management system. The change initiative was carried out in two ways; first is preventative or eliminating the psychosocial risks and second is remedial, equipping the therapists with the skills and information to negotiate stress in their work and personal life. There are very few physiotherapy studies on burnout, a field dominated by the nursing and medical professions. There is no evident
research for focus groups on either physiotherapist’s opinion or perceptions or what gives them vitality at work. The focal point for the twenty physiotherapy related studies was predicting burnout and stress. The increase in burnout associated with a demanding workload, patient load, the complexity of client and cross cover. The physiotherapist is as likely to have the moderate to high burnout risk as their nursing and medical colleagues. There is a strong correlation between the level of resources and burnout which in turn reliably indicates absenteeism. This reciprocity is set out in the change project evaluation and discussion.

High job requirements, little job resources and poor control lead to an increase in burnout. In the context of the physiotherapy team, their job demands and resources were the same throughout the six-month implementation period. The dynamic factor was an increase in control linked with the ameliorative approaches. The non-participants in the stress control programme agreed ‘to cover’ their colleagues work, to free them up to attend. There were no adverse reports from the non-participants after the event. Another predictor is unnecessary administrative tasks where a physiotherapist spends time on issues not clinical or relevant to patient care; 27% of their time spent on non-clinical, another study by Du Plessis et al. (2014) it was 25%. A substantial amount of physical contact and poor working conditions can increase the risk of burnout. There is a close physical proximity and deep engagement between a physiotherapist and their client. This close physical contact may create a desire for physical distance. The physiotherapist creates the space either physically or emotionally as expressed in the focus group:’ Anne: I physically left a patient and walked out-count to ten and go back again Phoebe: So if someone comes in with negative energy, you could take it on, not just through physical contact but by talking’. Patient overload contributes to disengagement.

5.2.3.2 Response to burnout and stress
The writer identified gaps in the literature and attempted to address these inconsistencies with this change project. Only a few burnout projects underpinned by sound evaluvative and theoretical models. It was exacting to establish if any
organisational change led to an individual burnout reduction. The link surmised, but no definite one established. This change project used the HSE change model and an evaluative framework, both underpinned by theory. The change project consisted of increased peer and management support for the physiotherapists and the implementation of a stress management system grounded in burnout theory. The organisational change contributed to a 17% reduction in emotional exhaustion for the team and a 30% reduction for the stress control participants. The organisational and personal interventions were successful. Both reduced a physiotherapist’s burnout level, proving the hypothesis. There is limited evidence of participatory interventions in the literature, so we matched the response to the stressors. The stress control response (White, 2000) included cognitive behavioural therapy and relaxation, interventions supported in the literature (Ruotsalainen et al., 2015; Awa et al., 2010). In summary, to achieve an effective change, the intervention is grounded in theory, connected with the psychosocial stressors and directed not only at the individual but also the organisation.

5.3 Strengths of the projects
The new change project informed by literature met its primary objective and is implemented. The absolute strength were the participants who collectively contributed to the implementation of this project and its favourable outcomes. The physiotherapists are actively teaching patients and other colleagues their new found skills and sharing the positive message. The writer believes the healthy relationships, communication and honesty were the primary drivers to making this change work. The focus group was an open and authentic dialogue by these professional caregivers which enabled the writer to stand in their shoes and articulate their opinions to management in pitches for resources. The partakers were able to reflect the tangible, rewarding and demanding aspects of physiotherapy as a profession. When they used self-reflection or reflection with their peers, this human dialogue was transformed into powerful learning. Collaborative efforts and effects were evident, as were understanding the culture of the team and important communication with the participants. The comprehensive stress management system was developed to be practical and deliverable, that is, in a language we understand, managing a work related stress risk assessment on each team’s risk registrar. Gilbert et al. (2015) state the compliance in
adopting a policy should not be the only focus, so is the actual changes brought about by its implementation. The change project is a cyclical process, no one change or objective is carried out in isolation, learning is over the long term. Kotter (1995) states the change process is a series of steps that require time to move from the old to the new way. The process also requires leadership to create some ‘short wins.’

Another strength of the project was the development of the writer’s leadership style throughout the change process. This style as a leader and a change agent was influential on the therapists and influenced by their interactions. Leadership is effective as long as the leader is flexible, respectful and committed to group goals and the recipients psychological well-being (Appelbaum et al., 2015). Tuckey et al. (2013) report that leaders can directly influence work engagement, optimising the environment for their staff, channelling work demands and resources, demonstrating a gatekeeping role. The change recipient, the physiotherapist, need help to structurally and strategically alter their health status and work conditions. In my personal quest, I gathered knowledge in project managing and communicating an organisational change, aware of and utilising my reflections and the perspectives of the team. Leavy (2016, p. 21) recommends valuable methods for inspiring and energising the workforce to his senior executive clients, ‘that who they are is just as important as what they know how to do’ that is awareness. The empathy epiphany was my most convincing lesson, how I related to the stakeholders and influenced others in my organisation and allowed me to work more efficiently. However, Hughes (2015) claims that it is commonplace to claim leadership is vital to all of the organisational successes or failures, the reality is it is not just good leadership, but also good management skills are needed for transformation. Al Haddad and Kotnour (2015) support the importance of systematic thinking and managing human behaviour and executing tasks and series of tasks. Allio (2015) sums it up leaders can fortuitously emerge at a particular period in society as a result of the collective effort of the followers. Ultimately effective leadership comes down to good strategy, fortune and management.
5.4 Limitations of the project

The project limited by time, particularly evident in the move from implementation to mainstream and assessing the sustainability of the change. The plan is for the findings to disseminate and aid developments in human resources management. But also, the limited time-frame galvanised to action, an early focus group, the evidence to support the policy and timely access to the HSE seminars and the stress control. Throughout the six-month implementation, work resources and conditions were the same. The project unfolded in ‘real time’, so even though it was a narrow time frame, it gave credibility to the findings, as there was a certain equilibrium in the conditions and context. McAuliffe and Van Varenbergh (2006) reports that change is at such a rapid pace in healthcare that we could not expect stability and balance. But for these six months, there was stability, the strategic objectives aligned with the context involving the physiotherapists in the design.

Another limitation or barrier to the project was the Primary care infrastructure, with the multiple sites and locations for physiotherapists and their Primary care team members. There are reports that the quality of inter-professional teamwork is impacted significantly by space and accentuated by their inability to meet up on a regular basis (Oanadsen et al., 2009; Kennedy et al., 2014). The stress control programme delivered at a central location and the participants could access this, but the time, both clinical and travel and the travel costs were factored in beforehand. The therapists had to prioritise ‘self’ ahead of the clinical caseload and Primary care team demands. Securing time to access the programme and to prioritise the healthcare provider’s ‘self’ over work priorities could prove difficult to replicate in the future.

5.5 Recommendations

The impetus from the Irish government is to deliver a more effective and efficient health and personal social care, and primary care is the vehicle for this delivery. A review of primary care research in the Irish context from 2001 to 2012 indicated that there were more barriers than levers in Primary care healthcare. These obstacles were a lack of leadership, resources, communication and maintaining skill sets; all alluded to in this project. The levers are, however, the people both the healthcare providers and the
real desire for community participation in teams, ‘a more integrated interdisciplinary team approach’ (O’Sullivan et al., 2015, p.69).

Further analysis of burnout and stress tailored with The Workplace Health and Wellbeing Unit. This new HSE venture launched in April 2016 to improve the general health and wellbeing of staff in the Heath Services and to support people with health issues to remain at work. A major Stress Preventative Programme planned with the healthcare nominees trained up in the delivery of future stress control programmes. The barriers to delivering stress control in primary care are geography, multiple sites and poor co-location of teams. Securing time to access the programme and to prioritise the health care provider’s ‘self’ over work priorities could prove difficult in the future to replicate. However, the support from the National Director of Health and Wellbeing to this unit and their initiatives make it more likely for the roll out of the writer’s programme across other sites and disciplines. The local policy on stress management will be audited annually to ensure it remains relevant.

The writer will make contact with the identified contacts for The Workplace Health and Wellbeing Unit and the organisers of the HSE stress management seminars. The change project findings could be presented at future seminars or training on stress and burnout management, as determined by this networking. The writer will present these findings to the key stakeholders. The intention is to use the positive evaluative findings (improved attendance, staff morale, reduced work burden) to embed the proactive stress management system in the physiotherapy service and to adopt as a system in the general Primary care area. There are few international physiotherapy studies on burnout and stress. Therefore, it would be invaluable to conduct theoretically informed investigations of the physiotherapy profession and compare with their Primary care colleagues- nursing, GP, other allied health professionals, etc. The enhanced evidence can only add to the worth of the patient and their clinical journey. Greenhalgh et al. (2004, p. 618) ask the question ‘How can leaders of service organisations set about achieving a receptive context for the change?’ The climate and culture for change have to exist, so this shift in thinking with advocating staff health to the same extent as their clients is crucial.
5.6 Summary and Conclusion

The organisational change project resulted in the implementation of a proactive burnout and stress management system including stress control for physiotherapists in primary care. The original idea developed and disseminated at an opportune time, designed to improve the psychological health of the care provider in a demanding, resource-depleted environment. The primary evaluation to reduce burnout and stress for this profession succeeded. The additional gains of reduced absenteeism and manageable work and patient loads were evident. The majority of the stress control participants acknowledged the programme learning enhanced their work and personal lives. This knowledge gave them additional control. The feedback from senior and physiotherapy management indicate the change embedded convincingly and sustain into the future. The benefits and interest to all the stakeholders forecast a new era, where the care provider’s health requirement equated with the health needs of the client.
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Welcome to Stress Control

Stress control is a six session class. Each class lasts for 60 minutes. ‘Stress Control’ was devised by Jim White, a clinical psychologist in Glasgow to help the large number of people who complained of stress and who were keen to learn how to tackle their problems themselves. Through research, the course has been improved over the years. Stress Control is now being delivered in primary care settings in Ireland, the UK and across the world.

