LEAFLET

PREVENTION AT SOURCE OF WORK-RELATED PSYCHOSOCIAL RISKS IN NURSE AND HEALTHCARE ASSISTANT JOBS

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LEAFLET

PREVENTION AT SOURCE OF WORK-RELATED PSYCHOSOCIAL RISKS IN NURSE AND HEALTHCARE ASSISTANT JOBS IN THE PRIVATE HEALTHCARE SECTOR TO REDUCE MENTAL HEALTH PROBLEMS

An approach with a gender perspective based on scientifically and socially grounded knowledge

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1.
WORK-RELATED PSYCHOSOCIAL RISKS

What are they?

In the field of occupational risk prevention, the term work-related psychosocial risks is used to refer to **working conditions arising from deficiencies in the design, organisation, and management of work for which there is sufficient scientific evidence demonstrating their potential to harm health**. They are termed psychosocial because they affect workers through psychological pathways (i.e., various psychological mechanisms), while their origin is social, and therefore modifiable, namely, the design, organisation, and management of work. Research to date indicates that **several aspects of labour management practices – such as staffing levels, the duration and variability of working hours, work methods, job design, employment arrangements, and wage structures – are modifiable occupational determinants that lie at the origin of work-related psychosocial risks and are critical to avoid and mitigate them.**

The Occupational Risk Prevention Act (**Law 31/1995, LPRL**) recognises that work-related harm can arise from more than just physical hazards such as machinery, substances, premises, or installations. It also acknowledges that the way work is designed, managed, and organised can have a significant impact on workers' health and well-being. Accordingly, the Act establishes that preventive action must address not only physical working conditions but also organisational factors. The law states that working conditions capable of causing harm, and therefore subject to preventive action, include "*all characteristics of work, including those relating to its organisation and arrangement*" (Article **4.7.d**).

The Regulation on Prevention Services (**Royal Decree 39/1997, RSP**) recognises Psychosociology as a mandatory discipline (Articles **18.2.a and 34.c**).

For nearly two decades, the World Health Organization (WHO) has defined psychosocial occupational risks as **social determinants of health**, given the extensive and high-quality scientific evidence on the health-related problems attributable to exposure to such risks. This evidence is based on longitudinal studies and complex analyses of large datasets that reliably

rule out chance and other non-occupational factors. Examples from this body of literature include systematic reviews and meta-analyses linking work-related psychosocial risks to highly prevalent health conditions such as **anxiety and depression**, **myocardial infarction**, and **stroke**. More recently, associations have also been identified with **suicide** and **suicidal ideation**, as well as with the use of **psychotropic medication** and **analgesics**. These risks are also considered among the most significant causes of more proximal health effects, such as **(chronic) work-related stress**, burnout **syndrome**, **sleep disturbances** or **fatigue**, and sickness-related **absenteeism** and **presenteeism**. They are likewise associated with an increased likelihood of certain types of **musculoskeletal disorders**.

Research has shown that exposure to psychosocial risks varies significantly by **occupational class and gender, resulting in unequal health outcomes**. These disparities arise because labour management practices are not applied uniformly across the workforce, even within the same organisation. Consequently, psychosocial risk assessments must present results disaggregated, at a minimum, by job or groups of jobs (Article 4.1, RSP) and by sex (Article 5.4, LPRL; Article 27, LOIEMH), in accordance with the applicable legal requirements.

How to address them?

From an occupational risk prevention perspective, **work-related psychosocial risks** are the harmful **exposures** that must be **avoid** or **assessed** in the workplace, and subsequently **reduced or eliminated combating them at source**. The source of these risks lies in **deficiencies in the design, organisation, and management of work**, which must be **addressed in order to eliminate, reduce, or control harmful exposure**. The resulting effects may include work-related stress, burnout syndrome, anxiety, depression, cardiovascular **disease**, and other health disorders associated with work-related psychosocial risks.

To illustrate this distinction, scientific evidence shows that **quantitative demands** are work-related **risk factor**, whereas **high quantitative demands** constitute the psychosocial risk itself, as they are associated with a 23% increase in the likelihood of diagnosed depression. **Depression** is the **resulting health outcome, arising from a combination of factors that may include working conditions characterised by excessive quantitative demands**. Preventive action at workplace level should therefore focus on addressing the risk at its **source** by reducing **workload** through measures such as increasing **staffing** levels, improving organisational **processes**, or modifying **materials and technology**.