Over the 6 Sessions

Each session deals with a separate aspect of stress but as they all link together; it is optimal if you attend all 6 sessions. Each step is one piece of the jigsaw. Only by putting the steps together will you get the full picture.

Coping with Stress

The course will teach you about stress and present strategies to help you cope better. There is no miracle cure for stress and learning to manage stress will require work and commitment on your part. These are life skills applicable across a range of stressful situations, thus it will be well worth it in the end.

Stress Control is a taught course so you will not be asked to contribute during the class but to listen to what is being presented in order to pick up new skills. In the intervening week you can work at what you’ve learned and come back the next week to learn the next step until, after the 6 weeks, you will be in a good position to tackle your stress.

The aim of the course is to teach you new skills that can fight stress. Make sure you keep all the handouts you get so that, in the future, you can use the information to keep a grip on stress. You will learn many new skills over the 6 weeks but it is in the months after the course that the real work takes place in applying what you have learned to the stressful situations in your life.

Stress affects people from all walks of life. Although no two people will have exactly the same problems, we all have a lot in common when we are feeling stressed. We can find it hard to relax, we can worry a great deal, we can lose confidence and a sense of control. We can get down about this. Life can seem a lot harder to cope with.

The 6 Sessions of the Course

Session 1: Learning about stress: We will look at the causes of stress and what keeps it going. We will look at the way it affects your thoughts, actions and body, explode the myths about stress. We will look at why stress affects people in different ways.

Session 2: Controlling your body: You will learn how to use relaxation. We will look at how breathing retraining and exercise can help stress. We will look at why too much caffeine can often make you more anxious.

Session 3: Controlling your thoughts – cognitive therapy. You will learn how stress affects your thinking and how your thinking in turn affects your thoughts. You will learn how to use your mind to control stress along with ways of nipping stress in the bud. We will look at ways of getting this under control.
**Session 4: Controlling your actions – behaviour therapy.** You will learn ways of facing up to stress along with very useful skills called ‘problem solving’ and ‘getting out of the safety zone’. We combine this with ‘face your fear’ and then combine these with what you learned in session 3 to create a powerful skill (cognitive-behaviour therapy).

**Session 5: Controlling panic.** Learning about panic attacks and how to deal with them will be useful, even for those who don’t have panic as the techniques work well with all kinds of stress. We will also look at ways to prevent stress. We will look briefly at the role of medication.

**Session 6: Controlling sleeping problems, wellbeing and controlling the future.** In this session we will look at common sleep problems. Then we look at how to sleep better. This lets you recharge your batteries. This helps you fight stress. Finally, we will pull everything together, look at wellbeing and use these to find ways to control your future.

While it is optimal to attend all 6 sessions, if you are interested in a particular topic or simply wish to sit in for one session to learn what stress control is about, you are welcome to do so.
Appendix 2

MASLACH BURNOUT INVENTORY

<table>
<thead>
<tr>
<th>How often:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>A few times</td>
<td>Once</td>
<td>A few times</td>
<td>Once</td>
<td>A few times</td>
<td>Every day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a year or less</td>
<td>a month</td>
<td>a month</td>
<td>a week</td>
<td>a week</td>
<td>or less</td>
<td></td>
</tr>
</tbody>
</table>

How Often

0-6 Statements:

1. ___________ I feel emotionally drained from work

2. ___________ I feel used up at the end of a workday

3. ___________ I feel fatigued when I get up in the morning and have to face another day on the job

4. ___________ I can easily understand how my recipients feel about things

5. ___________ I feel I treat some recipients as if they were impersonal objects

6. ___________ Working with people all day is really a strain for me

7. ___________ I deal very effectively with the problems of my recipients

8. ___________ I feel burned out from work

9. ___________ I feel I’m positively influencing other people’s lives through my work

10. ___________ I’ve become more callous toward people since I took this job

11. ___________ I worry that this job is hardening me emotionally.

12. ___________ I feel very energetic

13. ___________ I feel frustrated by my job

14. ___________ I feel I am working too hard at my job

15. ___________ I don’t really care what happens to some recipients

66
16. __________ Working with people directly puts too much stress on me

17. __________ I can easily create a relaxed atmosphere with my recipients

18. __________ I feel exhilarated after working closely with my recipients

19. __________ I have accomplished many worthwhile things in this job

20. __________ I feel like I’m at the end of my rope

21. __________ In my work, I deal with emotional problems very calmly

22. __________ I feel recipients blame me for some of their problems
Appended 3

Quality Assessment of review using criteria proposed by Khan et al. (2001, p. 9)
Harding (2009, p.157) for 20 studies

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
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<td>√</td>
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<td>√</td>
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<tr>
<td>2. Intervention clearly described?</td>
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<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>3. Were the groups comparable on important confounding factors?</td>
<td>√</td>
<td>x</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>x</td>
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<tr>
<td>4. Were the drop-out rates and patient characteristics lost out in follow ups?</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>√</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>5. Is the study based on a representative sample from a relevant population?</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td>6. Was an attempt made to blind those measuring outcomes?</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td>7. Was there adjustment made for confounding variables?</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>8. Were outcomes assessed using objective criteria?</td>
<td>√</td>
<td>√</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>9. Was appropriate statistical analysis used</td>
<td>x</td>
<td>√</td>
<td>x</td>
<td>√</td>
<td>√</td>
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Total criteria met | 6 | 6 | 4 | 9 | 8 | 5 |
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
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<td>2. Intervention clearly described?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Were the groups comparable on important confounding factors?</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>4. Were the drop-out rates and patient characteristics lost out to follow ups reported?</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>5. Is the study based on a representative sample from a relevant population?</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>6. Was an attempt made to blind those measuring outcomes?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>7. Was there adjustment made for confounding variables?</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>✓</td>
<td>X</td>
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<tr>
<td>8. Were outcomes assessed using objective criteria?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9. Was appropriate statistical analysis used</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>1. Are the inclusion criteria clearly described?</td>
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<td>2. Intervention clearly described?</td>
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<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>x</td>
<td>√</td>
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<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>x</td>
<td>√</td>
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<tr>
<td>4. Were the drop-out rates and patient characteristics lost out to follow ups reported?</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>5. Is the study based on a representative sample from a relevant population?</td>
<td>√</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
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<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<tr>
<td>7. Was there adjustment made for confounding variables?</td>
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<td>x</td>
<td>√</td>
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<tr>
<td>8. Were outcomes assessed using objective criteria?</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>9. Was appropriate statistical analysis used</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<td><strong>Total criteria met</strong></td>
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## Appendix 4 Overview of 20 included studies (Harding 2009)

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Disciplines involved/country</th>
<th>Number of quality criteria met (Khan 2003)</th>
<th>Sample</th>
<th>MBI Y OR N Other tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donohue 1993</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT (Physiotherapist) USA</td>
<td>6</td>
<td>N=129 PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Ogiwara 2002</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Japan</td>
<td>6</td>
<td>N= 163</td>
<td>JMBI=Y (Japanese version)</td>
</tr>
<tr>
<td>Lindsay 2008</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Australia</td>
<td>4</td>
<td>N= 80 PT</td>
<td>MBI=N No valid tool, own questionnaire on stressors</td>
</tr>
<tr>
<td>Campo 2009</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT USA</td>
<td>9</td>
<td>N=882 PT (random-1 year follow up)</td>
<td>MBI=N JCQ Job Turnover</td>
</tr>
<tr>
<td>Pavlakis 2010</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Cyprus</td>
<td>8</td>
<td>N= 172 PT (Private and public)</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Santos 2010</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Portugal</td>
<td>5</td>
<td>N= 55 (3 hospitals) small sample only to show trends</td>
<td>MBI=N Coping Resources inventory</td>
</tr>
<tr>
<td>Enberg 2010</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Sweden</td>
<td>6</td>
<td>N=262 (OT/PT)</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Disciplines involved/country</td>
<td>Number of quality criteria met (Khan 2003)</td>
<td>Sample</td>
<td>MBI Y OR N Other tools</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------</td>
<td>------------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Kowalska 2011</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT</td>
<td>5</td>
<td>N=64 (small sample)</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Saganha 2012</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT</td>
<td>7</td>
<td>N=106 PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portugal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saganha 2012</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT</td>
<td>7</td>
<td>N=106 PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portugal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiabane 2013</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT, nursing, nurse's aide and physicians Italy</td>
<td>6</td>
<td>N= 110 (28 PT)</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Fischer 2013</td>
<td>Evaluative Analysis-Questionnaire</td>
<td>PT</td>
<td>8</td>
<td>N= 132 PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Italy (South Tyrol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yeboah 2014</td>
<td>Empirical Analysis-Survey Questionnaire</td>
<td>PT and 16 other categories</td>
<td>3</td>
<td>N= 2331 but only 15/2331 are PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td>Silva 2014</td>
<td>Cross-sectional study</td>
<td>PT</td>
<td>8</td>
<td>N=1040 PT</td>
<td>MBI=N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brazil</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Al Imam 2014</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT</td>
<td>7</td>
<td>N=119 PT</td>
<td>MBI=Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saudia Arabia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Disciplines involved/country</td>
<td>Number of quality criteria met (Khan et al 2003)</td>
<td>Sample</td>
<td>Triage tool/criteria described</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Brattig 2014</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Germany</td>
<td>5</td>
<td>N=210 PT (random) Response rate is only 41%</td>
<td>MBI=N CPSQ Work Ability Scale</td>
</tr>
<tr>
<td>Du Plessis 2014</td>
<td>Descriptive quantitative PT/OT/Therapy Assistant South Africa</td>
<td>7</td>
<td>N=49</td>
<td>N= 13 PT</td>
<td>MBI= Y</td>
</tr>
<tr>
<td>Sliwinski 2014</td>
<td>Comparative-Survey Questionnaire</td>
<td>PT Poland</td>
<td>8</td>
<td>N=200 PT</td>
<td>MBI=N Burnout Inventory Scale LSQ</td>
</tr>
<tr>
<td>Sliwinski 2014 (b)</td>
<td>Comparative-Survey Questionnaire</td>
<td>PT Poland</td>
<td>8</td>
<td>N=200 PT</td>
<td>MBI=N Burnout Inventory Scale Life Satisfaction Questionnaire</td>
</tr>
<tr>
<td>Wilski 2015</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Poland</td>
<td>6</td>
<td>N=155 PT Assess coping styles</td>
<td>MBI(Polish)= Y</td>
</tr>
<tr>
<td>Nowakowska-Domagala 2015</td>
<td>Evaluative Survey Questionnaire</td>
<td>PT Poland</td>
<td>8</td>
<td>N= 117 PT</td>
<td>MBI=Y Coping Inventory</td>
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</table>
### Appendix 5

#### SWOT Analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad base of evidence to manage staff health</td>
<td>Time taken by physiotherapists to partake in stress control programme</td>
</tr>
<tr>
<td>Strong message from DOHC to look after staff (Healthy Ireland)</td>
<td>Future conflicts with time: i.e. clinical or personal elements with the programme</td>
</tr>
<tr>
<td>Buy in of a dedicated Physiotherapy team and senior management</td>
<td>Dependant on programme provision by other individual/s and department</td>
</tr>
<tr>
<td>Support and advice of our psychology and EASS colleagues</td>
<td></td>
</tr>
<tr>
<td>Will improve Physio to Physio/health colleague and Physio to client engagement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows a voice to physiotherapists in a challenging climate</td>
<td>Sustaining the stress management initiatives and keeping the momentum</td>
</tr>
<tr>
<td>Networking with stakeholders, PT’s, regional managers, Psychology service-health, occupational and third level, Employee Assistance Support Services</td>
<td>Securing time for PT’s in the future for their own self development and supervision with the competing demands of patients and referrers</td>
</tr>
<tr>
<td>To become known as the service that cares for its staff as much as its patients</td>
<td>The value the PT’s may or may not put on the initiative</td>
</tr>
<tr>
<td>Improve patient outcomes indirectly by increased support, decreased absences and improving quality and outputs in patient care</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 6

### PESTLE

| Political | Health and Safety Act 2005  
HIQA – Standards 6.3.7 (supports to the worker by line management)  
Support from DOHC (Health Ireland) to mental health initiatives  
HSE stress policy and campaigns (healthy work places managing stress from the European Agency safety and health work campaign 2014/2015) |
| --- | --- |
| Economic | Better health means economic growth  
Moratorium on recruitment in years of austerity, challenge with job fit/skills mix (HSE HR Circular 015/2009)  
Lost productivity-1.5 Billion euros per year in IRL due to stress (IBEC)  
Increased demand on a reduced resource (costs are financial and personal) |
| Social | The cultural norm of Primary care- open access  
Public perception / media of primary care delivery  
Lone working, PCT operating different sites, fractured teams  
Need for support (in private or work-life)  
Increasing need for supports at home, may be due to poor access to supports at work  
Due to moratorium, lack of opportunities in career pathways and poor flexibility in move/change of jobs, enforced choice |
| Technological | Efficient PT IT system for managing, W/L and compstats  
Clients are better informed in decision making due to IT/media  
Not all our clients have access to IT or understand it  
Difficulty accessing funds and time for CPD/Research and quality initiatives-impact on maintaining skills |
| Legal/Ethics | Legislation with stress and safety in work place and compliance with same (Health and Safety Act 2005)  
|             | Supported in HSE by risk registrar, health and safety statements and investment in QRPS services  
|             | HIQA- legal obligation (Standards 6.3.7) |
| Environment | Client and therapist values/public perception  
|             | Working environment and space  
|             | Primary care development rolled out quickly and with poor planning for future developments and needs  
|             | Few purpose built buildings, temporary structures dominate, members of PCT several sites  
|             | Absence of security and vulnerability at some sites mainly inner city |
### Appendix 7

**Force-field Analysis**

<table>
<thead>
<tr>
<th>Forces for change</th>
<th>Forces against change</th>
</tr>
</thead>
<tbody>
<tr>
<td>It makes sense - ‘for a person's wellbeing’</td>
<td>Not getting ‘buy in’ from stakeholders</td>
</tr>
<tr>
<td>Increasing stressors-austerity/resource depletion, patient expectation, media demands</td>
<td>Practicalities of delivering 60 minute’s lunch-time session for six weeks</td>
</tr>
<tr>
<td>Student interest</td>
<td>Geographical spread of staff</td>
</tr>
<tr>
<td>Team evaluation</td>
<td>Scope and scale of change</td>
</tr>
<tr>
<td>Senior Management</td>
<td>Costs? Of stress management if difficulty providing in-house</td>
</tr>
<tr>
<td>Legitimate leadership (responsibility as a manager)</td>
<td>Organisational structures and processes</td>
</tr>
</tbody>
</table>

**Current State**  |  **Desired State**
<table>
<thead>
<tr>
<th><strong>High Importance/Low Influence</strong></th>
<th><strong>High Importance/High Influence</strong></th>
<th><strong>Low Importance/Low Influence</strong></th>
<th><strong>Low Importance/High Influence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users</td>
<td>Primary care Physiotherapists</td>
<td>Administration</td>
<td>ISCP</td>
</tr>
<tr>
<td>Primary care colleagues</td>
<td>Clinical Psychologists</td>
<td></td>
<td>HR Management</td>
</tr>
<tr>
<td>Occupational Health/Employee Assistance Programme</td>
<td>Psychology Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior HSE Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Physiotherapy Managers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 9

Organisational Cultural Assessment Instrument
or Competing Values Framework
Primary Care Physiotherapy

Now
Preferred

Clan
Adhocracy
Hierarchy
Market
Appendix 10

Focus group for Primary care physiotherapists (22.10.15)

1.0 Introduction:
The central aim of this focus group for physiotherapists is to gather themes around supports and vitality and use them to inform a stress management guideline.

1.1. Objectives:

a) To collect qualitative data from physiotherapists in a focus group around vitality at work, supports, where to go for help, what encourages and prevents them from seeking help.

b) The focus group themes will be utilised in a local guideline on managing stress for Physiotherapy in the local region.

c) The writer has a legal obligation as a manager, under the Safety Health and Welfare at Work Act 2005, (Ireland. Office of the Attorney General, 2005, p.12) to identify risks or stressors for staff and collate information from a number of sources including this focus group. (Stress Management Information Leaflet, 2015, p.3)

The feedback gained will be utilised in a local guideline on managing stress for Physiotherapy in the local region.

1.2 Findings (Appendix 1)

There are three main themes-relationships, need for respect and acknowledgement and coping mechanisms. The first theme relationships reflect how the participants inter-relate with their colleagues, clients and GP’s or other medical referrers and the strong need for a connection with others. The second theme is their need for respect and acknowledgement. This is further sub-divided into leadership and a need for respectful, listening and flexible leader/s. Subdivided further into fear, fear of lack of support from the organisation and things going wrong in litigation fear of domination of their profession and the open access of primary care. The next subdivision is emotional dumping from the client, the system and again a recurring theme, emotional dumping from the GP’s and medical referrers. The final theme is coping mechanisms, what do the therapists do to manage, namely talking, actively listening, self-reflection, physical exercise and counselling.
2.0 Methodology:

The writer searched the databases Emerald, Cinahl, Lenus and Google scholar using the search terms- physiotherapy*, 'physical therap*','allied health profession', ‘focus group’, ‘focus groups’, support*, vitality, view*, perception* and profession were used. The timeframe for the search was January 2010 to November 2015. There is no evidence of specific focus groups looking at support or vitality for physiotherapists or seeking the views and perceptions of their profession. Stevenson et al, (2011, p.543) utilised focus groups to explore the experiences and perceptions of allied health professions and nursing, but only one physiotherapist participated. Similar themes to our focus group appeared in her study, namely around organisational support, professional isolation and role overload.

2.1 Procedure/Data Collection:

19 physiotherapists in Primary care were invited to discuss their views on support and vitality at work. Six physiotherapists (all female) chose to attend the focus group and they gave their informed signed consent. They consisted of four senior staff and two staff grade, working in a mix of rural and city work locations. The group lasted approximately one and a half hours resulting in a 17,101-word transcript and this was recorded and transcribed, verbatim. Assurance was given to the participants regarding the confidentiality of the report, that no-one would be identified. Names of celebrities were picked by each candidate to protect their anonymity Mary, Phoebe, Miley, Sharon, Anne and Marilyn.

The information will be stored safely according the HSE data protection and destroyed on completion of the project. The group was facilitated by a senior clinical psychologist using a semi-structured interview style (Appendix 1).

2.2 Data Analysis:
The writer used thematic analysis-inductive and exploratory method (Braun and Clarke, 2006, p. 83-84) in analysing the data. The focus group conversation was recorded and transcribed verbatim. A PHd Psychology post-graduate student provided a 1:1 seminar to the writer on a systematic approach to thematic analysis prior to the analysis. The analysis was undertaken by the writer and discussion was undertaken with a colleague (Physiotherapy Manager) on agreeing the developing themes. The transcript was read and re-read several times, immersing oneself in the material in an ‘active way’ locating meanings and patterns (Braun and Clarke, 2006, p.87). Initially the repeating words in the text were listed and then repeating concepts, labelling categories and seeing connections between themes (Lofgren, 2013). The discussion was very authentic and open from the professional caregivers. Due to the richness of the material, the analysis resulted in some thought provoking and useful themes with contribution from all the participants.

### 2.2.1 Relationships: (100% of participants contributed).

Within the first main theme of ‘relationships’, three subthemes were identified, relationships with colleagues, relationships with clients and relationships with GPs. The need for connection and a good relationship with their colleague- is identified by the participants, especially with their peers. This is expressed in a need to meet up regularly, in face to face contact. *Phoebe: Connection is important for me, a connection with your peers.*

There is a need for avoiding professional and personal isolation.