From an occupational health and safety perspective within an organisation or institution, **work-related psychosocial risks are harmful working conditions and direct causes of adverse health outcomes. Their underlying source—deficient labour management practices—is modifiable through organisational preventive measures**. Most researchers studying the relationship between work-related psychosocial risks and health conclude that reducing these risks requires **organisational change, particularly improvements in workplace management practices, thereby decreasing the proportion of disease attributable to work. For example, it has been estimated that 30.6% of depression cases among women in Spain could be prevented if exposure to certain work-related psychosocial risks were eliminated.**

The most recent joint guidance issued by the World Health Organization (WHO) and the International Labour Organization (ILO) on addressing **mental health in the workplace**, together with the ILO's latest global report, advocate the same approach: prioritising the **prevention of work-related psychosocial risks through the implementation of organisational measures**. Such measures can also **facilitate employees' return to work following sickness absence** and help prevent relapse, as workers would return to a work environment in which the **unhealthy employment and working conditions** that may have contributed to their illness **had been addressed**. Furthermore, by ensuring healthy working conditions from a psychosocial risk perspective, organisations lay the foundations for a more **inclusive workplace**. Individuals living with mental health conditions

or cardiovascular diseases can therefore be employed in work environments that support, rather than undermine, their health and well-being.

This approach is also **required by the Occupational Risk Prevention Act** (Law 31/1995), which establishes that **preventive action should prioritise to avoid risks (Article 15 (a)) or evaluating them and addressing risks at the source (Articles 15 (b and c)) by modifying the design, organisation, and management of work in order to eliminate or reduce occupational risks. Furthermore, the Act requires work to be adapted to the individual through organisational measures (Article 15 (d))**, including changes to job design, the selection of equipment, and working and production methods.

Furthermore, the legislative framework views prevention as a sociotechnical process in which the **participation** of management, workers, and their legal representatives is a fundamental requirement. The **scientific and technical expertise provided by occupational risk prevention professionals** (Article 38.2, LPRL) complements the practical knowledge and **experience of management, workers, and their representatives**. Both forms of knowledge are essential to the preventive intervention process. Their active involvement is also a prerequisite for effective prevention since management and labour are ultimately the ones with the ability to take decisions and implement changes within the organisation or institution.

The Act strengthens the role of workers' representatives by granting them rights to **information**, **prior consultation**, and the submission of **proposals** on any matter that can affect workers' health and safety. This specifically includes issues relating to technology, work organisation, and production processes. Furthermore, where an employer rejects proposals put forward by workers' representatives, the employer is required to provide a **reasoned justification** for that decision. This obligation promotes meaningful dialogue and **negotiation** throughout all stages of the preventive process (**Articles 14, 18, 33, 34, and 36, LPRL**).

The New Corporate Makeover: Are You Going to Fall for It?

The current trend is to train workers to become more resilient, offer tai chi or yoga classes to help them relax and improve their emotional well-being, or organise marathons, excursions, and barbecues to improve workplace morale. Some organisations even pay professionals to spend a few hours listening to workers whose problems are said to "come from home." Yet none of these activities eliminates work-related psychosocial risks or addresses them at their source. They may be negotiated as "social measures" if desired, **but such initiatives do not change the fact that workers may still be expected to perform more work than can reasonably be completed within working hours, forcing them either to extend their working day or to work at an unsustainably high pace. Nor do they resolve situations in which workers do not know how much they will earn each month under part-time contracts or are unable to predict their work schedules because the notice given for frequent changes is inadequate. The underlying causes of work-related psychosocial risks remain unchanged, and the risks themselves are not being prevented.** This is the new occupational health industry: **the mental health commercial boom.**

Resilience training provides a clear example. It is often based on the idea that people cannot choose what happens to them, but they can choose how they respond. They are encouraged to develop optimism, maintain a sense of humour, and adapt to circumstances—in other words, to resign themselves. The principal criticism of resilience-based approaches is that they **require workers, as individuals, to assume responsibility for managerial decisions and systemic or organisational failures, and to do so with a smile**. Numerous studies, particularly in the healthcare sector, have examined such interventions and concluded that techniques based on relaxation, mindfulness, resilience, and similar approaches have no measurable effect on mental health outcomes such as depression, anxiety, and stress.