*Marilyn: I’d be very nervous going working in a clinic on my own at the moment.*

A value and respect is put on their colleagues who have a positive approach or ‘newer’ colleagues who bring vitality to the services.

*Miley: It’s nice to be with your team, its good, OT’s and their different perspectives. There was agreement to this statement from several of the participants- Mary, Marilyn and Phoebe. Their administrative colleagues*
when up-skilled for the job and with adequate time to support them are described by Miley 'she will add happiness to your life'.

The relationship with the client can be very rewarding and motivating, Marilyn: and actually enjoying the patients and learning from them.

On the reverse side, client contact can be draining, there is a need to take a ‘step back’ and create some healthy distance in order to function in their role.

Anne: I physically left a patient and walked out-count to ten and go back in again.

The participants report mixed feelings on their relationships with GP’s or medical referrers some can be supportive but they act ‘outside’ or separate to the primary care team. Work is directed one way towards the physiotherapy service without the support of referring back.

Mary: It’s frustrating…about GP’s advantages of the team without actually giving back.

2.2.2 Need for respect and acknowledgement (100% of participants contributed)

The second main theme ‘need for respect and acknowledgement, has three further subthemes, leadership, fear and emotional dumping. The sub-theme of emotional dumping branches further into emotional dumping from patients, from the system and from the GP’s or medical referrers.

Leadership- The participants want a leader or leaders who foster both respect and flexibility. Mary makes a statement that is confirmed by Phoebe and Miley ‘And flexibility gives you a huge boost…you feel respected as an employee, then you respect them back’. There is a sense of senior management being invisible and not valuing the physiotherapy profession. Miley: so there is no sense of you working together with management. The invisibility and the sense of worthlessness in how the
profession is perceived, creates strong negative feelings. Words are used such as ‘anger, cynical and frustrating’.

Fear-The fear exists for the participants that the organisation does not support them. The constant changes in the past number of years lead the participants to being consumed by what may or may not happen. There is a desire to manage this fear in a controlled way.

Mary: I think there is a huge culture in the HSE about covering your back.

This fear has spiky tentacles -one tentacle is fear of missing something clinical with a patient or being sued, Miley: just the whole litigation side of things. Another fear tentacle is being so accessible in primary care, almost in a war zone where everyone is battling, described by Marilyn ‘there is off-loading’ There are no protection or defences, no leadership. Mary describes this as ‘no real proper planning, it’s just a hurry to set up those teams’.

Emotional dumping- the client: Marilyn describes clients who emotionally dump on you and Phoebe and Mary discuss medico-legal clients who may not be motivated to improve. This can be particularly difficult if the therapist is in the client’s own home, on their turf so to speak. Phoebe: so if someone comes in with negative energy, you could take it on, not just through physical contact, but by talking’. The therapists are well aware of the balancing of their emotions between empathy and compassion for a client and becoming desensitised. Anne: I think the balance between desensitisation and empathy…just you need your softer heart sometimes and compassion’.

This is a return to our first theme of relationships, and a need for a healthy distance from the client in order to function well as a therapist.

Emotional dumping-the system: There is a view that the organisation is not investing in them. Yet the first line in the local stress guideline is ‘the Health Service Executive (HSE) believes that our employees are our most important asset in the delivery of high quality health and social services underpinning the core values of ‘care, compassion, trust and learning’.

They want to progress ideas and initiatives with collaborations at all levels
of the organisation, endorsing variety and health promotion and as Marilyn says ‘they (the clients) would get the level of care they deserve to get’. There are pressures of client and organisation demands, reduced resources due to the staffing moratorium, and waiting lists spiralling out of control, ‘going bananas’ as described by Sharon. She also relates this fragmentation in the system ‘And there is very little support you know it can be disjointed’. Pacing and longevity in their job competes with ‘emotional dumping’ on the therapist or other motivations not to improve.

**Emotional dumping-from GP’s and medical referrers:** The participants feel that the medical referrers and GP’s do not pay any attention do their professional opinion, *Sharon: Our care is a bit of a dumping ground and it’s one way.* Clients are re-referred who have already been seen and allow poor access to information and diagnostics such as x-rays. *Phoebe: Our prognosis is not respected by someone you know by having them refer them back in to.* The lack of clinical information on referrals, sometimes mean clients are poorly prioritised and this ratchets up the fear factor of something going wrong.

### 2.2.3 Coping mechanisms-(100% of participants contributed).

‘Coping mechanisms’ are the third theme and sub-themes stemming from this would be talking and active listening, self-reflection, exercise and counselling.

**Talking and active listening:** The need for connection as explored in theme one and the need of team members to talk together and give each other support. *Miley describes this as ‘a good talk – we just solve the world discussions you know’.*

**Self-reflection:** But in the course of the focus group and their own dialogue, the physiotherapists, acknowledged that as well as talking, self-reflection on their part led to the actual learning, when discussed with their peers. They were demonstrating their logical, problem solving natures. *Phoebe: I need to have that intimate knowledge of self.* As this is the
method they are most comfortable with it, it should be explored more as a support mechanism.

**Physical exercise:** The participants probably through the nature of their professions, use physical exercise as means to de-stress-running, yoga, meditation, a quick walk after walk. But, the actual 'talking about' their stresses or difficulties proved much more challenging for them.

**Counselling:** The challenge for the participant is actively seeking psychological support or help, understanding what it is, expressing their emotions and asking for help in a non-shameful way. They do not want to feel judged. Sharon: *It might be kind of maybe hard to admit you aren’t coping.* On the subject of counselling, some of the participants (Miley and Anne) were concerned about the confidentiality aspect. But one participant, Phoebe shared her positive experience of counselling, this had a transformative effect on the group due to her openness. It was she reiterated the help she received and that the confidentiality was upheld. Phoebe: *I nipped it in the bud because I talked to (the writer) about it and she facilitated a meeting with her (the counsellor).* Sharon had never considered going further than her line manager, that this counselling service was there for her.

On summarising the original objectives, the first objective is collecting qualitative data from the physiotherapists around vitality at work, supports, where to go for help, what encourages and prevents them from seeking help. This was achieved and the data analysed accordingly into the three key themes of relationships, need for respect and coping mechanisms and their subthemes. The themes reflect the real human, tangible and demanding aspects of physiotherapy as a profession. The second objective was to incorporate the themes in a local stress management guideline (PHYMW012), a four stage guideline of identifying risk (stressors), preventing, supporting and monitoring. In the identification section, there is a specific reference to the focus group and its themes and referenced in an appendix. In the support stage of the guideline (Appendix3). There are specific actions outlined from
the focus group. The planned implementation of the guideline is 4 January 2015 with an audit on compliance by the Physiotherapy managers in the region by March 31 2016.

References:


Stress Management Information sheet. (2015). Retrieved from the HSE website:
Appendix 1

**Focus group questions:**

1. Do you have vitality at work?
2. If you do have vitality, what gives you vitality at work?
3. Do you know what supports you at work?
4. Do you know where to go for help?
5. What stops you for going for help?
6. What encourages you to go for help?
### Appendix 2

**Five themes from the focus group**

<table>
<thead>
<tr>
<th>Three themes from the focus group</th>
<th>Subthemes</th>
<th>Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Relationships with colleagues</td>
<td>Need for connection with others (especially peers)- regular meet-ups, face to face contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoid working in isolation</td>
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<td></td>
<td></td>
<td>Value and need for other discipline perspectives</td>
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<td></td>
<td></td>
<td>Increased vitality with ‘new’ physiotherapists starting work</td>
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<tr>
<td></td>
<td>Relationships with clients</td>
<td>Positive and motivating OR</td>
</tr>
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<td></td>
<td>Relationships with GP’s or medical referrers</td>
<td>Mixed, can be supportive</td>
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<td></td>
<td></td>
<td>More likely not to be supportive, separate and act outside the PCT</td>
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<td></td>
<td></td>
<td>Work goes one way- towards physiotherapy and no support other way</td>
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<tr>
<td>Need for respect and acknowledgement</td>
<td>Leadership</td>
<td>Lead by example-trust, respect and being flexible</td>
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<tr>
<td>Emotion <strong>dumping</strong> from</td>
<td>Sense of non-investment in the physiotherapists by the HSE</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>the GP’s and medical referrers</td>
<td>Desire for progression of ideas and initiatives (learning) and collaboration at all levels</td>
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<tr>
<td>the system</td>
<td>Endorse variety and health promotion at work</td>
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<tr>
<td>clients</td>
<td>Emotional dumping from clients Compassion and empathy for the client alternates with desensitisation</td>
<td></td>
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<tr>
<td>clients</td>
<td>Care for self and not only caring for others</td>
<td></td>
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<tr>
<td>the system</td>
<td>Emotional dumping from the system Pacing/longevity in their job competes with not ‘being blinded’ by the pressure of waiting lists and high work demands</td>
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<td></td>
<td>Equity/fairness between disciplines (CPD/leave)</td>
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<tr>
<td>the GP’s and medical referrers</td>
<td>Emotional dumping from the GP’s and medical referrers Not respecting physiotherapist’s professional opinion</td>
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<td></td>
<td>Off-loading with re-referring clients especially chronic</td>
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<td></td>
<td>Insufficient clinical and diagnostic information: incorrect</td>
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<tr>
<td>Prioritisation and more chance of things going wrong</td>
<td>Fear</td>
<td>Worry around litigation- ‘minding oneself’</td>
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<tr>
<td></td>
<td></td>
<td>Being dominated or controlled as a profession and as individuals</td>
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<td></td>
<td></td>
<td>Highly accessible in Primary care- no boundaries/defences</td>
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### Coping Mechanisms

<table>
<thead>
<tr>
<th>Talking and active listening</th>
<th>Talking and active listening</th>
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</thead>
<tbody>
<tr>
<td>Self-reflection</td>
<td>Self-reflection and discuss learning with peers</td>
</tr>
<tr>
<td>Physical exercise</td>
<td>Running, yoga, meditation</td>
</tr>
<tr>
<td>Counselling</td>
<td>Express emotions and ask for help in a non-shameful way. They do not want to feel judged</td>
</tr>
</tbody>
</table>
Appendix 3

7.2 Support and Assistance: This is the third stage of the Cycle of Stress Management (7.3.1 to 7.3.5 are specific actions from the focus group).