What this approach does achieve is avoiding any challenge to existing workplace management practices, **transforming mental health disorders that originate in working conditions into a matter of individual responsibility and public health. In doing so, it leaves untouched ways of designing, organising, and managing work that may be harmful to health while remaining economically profitable. As the ILO and WHO have argued, improving mental health in the workplace requires first addressing employment and working conditions**, reshaping labour management practices to promote **decent work that is fairer, more democratic, and therefore healthier**. There is extensive experience in this area, as reflected in sectoral collective agreements, national and regional social dialogue agreements, and company-level agreements, both within and beyond the field of occupational health. This is a cross-cutting issue, and further progress is needed with greater urgency and ambition.

2.
PREVENTING AT SOURCE WORK-RELATED PSYCHOSOCIAL RISKS IN NURSE AND HEALTHCARE ASSISTANT (HAS) JOBS IN THE PRIVATE HEALTHCARE SECTOR

Some of the most prevalent **work-related psychosocial risks** in the healthcare sector were selected. In the sections that follow, a list of the **prevention recommendations** is presented. They are the ones that achieved the greatest consensus during a **co-creative** dialogue between **scientific knowledge** (summarised in the literature review document available **here**) and the **experience-based insights of 140 healthcare workers employed in two predominantly female nursing roles: nurses and healthcare assistants (HCAs)**. This process was carried out through a series of five one-day workshops held in Barcelona, Madrid, Palma, Sevilla and València.

These recommendations **are intended to guide** occupational health and safety professionals, management, workers' representatives and the workers themselves in private healthcare jobs **towards healthier ways of designing, managing, and organising work in the nurse and healthcare assistant jobs**.

IDENTIFY THE RECOMMENDATIONS FOR AVOIDING, REDUCING OR ELIMINATING PSYCHOSOCIAL WORK-RELATED RISKS IN NURSE AND HEALTHCARE ASSISTANT (HCA) JOBS IN THE PRIVATE HEALTHCARE SECTOR.

High Quantitative Demands

This work-related psychosocial risk is defined as an imbalance between the volume of work and the time available to complete it. It can manifest in the form of excessive workloads, time pressures, fast work pace, and/or extended working hours. It is also associated with other psychosocial work-related risks, including high role conflict arising from the inability to meet professional standards; low levels of co-worker support due to insufficient time to help colleagues; and extended workdays leading to increased work-family conflict.

Guidance on avoiding, reducing or eliminating high quantitative demands

1. Establish **minimum staffing ratios for each professional group on every shift**, considering the **number** and **complexity** of patients in each unit, to ensure that **services** are delivered on **time** and to the required **standard**. **Ensure** that a sufficient number of staff are **present on every shift**.

2. **Immediately cover for staff who are absent due to exercising their rights** (reduced working hours, holidays, daily/weekly breaks, sick leave, leaves of absence, etc.) with permanent staff to ensure the continuity of the service.

3. **Include time** in the workload for **sharing information** with the next shift (in addition to the information provided in writing).

4. **Distribute tasks and workloads based on sound planning** in terms of **quantity, quality, work times** and **rest times. To that end, avoid unilateral imposition by management and encourage participatory planning, creating multidisciplinary working groups**. The entire staff of the unit/department must take part in these groups on a rotating basis, so that frontline staff are involved in **reaching a consensus** on task planning and workload distribution. **Verify the suitability of the planning** at least **once a month** through a participatory process. **Allocate time for this during the shifts** of the workers involved at any given time.

5. **Limit administrative tasks** to those that are strictly necessary.

6. **On every shift, ensure that interdisciplinary backup teams** comprising permanent staff are in place to deal with **unforeseen events**.

7. Use a participatory process to **prioritise criteria for unforeseen events** (see point 4 for details).

8. **Eliminate "loophole" clauses** that allow tasks outside the scope of one's professional group – usually in a lower category – to be assigned, which increases the daily workload (e.g., staff in HAS jobs performing cleaner's job tasks).

9. Implement a participatory process to develop a **clear description of the tasks to be performed by each professional group and job and make them available to everyone within the organisation**. This also promotes role clarity. **Set up an ad hoc working group involving frontline staff (see point 4), alongside their legal representatives and management.**

10. **Shorten shift lengths**, avoiding 12-hour shifts, particularly in units where workloads never decrease and intensive care units (ICUs); the minimum shift length should not be less than 6 hours.

11. **Hire more staff** across all categories (nurses, healthcare assistants, porters) to work during **peak hours; these additional staff members should not work split shifts or shifts that are less than six hours**.

12. Ensure **the availability of sufficient supplies and up-to-date technology by planning for maintenance and systematic procurement** to guarantee operational readiness.

13. **Implement an onboarding protocol with paid on-the-job training. Allocate time** during the workday of those involved in onboarding on each shift and provide substitutes to cover the trainers' normal workload.

High Emotional Demands

This work-related psychosocial risk is defined as the need to avoid becoming emotionally attached to or involved in the situations arising from the interpersonal relationships inherent to the work, particularly in service provision jobs, which may entail a transfer of feelings and emotions. In the healthcare sector, these interpersonal relationships often take place in difficult, traumatic circumstances involving suffering, bereavement and, at times, aggression. Dealing with such situations also requires expressing emotions which are sometimes not genuinely felt towards patients and their families. These demands can also arise from ethical dilemmas when professional standards cannot be met due to a lack of human and material resources (role conflict).

Guidelines for avoiding or reducing high emotional demands

1. Reduce exposure to these demands by: a) **setting limits** on the **number of patients to be cared** for (reducing staff-to-patient ratios and ensuring ratios consider both the number of patients and the complexity of their cases, in light of the emotional demands involved); b) increasing **breaks**; and c) **rotating between tasks that are more and less emotionally demanding**, with the agreement of staff and following the appropriate training (e.g., alternating between inpatient care, day hospital duty and outpatient consultations).

2. **Provide specific training** during working hours to facilitate the **acquisition and development of emotional management skills** (emotional control to balance over-involvement and indifference, assertiveness, coping with situations of suffering and trauma, supporting family members, etc.). Ensure that there are enough staff members scheduled and physically present to make it possible.

3. **Institute mandatory paid breaks** (20 minutes) following a life-threatening emergency or death to allow for **emotional recovery. Ensure that there are enough staff members scheduled and physically present** to make it possible.

4. **Improve communication systems for patients and their families** (posters, information screens, emails, etc.) regarding actual **waiting times**, the severity of cases and other matters that may help to reduce their hostility towards the staff, particularly those in triage and reception.

5. **Introduce a daily multidisciplinary clinical handover meeting for the unit, involving doctors, nurses and HCAs** (to discuss care plans and the condition of patients and staff).

6. **Work in pairs** to foster mutual functional support and prevent emotional and physical vulnerability. This is essential when dealing with patients who have a history of aggression and during night shifts.

7. **Establish a protocol of actions to be taken by all staff** (colleagues and supervisors) in the event of **conflicts and violent incidents** involving external individuals or patients. Develop this through direct group participation (see how under the "limited control" section).

8. **Establish an internal protocol for resolving interprofessional conflicts**, developed through direct group participation (see how under the "limited control" section).

9. Make sure there is an **on-duty supervisor to relieve staff members who are emotionally overwhelmed**.

10. Organise **therapy groups during working hours** and include these in the workload.

11. **Ensure sufficient staffing levels to perform the work** to a **professional standard, reduce the number of** emotionally **complex patients**, and facilitate **in-service training** on managing emotions, breaks for emotional recovery, **clinical sessions and therapy groups, without overburdening other colleagues.**

12. **Offer individualised psychological support on demand**.

13. **Hire security staff** so that healthcare staff do not have to deal with theft or non-pathological aggression from patients, or aggressive conduct from people external to the hospital, such as relatives or intruders.