7.2.1 7.3.1 Sit down with a colleague and make things clearer through talking. Agree or map a way forward which you think you can manage. The managers need to facilitate regular supervision for everyone (every six weeks at least), this may include peer supervision and self-reflection.

7.3.2 Identify what you need to keep you stress-free and express this assertively

7.3.3 Ensure you have a healthy lifestyle-sleeping, eating and exercising regularly in line with your mental and physical needs.

7.3.4. Consider inviting an Employee Assistance Program Support counsellor to speak to your team around the value and fundamentals of counselling. Another action is facilitating an external provider e.g. clinical or occupational psychology, to complete some work with the physiotherapy teams around self-preservation, setting boundaries, dealing with compassion fatigue and client expectation.

Access for primary care physiotherapists to a validated stress control program (Switzer, 2013 September) (White 1998) devised by clinical psychologist Jim White. Or access for physiotherapists if local health and wellbeing programs are offered-mindfulness, Cognitive Behavioral therapy, meditation etc. These are interventions aimed at controlling stress and creating a safer place to work even with psychosocial hazards (stressors).

7.3.5. Relax and enjoy leisure time when not at work. Work-life balance is crucial so that stresses are more easily met, regardless of their source.
Primary, Community and Continuing Care Services

Policy Document: Guideline on Managing Stress in Primary Care Physiotherapy Services

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<th>XXXX PT Manager</th>
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</tr>
</tbody>
</table>
Table of Contents:

1.0 Policy

2.0 Purpose

3.0 Scope

4.0 Legislation/other related policies

5.0 Glossary of Terms and Definitions

6.0 Roles and Responsibilities

7.0 Procedure

8.0 Implementation Plan

9.0 Review and Audit

• References/ Bibliography

• Appendices:
1.0 Policy:

The Health Service Executive (HSE) believes that our employees are our most important asset in the delivery of high quality health and social services. At its core are the values ‘Care, Compassion, Trust and Learning. The Corporate Safety Statement, 2014, reaffirms the HSE’s commitment to placing people at the centre of the organisation.

We recognise that workplace stress is a health and safety issue and it is important to identify and reduce workplace stress. This local guideline sets out a framework in which to achieve this with reference to HSE Policy for Managing Stress in the Workplace and the European
Safety week’s campaign (October 19-23, 2015) [http://www.hse.ie/eng/staff/safetywellbeing/]. The key focus of this campaign was ‘healthy workplaces managing stress’ which the HSE used as a platform to assist managers and employees to deal with the important issue of unhealthy stress.

The Safety, Health and Welfare at Work Act states that the HSE has a duty of care and must do what is reasonably practicable to provide a safe working environment for all employees. We have a duty of care to ourselves and our colleagues which is important. This positive work environment within a healthcare setting leads directly to improved patient experience and outcomes.

- **Purpose:**
  The purpose of this guideline is to give guidance to HSE Physiotherapists and Physiotherapy managers on how to identify, prevent, support and assist and monitor stress in the workplace, with a focus on risk assessment, identifying stressors and providing supports as identified in a local context.

- **Scope:**
  This guideline applies to all the physiotherapy staff in the XXXX region.

### 4.0 Other related policies and relevant legislation

This guideline should be used in addition to the following:

**Policies**

- The Dignity at Work Policy (2009)
- HSE Rehabilitation of Employees back to work after illness or injury policy and procedures. (2011)
- HSE Policy for Preventing and Managing Stress in the Workplace (2012)
- HSE Policy for Long-term absence benefit schemes guidelines (2012)
• HSE. Healthy Ireland-A framework for improved health and well-being (2013-2025)
• HSE Policy for Managing Attendance (2014)
• European Agency Safety and Health work campaign (2014-2015)

Legislation:

• The Safety, Health and Welfare at Work Act 2005
• HIQA Standards, in particular Standard 6.4.3 where the HSE are expected to provide ‘A working environment that in line with relevant legislation and national policy supports and protects the workforce in delivering high quality, safe care’ (HIQA. 2012. P 118)
• The organisation of Working Time Act 1997
• The Employment Equality Act 1998 and 2007
• The Equal Status Act 2000-2004
• The Disability Act 2005

5.0 Glossary of Terms and Definitions:

There are many definitions of stress-related terms. (Health and Safety Authority. n d). For this guideline, we use the following:

• **Stress** is a mental and physical condition which results from pressure or demands that strain or exceed your capacity or perceived capacity to cope. The sources of such pressure or demands are **stressors**.

• **Work related stress (WRS)** are the conditions, practices and events at work which may give rise to stress. WRS is stress caused or made worse by work. While stress may result from different aspects of life, the main focus of this guideline is on work-related stress. Factors that are not work-related can affect you in the workplace.

It should be noted that work generally provides opportunities for developing and maintaining positive mental health and well-being. There is a difference between positive stress, which is associated with a sense of challenge and vitality and negative stress which is dominated by worry, anxiety and agitation.

• **Stress response**: The normal way the body reacts to challenging events, which energises the human system to meet the challenge.

• **Chronic Stress**: Although the initial stress response is normal, if it remains active
over a long period as a result of chronic stress, it can drain your physical and mental resources. **Burnout** is a crisis in a person’s work related state of mind (Ruotsalainen et al, 2015. P.6).

Most forms of stress are caused by stressors that gradually push people beyond their capacity to cope comfortably. Underlying stress factors for healthcare workers can be a heavy workload (Maslach et al, 2015, p.6) (Nolan and Ryan, 2008, p.35) along with a role conflict and ambiguity (Ireland. Health and Safety Authority, 2008, p.46). A significant stressor can be their emotional response to dealing with the sick and the dying (Ruotsalainen et al, 2015, p.6) but minimal research on the impact of burnout has been carried out on service recipients. (Maslach et al, 2015, p.39).

**Critical Incident:** Staff who experience (either routinely or once off) critical incidents in the workplace may develop symptoms, which if left unattended, may impact negatively on their lives and could develop into post-traumatic stress symptoms or full-blown post-traumatic stress disorder. Critical incidents tend to involve sudden exposure to death or life threatening injury to yourself or others, for example serious accidents, abuse or violence. These incidents can be traumatic.

**Stress management:** is a term used for all activities aimed at controlling stress. It includes efforts to identify, prevent and reduce stressors in the workplace and to assist employees affected by or at risk of stress. We need stress management systems at a number of levels rather than at one level.

**What are the sources of Work Related Stress?**

- **Demands** - Includes issues like workload, work pattern and the work environment
- **Control** - How much say the person has in the way they do their work
- **Support** - this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- **Relationships** - This includes promoting positive working to avoid conflict and dealing with unacceptable behavior.
- **Role** - Whether people understand their role within the organisation
- **Change** - How organisational change (large or small) is managed and communicated in the organisation.
- **Reward and contribution** - Includes pay, benefits, reward and positive feedback.

(Health Services Executive, 2015)

- **Roles and Responsibilities:**
6.1 It is the responsibility of the Physiotherapy Manager to ensure that all staff are aware of, and comply, with this document.

6.2 It is the responsibility all Physiotherapy staff to participate in workplace assessment of occupational/workplace stress.

6.3 It is the responsibility of each physiotherapist to familiarise themselves with the policies and legislation referred to in this document and to comply with them.

We could significantly reduce the human and organisational cost of stress from ill-health, absences from work and lower productivity, if we all work together to address work-place stress.

Managers have a crucial role to play in the successful identification of work related stress within their workforce. They also have a legal obligation under the Safety Health and Welfare Act 2005, Section 19, to identify hazards (stressors) and assess the risks associated with them in consultation with their employees- the cycle of stress management (Appendix 1).

7.0 Procedures

7.1. All Physiotherapy Staff

7.1.1 It is recommended to use a risk assessment tool to assess psychosocial hazards. An example of a HSE developed tool is the Workplace Assessment Risk Assessment form (Appendix 2). All staff should try and contribute to this assessment, in a team setting.

7.1.2. Stress Management and support is a topic on the agenda of the physiotherapy manager at least once a year.

7.1.3 All staff members should identify the causes of stress with their manager, as described in information sheet 1 (Appendix 3).

7.1.4 All staff members should talk with their managers at an early stage. If your stress is work-related or non-work-related, this will give them an opportunity to help and prevent the situation getting worse. This will be done in a confidential and non-judgmental way.

7.1.5. Each staff member should have time and autonomy to carry out their work load.
7.1.6. There should be support and flexibility around leave-parental, annual, career, unpaid etc. within the locus of control of the physiotherapy manager and based on the exigencies of the service.

- Continued advocacy by all for improving the level and training of administrative support to the physiotherapists.

(7.1.8 to 7.1.10 are specific actions from a local physiotherapy focus group, as are 7.2.13 see Appendix 3 for themes)

7.1.8 All staff should sit down with a colleague if stressed and make things clearer through talking. Agree or map a way forward at work that you think you can manage and bring to your manager.

7.1.9. Identify what you need to be stress-free and express this assertively.

7.1.10. Ensure you have a healthy life style – sleeping, eating and exercising regularly in line with your mental and physical needs.

7.2.11. For more information, please refer to the HSE (2012) Policy for prevention and Management of Stress in the Workplace, HSAG 2012/2.

7.2. Physiotherapy Managers

7.2.1. The Workplace Assessment Risk Assessment form (Appendix 2) can be used with an individual employee and/or with the team in assessing risk. It should be carried out on an annual basis and contribute to the risk assessment on occupational/work related stress. (Appendix 4)

7.2.2. Other information collated from other sources e.g. employee questionnaires, sickness absence records, interviews with staff can inform the work-place/ occupational stress risk assessment.

7.2.3. Use the HSE Workplace Stress Flowchart (Appendix 6) when managing an individual who has reported work stress or if you have received a medical certificate stating that employee is off work due to stress.

7.2.4. Ensure fair work distribution and rewards for each staff member.
7.2.5. Clarify roles and tasks for each staff member and provide regular constructive feedback.

7.2.6. Relate any information on organisational change to the team in an honest and transparent way.

7.2.7 Ensure your service has a current health and safety statement and a risk registrar.

7.2.8 Ensure health and safety is a monthly team item.

7.2.9. Implement policies to prevent work related stress-dignity at work policy, managing attendance, lone-working, Rehabilitation of employees back to work after illness or injury, Long term absence benefit scheme, Healthy Ireland – a framework for improved health and well-being (2013-25).

7.2.10 Facilitate regular physiotherapy team/network meetings.

7.2.11. Induction for all new employees to the service and policies.

7.2.12 The managers need to facilitate regular supervision for everyone (every six weeks at least), this may include peer supervision and self-reflection.

7.2.13

- Consider inviting an Employee Assistance Program Support counsellor to speak to the team around the value and fundamentals of counselling.
- Consider facilitating an external provider e.g. clinical or occupational psychology, to complete some work with the physiotherapy team around self-preservation, setting boundaries, dealing with compassion fatigue, chronic pain clients and client expectation.
- Allow access for the primary care physiotherapists to a validated stress control program (Switzer, 2013 September) (White 1998). Other options are access for physiotherapists if local health and wellbeing programs are offered-mindfulness, Cognitive Behavioral therapy, meditation etc. These are interventions aimed at controlling stress and creating a safer place to work even with psychosocial hazards (stressors).

7.2.13 The role of Organisational health and safety in managing stress and psycho-social risk at work (Appendix 7).

- Implementation Plan:

8.1 The draft guideline was forwarded to the Physiotherapy Managers in Limerick, North Tipperary/ East Limerick and Clare by 14.12.15 prior to implementation.
8.2 Once agreement to implement the guideline is reached, a start date of the beginning of 4.1.16 will be set.

8.4 All involved with the implementation had the Master guideline distributed to them by the 23.12.15

- **Revision and Audit**

An essential part of the risk assessment process for physiotherapy managers is to implement the changes needed to eliminate or reduce risk of stress in the workplace. Once you have completed all stages of the Cycle of Stress Management you should have an improved environment for your staff to best fulfil your duties and roles.

9.1 By the end of the initial period of implementation (4.1.15 to 31.3.15), compliance with the PPPG and the outcome was audited. (See Appendix 6)

9.2 The desired outcome was:

- A proactive, inclusive and standardised process for all physiotherapy managers in identifying, preventing, supporting and reviewing stress in the workplace using the workplace stress risk assessment form. actions/controls are completed
- Evaluate a percentage of physiotherapists attending the Stress Control program 1) before and after MBI outcome (Maslach et al 2015) 2) Send a questionnaire post program using a Likert scale (1 to 5) to ascertain if this program was beneficial to the participants?
- To evaluate attendance at work (sick leave), the number of therapists leaving active work (resignations, career leave, maternity leave), the productivity of each therapist by number of contacts and the number of reported incidents in the first quarter. (2014, 2015 and 2016)

9.3 The outcome was measured by
(a) The actions/controls that were devised by each team from their risk assessment are carried out e.g. evidence of team/network meetings, discussion of stress as a team topic, information provision on shared folder.

(b) The feedback from the percentage of physiotherapists who attended the stress control program – was it beneficial? including their MBI outcomes (before and after)

(c) Measure 1) absenteeism rates 2) numbers of therapists leaving active work (resignations, career leave, maternity leave), 3) productivity levels (average contacts per therapist) 4) Number of incidents reported for the first quarter in 2014, 2015 and 2016. How do these figures compare each year?

(d) Feedback from the relevant personnel implementing the guideline was gathered to inform the process (Circulated with the audit tool).

The guideline will be reviewed in October 2016 and any procedure or supports will be amended based on the feedback from the participating physiotherapy managers and stress control participants.

References


Appendix 1

Cycle of Stress Management

- Identify and eliminate the source of risk hazards (stressors) - this involves effecting change
- Prevent unhealthy stress with risk assessment and using the appropriate tools
- Support and Assistance by the HSE
- Monitor and Review - an essential part of the risk assessment process for managers is to implement the changes needed to eliminate or reduce the stressor
Health & Safety Risk Assessment Form

Ref: CF:013:00

RE: Workplace Stress Risk Assessment Form

Issue date: October 2015

Review date: October 2017

Author(s): National Health & Safety Function, ERAS, HR and Organisational Psychology Unit, HR, HSE West

Legislation: Under Section 19 of the Safety, Health and Welfare at Work Act, 2005 and associated Regulations, it is the duty of the employer to identify the hazards and assess the associated risks in the workplace. All risk assessments must be in writing and the necessary control measures to eliminate or minimise the risks documented and implemented

Notes:
- It is the responsibility of local management to implement any remedial actions identified
- To assist in carrying out the risk assessment, guidance on completing a Workplace Stress Risk Assessment is included
- Work related stressors are grouped into Management standards – i.e. demands, control, support, relationships, role, change
- OQR010 - Developing and Populating a Risk Register Best Practice Guidance
- See also HSE Policies and associated guidelines: Prevention and Management of Stress in the Workplace; and Preventing & Managing Critical Incident Stress

Workplace Stress: Risk Assessment Form – Part 1 of 3

<table>
<thead>
<tr>
<th>Administration Area:</th>
<th>Source of Risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Primary Risk Category:</td>
</tr>
<tr>
<td>Section/Ward/Dept:</td>
<td>Secondary Risk Category:</td>
</tr>
<tr>
<td>Assessment type:</td>
<td>Tertiary Risk Category:</td>
</tr>
<tr>
<td>Individual</td>
<td>Group</td>
</tr>
</tbody>
</table>
### Workplace Stress: Risk Assessment Form – Part 2 of 3

Was there a specific issue/incident that triggered this risk assessment?

<table>
<thead>
<tr>
<th>Potential work related stressors</th>
<th>Employee’s concerns</th>
<th>Existing controls/What is happening now?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demands</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is causing you to feel under excessive pressure at work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are key aspects of your role/ job description?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you clear on service priorities? How do you prioritise your daily work duties?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you clear on work deadlines and are they realistic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel you have the right skills &amp; knowledge to do your job?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you the resources you need to do your job?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you find your work boring or repetitive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you clear about who does what in your Dept/area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do I, as your manager, give you enough guidance &amp; support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have opportunities to develop your skills/ use your initiative?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you any flexibility in when you take your breaks/Annual Leave?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there good communication in your Dept/area? e.g. One-to-one meetings with manager/ team meetings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are your work colleagues supportive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Do you require further training / skills development?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Are there pressures outside work that are affecting you at work?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Would you like support to deal with these pressures?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Are you aware of HSE employee supports available? Do you need information on how to access any of them?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Workplace Stress: Risk Assessment Form – Part 2 of 3 (Continued)**

### Relationships

| **Are there any issues or tensions within your team/service?** |
| **Have you seen any bullying/harassing behaviour in your team?** |
| **Do you have difficulty working with anyone? Manager/colleague/other health care worker?** |
| **Do you and your work colleagues support each other?** |
| **What is morale like within your team?** |

### Role

| **Do you feel you have been properly inducted into your role?** |
| **Do you understand your role?** |
| **Do you have a clear reporting structure?** |
| **Do you know what is expected of you at work?** |
| **Have you work demands that are outside/conflict with your role?** |

### Change

<p>| <strong>Is there a lot of change in your service?</strong> |
| <strong>Have you had an opportunity to discuss/comment on these changes within your service – e.g. at team meetings?</strong> |
| <strong>Am I, as your manager, supporting you enough in this change?</strong> |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do your colleagues/team provide support through the change?</td>
<td></td>
</tr>
<tr>
<td>Is there further information/support you require?</td>
<td></td>
</tr>
<tr>
<td><strong>Other Stressors</strong></td>
<td></td>
</tr>
<tr>
<td>Are there any other issues that you would like to raise?</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: **Information Sheet – Stress risk factors at work**

The factors at work which can create a risk of stress and other health problems are well-known. They are referred to as psychosocial risks. Some other guides to work-related-stress or psychosocial risk assessment might present them slightly differently or use a slightly different emphasis but, in general terms they can be summarised as:

- **Excessive demands** - Excessive demands or conflicts in the working environment.
- **Lack of personal control** - Having inadequate say over how work is done
- **Inadequate support** - Having inadequate support from managers or co-workers
- **Poor relationships (including harassment)** - Being subjected to unacceptable behaviours - including harassment or violence
- **Role conflict or lack of clarity** - Not understanding roles and responsibilities
- **Poor management of change** - Not being involved and informed in organisational changes

These factors can act together. For example, it is recognised that a person is more likely to experience stress due to high demands when they have little control over how they meet those demands.

Appendix 4 HSE Risk Assessment of Occupational Stress

Appendix 5: Three key themes from local focus group (relationships, need for respect/acknowledgement and coping mechanisms)
HSE Workplace Stress Flowchart

Employee at work reports symptoms of stress

Arrange to meet employee.
Identify risks using HSE Management Standards Checklist.

You receive a Medical Cert stating that employee is off work due to stress

Note: Follow guidelines in HSE Managing Attendance Policy.
Make contact with employee & arrange suitable time/place/way to discuss sick leave e.g. phone/visit.

If stress symptoms are work-related:

Following risk assessment, identify solutions with employee & complete Action Plan.
Agree implementation & review timeframe.
Make employee aware of employee support(s) e.g. Staffcare/EAP/Occupational Health.
Implement actions.
Meet regularly & monitor situation.
Readjust actions if necessary & agree if readjustments are temporary/permanent.
If symptoms persist, refer employee to Occupational Health.