14. **Keep records** of workplace incidents or assaults.

High Work-Family Conflict and High Job Insecurity

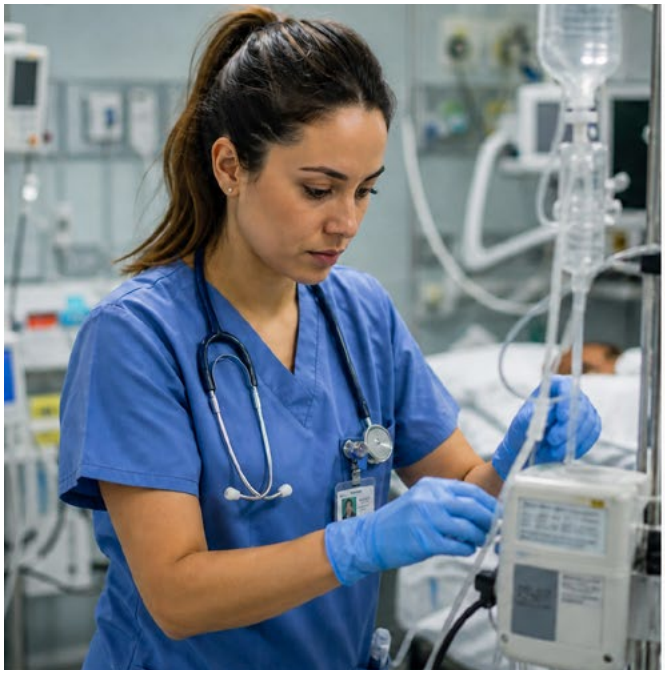
High work-family conflict is defined as the negative impact of work demands on the time and energy required for unpaid domestic and caregiving responsibilities at home (double burden), as well as the need to respond simultaneously to the demands of paid work and care responsibilities at home (double presence). High job insecurity is defined as a lack of stability in fundamental working conditions, particularly working hours.

Guidelines for avoiding, reducing or eliminating high work-family conflict and job insecurity

1. **The work schedule should include actual working days, start and finish times, weekly days off, public holidays and annual leave**. It should be **fixed** but should also **allow workers to swap shifts in writing**. All aspects of the work schedule must be communicated annually. Involve workers' representatives in the drafting of the work calendar.

2. Publish the **calendar** during the **fourth quarter of the year for the next year**.

3. **Schedule workers** (shifts, days off, etc.) considering their **needs** according to their **stage of life** (age, family responsibilities and other factors), following prior **consultation with the entire workforce**, the results of which must be made public. However, avoid **consistently assigning** unsociable daily or weekly schedules or excessive working hours to **younger staff** or those **without family responsibilities**. Allow workers' representatives participation in these assignments and always include these criteria in the algorithmic management of working hours.



4. Give workers **control** over the specifics of their **reduced** working hours (hours per day, full days, which days, etc.).

5. **Ensure there are sufficient staff on duty to avoid changes to working hours**. When planning daily staffing levels, consider the volume and complexity of the workload on each shift, including the emotional strain. Take holidays and days off into account in the annual schedule and use the experience from prior years to estimate the staff needed to cover sick leave, leaves of absence, employer-approved days off, labour union leave, and similar absences.

6. Establish a clear **policy for unavoidable schedule changes and how workers will be compensated**, whether or not the changes count as overtime, irregular hours, or additional hours, and whether or not they are voluntary. This policy should cover **changes announced at least 24 hours in advance, rotating** assignments across the workforce in alphabetical order, written **shift swaps** between workers, payment of a **premium for each additional hour** (usually **double** the normal rate, which increases to **triple** if the change involves working at the weekend or on a public holiday); **compensatory time** for excess working hours which is accumulated and **taken every three months, at the worker's discretion**.

7. **Eliminate the use of "time banks"** which create uncertainty regarding working hours and income for **part-time** workers.

8. **For unfilled absences, set and apply a surcharge (triple the rate) to each hour worked by colleagues who must assume the workloads of their unfilled colleagues.**

9. **Eliminate split shifts across all services; all shifts should be continuous and at least six hours long.**

10. Introduce the role of the "shift swapper" (if it does not already exist) and **staff this job with personnel to cover the reduced working hours of other colleagues.**

11. **Recruit students to work weekends and public holidays**, offering financial incentives. This gives staff with family responsibilities more time off, while accommodating the different needs of these groups who are at different stages in their lives.