If stress symptoms are not work-related:

Advise/encourage employee to visit their GP or self refer to Occupational Health/Staffcare/EAP Service
Keep in regular contact with employee and agree actions required
When employee returns to work, meet regularly & monitor situation
If symptoms persist, refer employee back to Occupational Health.

If stress symptoms are work-related:

Make employee aware of employee support(s) e.g. Staffcare/EAP/Occupational Health.
Invite employee to meet you, identify risks using HSE Checklist.
If you require professional advice, consult with Occupational Health who can assist with risk assessment.
Following risk assessment, agree Action Plan with employee.*
On return to work, meet regularly, monitor situation & readjust actions, if necessary.
If symptoms persist or you require additional guidance, consult with Occupational Health.
*Refer to HSE Rehabilitation policy
Appendix 7

Role of Occupational Health and Safety in Managing Stress and Psychosocial risk at work:

Occupational Health (OH) provides a confidential independent advisory service whose role is to provide impartial advice regarding fitness to work to line managers, aimed at assisting employees to regain their good health and return to a suitable job as soon as their recovery allows. It is a preventative service not a treatment service and it is not a substitute to attending your GP. There is a therapeutic component to the employee/occupational health interactions. The OH knowledge of the work place positions OH in providing guidance to employees and management in certain cases. It is perceived by employees as another form of support or a second opinion.

Counselling is available through the Employee Assistance (support). Physiotherapy Managers and physiotherapists can refer/self-refer directly to the Employee Assistance Support Service without the requirement to refer to Occupational Health first-essentially the services are independent of each other. The Employee Assistance support service may be needed when problems become too much for a person to handle and so affects their happiness, relationships, performance at work and health. Counselling/support is about helping people gain a new awareness and to make positive change which helps them grow in personal development.

- OH assesses the employee’s fitness to engage with management to complete the Workplace Stress Risk Assessment Checklist (Appendix 1) in the case where an employee is certified unfit for duty and stress is cited on the sickness certificate.
- Assess medical fitness to work
- If appropriate advises on a phased return to work
- Access: 1. Physiotherapy Manager may refer an employee out of concern when-a) an employee presents with symptoms of stress or b) an employee submits a sick certification citing stress
- 2. Employees may self-refer *
  *Typically, when an employee contacts Occupational Health Department, they are encouraged to inform their manager, even if the stress is from factors outside work. It will be explained if the manager is unaware of their perceived difficulties, then they cannot be expected to help to find a solution. Employees are advised to contact the employee assistance support services and attend their GP if deemed appropriate.
**Confidentiality:** At the end of an assessment with OH, the doctor or nurse will make a determination of the employee’s fitness for work. The doctor or nurse may make recommendations about ‘reasonable accommodations’ to management. The individual’s personal, social and medical history and examination findings are not disclosed as part of the OH report except rarely, and even then, only with the expressed written consent from the employee. Medical information will only be disclosed to management with employees consent and if it is relevant to the employee’s health and safety at work.

Employee Assistance support service records are kept separate from HR, Medical or OH records and accessed only by the counsellor/therapist. The service will not reveal issues discussed by an employee or their attendance without their written consent. However, if a manager refers an employee he/she ONLY have the right to know if the employee has attended. Confidentiality will be maintained except in the following circumstances.

- Where an employee discloses the intention to harm self or others
- Where an employee discloses the intention to commit a crime or a crime has been committed
- Where ordered by a court of law
- Where mandatory reporting is required under legislation

**Role of the employee’s General Practitioner (GP)/Family Doctor:**

Although stress is not an illness it can cause illness. If the employee has symptoms of stress, presents in a crisis, or has psychological ill health it is the role of the employees GP to manage the employee from a medical perspective.
Appendix 8

Audit tool for Guideline on Managing Stress in Primary Care Physiotherapy Services (PHYMW012)

• Is the guideline on managing stress in primary care physiotherapy service’s implemented with your team? Yes □ No □

• If the guideline is implemented was it an agenda item for a team meeting? Yes □ No □

• Do you have a current health and safety statement? Yes □ No □

• Do you manage a current risk registrar? Yes □ No □

• Do you have a risk assessment on stress in the workplace/occupational stress? Yes □ No □

• Where is this risk assessment stored- please tick as appropriate? Health and Safety statement □ Risk Registrar □ if other Please specify_____________________________

• Did the Workplace stress risk assessment form (Appendix 1) inform your risk assessment? Yes □ No □

• Have you carried out any individual stress risk assessments using this form? Yes □ No □

• What did your team score as in risk? Low □ Medium □ High □

• How many control measures or actions did you identify on your workplace/occupational stress risk assessment? ________

• How many of these control measures/actions remain outstanding? ________

• Has stress management been an agenda item for discussion with your team? Yes □ No □

• Have the team been informed of supports and information on stress management? Yes □ No □

• If so, how were they informed?_____________________________

• Where is the information kept?_____________________________

• In the future would you be prepared to release staff to attend a stress control program or other (e.g. mindfulness) Yes □ No □

• Do new staff receive an induction? Yes □ No □

• Do all the physiotherapists have the option of regular supervision? (every six weeks minimum) Yes □ No □
• Do you hold monthly team meetings with minutes/actions? Yes □ No □
• Do your team hold any other regular meetings (outside of the Primary care clinical
team and business meetings)? Yes □ No □
  If yes, please specify_________________________________

Thanks!
Appendix 12

Maslach Burnout Inventory scores

<table>
<thead>
<tr>
<th>MBI n=19</th>
<th>Emotional Exhaustion</th>
<th>Depersonalisation</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>27 or over</td>
<td>13 or over</td>
<td>39 or over</td>
</tr>
<tr>
<td>Moderate</td>
<td>17-26</td>
<td>7-12</td>
<td>32-38</td>
</tr>
<tr>
<td>Low</td>
<td>0-16</td>
<td>0-6</td>
<td>0-31</td>
</tr>
<tr>
<td>Before</td>
<td>19.8 (Moderate)</td>
<td>6.5 (Moderate)</td>
<td>40.2 (High)</td>
</tr>
<tr>
<td>intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Maslach et al., 2015)
### Data for Primary Care Physiotherapists

#### Appendix 13

<table>
<thead>
<tr>
<th>N=19</th>
<th>Male or Female</th>
<th>Male=2 (10.5%)</th>
<th>Female= 17 (89.5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>30-39 = 12 (63%)</td>
<td>40-49 = 6 (32%)</td>
<td>50+ = 1 (5%)</td>
</tr>
<tr>
<td>Status</td>
<td>Married= 15 (79%)</td>
<td>Single= 3 (16%)</td>
<td>Divorced = (5%)</td>
</tr>
<tr>
<td>Children</td>
<td>Yes= 12 (63%)</td>
<td>No= 7 (37%)</td>
<td></td>
</tr>
<tr>
<td>Place of Residence</td>
<td>City= 7 (37%)</td>
<td>Rural= 12 (63%)</td>
<td></td>
</tr>
<tr>
<td>Work Experience (Range of years 4-20, Mean is 15.6 years)</td>
<td>4-10 = 8 (42%)</td>
<td>11-20=6(32%)</td>
<td>21-30=5(26%)</td>
</tr>
<tr>
<td>Do you cover number of PCTs?</td>
<td>1 PCT= 6 (32%)</td>
<td>2 PCT’s= 9 (47%)</td>
<td>3 PCT’s or regional = 4 (21%)</td>
</tr>
<tr>
<td>Do you have an overwhelming workload?</td>
<td>Yes=10 (53%)</td>
<td>No= 9 (47%)</td>
<td></td>
</tr>
<tr>
<td>Do you have an overwhelming patient load?</td>
<td>Yes=10 (53%)</td>
<td>No= 9 (47%)</td>
<td></td>
</tr>
<tr>
<td>% of patient contact</td>
<td>60-69=4 (21%)</td>
<td>70-79=8 (42%)</td>
<td>80-89 = 5 (26%)</td>
</tr>
<tr>
<td>% of total administration</td>
<td>5-10=2 (11%)</td>
<td>11-20=3(16%)</td>
<td>21-30=10 (56%)</td>
</tr>
<tr>
<td>Do you have a poor work environment?</td>
<td>Yes = 2(16%)</td>
<td>No= 16 (84%)</td>
<td></td>
</tr>
<tr>
<td>Do you ever postpone contact with patients?</td>
<td>Yes=5 (26%)</td>
<td>No= 14 (74%)</td>
<td></td>
</tr>
<tr>
<td>Do you exercise regularly?</td>
<td>Yes=5 (89%)</td>
<td>No=14 (11%)</td>
<td></td>
</tr>
<tr>
<td>Do you take a break/’time out’ 1-2 per day?</td>
<td>Yes=17(89%)</td>
<td>No= 2(11%)</td>
<td></td>
</tr>
<tr>
<td>Number of working hours per week</td>
<td>14-18.5= 4(21%)</td>
<td>27.5-35=5 (26%)</td>
<td>37 = 10 (53%)</td>
</tr>
</tbody>
</table>
### Appendix 14

**Questions to the physiotherapists**

<table>
<thead>
<tr>
<th>Questions to Physiotherapists</th>
<th>Before (10.10.16)</th>
<th>After (31.3.16)</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do you have an overwhelming workload?</strong></td>
<td>Yes=10 (53%) No=9 (47%)</td>
<td>Yes=8 (42%) No=11 (58%)</td>
<td>↓<strong>workload by 11%</strong></td>
</tr>
<tr>
<td><strong>Stress Control only</strong></td>
<td>Yes=5 (50%) No=5 (50%)</td>
<td>Yes=3 (30%) No=7 (70%)</td>
<td>↓workload by 20%</td>
</tr>
<tr>
<td><strong>Do you have an overwhelming patient load?</strong></td>
<td>Yes=10 (53%) No=9 (47%)</td>
<td>Yes=5 (26%) No=14 (74%)</td>
<td>↓<strong>patient load by 26%</strong></td>
</tr>
<tr>
<td><strong>Stress Control only</strong></td>
<td>Yes=5 (50%) No=5 (50%)</td>
<td>Yes=2 (20%) No=8 (80%)</td>
<td>↓<strong>patient load by 30%</strong></td>
</tr>
<tr>
<td><strong>Do you have a poor work environment?</strong></td>
<td>Yes=2 (16%) No=17 (84%)</td>
<td>Yes=2 (16%) No=17 (84%)</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Do you ever postpone contact with a patient?</strong></td>
<td>Yes=5 (26%) No=14 (74%)</td>
<td>Yes=5 (26%) No=14 (74%)</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Do you exercise regularly?</strong></td>
<td>Yes=17 (89%) No=2 (11%)</td>
<td>Yes=17 (89%) No=2 (11%)</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Do you take a break or ‘timeout’ 1-2 times per day?</strong></td>
<td>Yes=17 (89%) No=2 (11%)</td>
<td>Yes=17 (89%) No=2 (11%)</td>
<td>No change</td>
</tr>
</tbody>
</table>
# Appendix 15

The focus group themes applied to the stress management policy

<table>
<thead>
<tr>
<th>Themes</th>
<th>Achieved in the PPG</th>
<th>Elements</th>
<th>Where in the PPG?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationships</strong></td>
<td>√</td>
<td>Identify stressors</td>
<td>7.1.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Converse with manager and peers</td>
<td>7.14 and 7.1.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular meetings</td>
<td>7.2.10</td>
</tr>
<tr>
<td><strong>Need for respect and</strong></td>
<td>√</td>
<td>Self-managing stress</td>
<td>7.1.5</td>
</tr>
<tr>
<td><strong>acknowledgement</strong></td>
<td></td>
<td>Equitable work distribution</td>
<td>7.2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Role clarity</td>
<td>7.2.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relating organisational change</td>
<td>7.2.6</td>
</tr>
<tr>
<td><strong>Coping Mechanisms</strong></td>
<td>√</td>
<td>Healthy lifestyle</td>
<td>7.1.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employee support, Occupational health, stress control</td>
<td>7.2.13 and 7.2.14</td>
</tr>
</tbody>
</table>
### Maslach Burnout Inventory (Health Services Score)

**Categorisation: The average rating per subscale (Maslach et al. 2015)**

<table>
<thead>
<tr>
<th>Index</th>
<th>Emotional Exhaustion</th>
<th>Depersonalisation</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High (H)</strong></td>
<td>27 or over</td>
<td>13 or over</td>
<td>39 or over</td>
</tr>
<tr>
<td><strong>Moderate (M)</strong></td>
<td>17-26</td>
<td>7-12</td>
<td>32-38</td>
</tr>
<tr>
<td><strong>Low (L)</strong></td>
<td>0-16</td>
<td>0-6</td>
<td>0-31</td>
</tr>
</tbody>
</table>

### Stress Control group: numbers in bold and *

<table>
<thead>
<tr>
<th>Physio Number</th>
<th>Emotional Exhaustion</th>
<th>Depersonalisation</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
<td>Before</td>
</tr>
<tr>
<td>1*</td>
<td>33 H</td>
<td>24M</td>
<td>11M</td>
</tr>
<tr>
<td>2*</td>
<td>30H</td>
<td>33H</td>
<td>17H</td>
</tr>
<tr>
<td>3</td>
<td>21M</td>
<td>27M</td>
<td>5L</td>
</tr>
<tr>
<td>4</td>
<td>43H</td>
<td>14L</td>
<td>18H</td>
</tr>
<tr>
<td>5*</td>
<td>16L</td>
<td>9L</td>
<td>6L</td>
</tr>
<tr>
<td>6</td>
<td>12L</td>
<td>7L</td>
<td>2L</td>
</tr>
<tr>
<td>7</td>
<td>16L</td>
<td>24M</td>
<td>0L</td>
</tr>
<tr>
<td>8</td>
<td>22M</td>
<td>23M</td>
<td>9M</td>
</tr>
<tr>
<td>9</td>
<td>40H</td>
<td>34M</td>
<td>9M</td>
</tr>
<tr>
<td>5*</td>
<td>0L</td>
<td>3L</td>
<td>0L</td>
</tr>
<tr>
<td>11</td>
<td>19M</td>
<td>12L</td>
<td>5L</td>
</tr>
<tr>
<td>12</td>
<td>8L</td>
<td>14L</td>
<td>3L</td>
</tr>
<tr>
<td>13*</td>
<td>10L</td>
<td>2L</td>
<td>0L</td>
</tr>
<tr>
<td>14*</td>
<td>35H</td>
<td>22M</td>
<td>7L</td>
</tr>
<tr>
<td>15*</td>
<td>14L</td>
<td>6L</td>
<td>1L</td>
</tr>
<tr>
<td>16*</td>
<td>8L</td>
<td>6L</td>
<td>2L</td>
</tr>
<tr>
<td>17</td>
<td>12L</td>
<td>26M</td>
<td>5L</td>
</tr>
<tr>
<td>18*</td>
<td>7L</td>
<td>4L</td>
<td>7L</td>
</tr>
<tr>
<td>19*</td>
<td>31H</td>
<td>21M</td>
<td>16H</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>19.8M</td>
<td>16.4L</td>
<td>6.5M</td>
</tr>
<tr>
<td><strong>Standard Deviation (SD)</strong></td>
<td>12.3</td>
<td>10.4</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Variance (SD)</strong></td>
<td>150.1</td>
<td>107.4</td>
<td>32.4</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>16</td>
<td>14</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 17

Mean MBI scores

The stress control group scores (Mean)

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>18.4 (M)</td>
<td>12.9 (L)</td>
<td>↓5.5</td>
<td>↓30%</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>6.7 (M)</td>
<td>5 (L)</td>
<td>↓1.7</td>
<td>↓25%</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>41.4 (H)</td>
<td>44.1 (H)</td>
<td>↑2.7</td>
<td>↑6.5%</td>
</tr>
</tbody>
</table>

Maslach Burnout Inventory (MBI)
Variation in subscales
The entire team scores (Mean)

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>19.8 (M)</td>
<td>16.4 (L)</td>
<td>↓3.4</td>
<td>↓17.2%</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>6.5 (M)</td>
<td>5.4 (L)</td>
<td>↓1.1</td>
<td>↓17%</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>40.2 (H)</td>
<td>42.6 (H)</td>
<td>↑2.4</td>
<td>↑6%</td>
</tr>
</tbody>
</table>

122
## Appendix 18
The stress management policy audit tool
Compliance

<table>
<thead>
<tr>
<th>Team</th>
<th>Audit tool compliance (n=13)</th>
<th>Number of controls</th>
<th>Number of controls outstanding</th>
<th>Level of Risk</th>
<th>WRS used for an individual?</th>
<th>Risk Assessment on risk registrar?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team A</td>
<td>13=Y</td>
<td>10</td>
<td>0</td>
<td>Medium</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Team B</td>
<td>13=Y</td>
<td>3</td>
<td>3</td>
<td>Medium</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Team C</td>
<td>13=Y</td>
<td>13</td>
<td>3</td>
<td>Medium</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Team D</td>
<td>12=Y 1=N</td>
<td>10</td>
<td>10</td>
<td>Medium</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Total</td>
<td>51/52 (98%)</td>
<td>36</td>
<td>16/36 (44%)</td>
<td>Medium (100%)</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix 19
Top three things that worked well from the Likert feedback

<table>
<thead>
<tr>
<th>Question 5 What are your top three things that worked well for you on the stress control programme? Level 2 and Level 3</th>
<th>Top Items</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sleep Hygiene</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Learning about stressors, physiological link between stress and body</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>PT’s using techniques with their own clients</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Clarity of presenter</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Beneficial carry over to personal life</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Relaxation CD and relaxation techniques</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Breathing techniques and grounding</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Controlling negative thoughts</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>The progressions and the last session ‘tying up’ all the information</td>
<td>1</td>
</tr>
</tbody>
</table>
### Appendix 20

Three things that didn’t work from the Likert feedback

<table>
<thead>
<tr>
<th>Question 6: What are your <strong>three things</strong> that <strong>did not</strong> work so well for you on the stress control programme? Level 2 and Level 3</th>
<th>Items that didn’t work</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The 1.5 hour class was delivered in 1 hour (Rushed)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Too much material – a lot covered, very theoretical</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Warm environment – near a building site</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Poor time slot of 2.30 pm as people had to travel</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Initial distractions in first 10/15 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No relaxation practical</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Not very interactive</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Absence of handouts in advance and use of slides.</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix 21

The Reduction of Burnout and Stress
For Primary care Physiotherapists by proactive stress management

Introduction & Background
Burnout and stress are the number one occupational reasons for absenteeism in Europe, contributing to 50-60% of lost work days.1

Burnout results in:
• Increased physical illness
• Reduced engagement and vitality at work
• Reduced communication and withdrawal from people
• Increased costs to the Health Service from staff absenteeism and poorer patient care and clinical outcomes.

This project endorsed predicting burnout, matching the interventions to the stressors directing the intervention not only at the individual but the organisation.

The proactive stress management systems implemented in the Mid-West Primary care physiotherapy (PT) service. The policy included a workplace stress risk assessment.

Aims & Objectives
Aim:
To reduce burnout and stress for primary care PTs by implementing a local stress management policy including stress control (SC). This goal will be achieved by predicting burnout with the NBI tool2, assimilating focus group themes into the evidenced policy and enabling PTs to go to stress control classes.

Objectives:
• To reduce burnout by 10%
• The PT’s to attend 90% of classes
• Policy uses all focus group themes
• Ensure compliance of PT managers
• Reduce absenteeism by 30%