12. **Respect digital disconnection and daily and weekly time off**. No work-related WhatsApp messages should be sent to staff outside of working hours.

Low Control

This work-related psychosocial risk is defined as the inability to influence one's work, the lack of autonomy over how the work is carried out, and limited opportunities to apply technical skills and knowledge derived from experience, or to learn new ones whilst performing the work.

Guidance to avoid, reduce or eliminate lack of control

1. Foster **delegative direct participation in groups**:

    a. Rather than authoritarian supervision that ignores staff proposals, or a *laissez-faire* approach ("you'll sort it out yourself"), set up **multidisciplinary working groups** in which the **entire staff** of the unit/department participates on a **rotating basis during working hours**. This way, **frontline staff** can decide reaching a consensus on task **planning**, distribution of workloads and monthly **reviews**, work **processes**, job **descriptions** for the various jobs and professional groups, the protocol for **resolving conflicts** with patients and their families, prioritisation to deal with unforeseen events, **onboarding** protocols, etc. This avoids unilateral imposition by management and gives staff greater control. It is very important to **allocate** protected **time** (an average of **two hours per week**) as part of the workloads of those involved at any given time so that no additional burden is placed on them or their colleagues. In a heavily overburdened workforce, this means increasing staff numbers to cover for workers as they take part in these activities alongside their usual duties. Participating in these decision-making groups can also reduce other risks, such as the emotional demands arising from ethical or professional conflicts (role conflict), increase professional recognition and control.

    b. **Self-organised teams:** Provided there is duly recorded consensus, multidisciplinary teams should be allowed to redeploy staff between areas within the same department based on the actual workload at any given time (e.g., in emergencies, staff can be moved from quieter areas to those under greater pressure). This measure can only be implemented once the issues of high quantitative demands and work-family conflict have been addressed.

2. Develop **consultative direct participation in groups**. For example, hold monthly meetings lasting between **1 and 2 hours** during which those in charge of each unit **listen to staff concerns** and hear their suggestions for improvement. The **agreed solutions** are then **implemented** to assess their effectiveness. It is very important to allocate time to participate during the worker's shift.

3. **Train managers in participatory methods:** Train managers in participatory leadership to avoid authoritarianism or unilateral standardisation, and in fair team management so that they act as a source of support rather than mere monitors, and to avoid favouritism and arbitrary decisions. Method: learn-by-doing.

Low Support

This work-related psychosocial risk is defined as a lack of practical assistance from colleagues and superiors in carrying out work when it is needed.

Guidance to avoid, reduce or eliminate low support from colleagues

1. **Ensure that staff are scheduled and on duty** for the time required to foster mutual support among colleagues (see specific measures under "High quantitative demands").

2. Encourage **teamwork** (see specific measures under "Low control") or, at the very least, **work in pairs**.

3. **Facilitate participation in multidisciplinary meetings** to foster support from other professional roles (see specific measures under "Low control").

4. Develop and implement an **onboarding protocol based on paid on-the-job training** for new hires and set aside **time** during the workday for **mentors** and staff who cover their usual duties.

5. **Eliminate discretion to avoid favouritism** (see examples in the preceding and following sections).

6. **Train managers in fair team management:** Train managers in fair team management so that they act as a source of support rather than mere monitors, and to avoid favouritism and arbitrary decisions, and in participatory leadership to avoid authoritarianism or unilateral standardisation. Method: learn-by-doing.

Low Recognition

This risk is defined as low pay, low professional regard and unfair treatment resulting from arbitrary management decisions.

Guidance to avoid, reduce or eliminate lack of recognition

Ensure fairness:

1. **Transparent career progression website:** Publish all promotion and transfer opportunities on a general platform that clearly states the application requirements.

2. Develop separate **procedures** for **promotions and transfers** that **clearly** state the training, length of service and other **requirements**, and allow the workers' legal representatives to be involved.

3. **Include workers' legal representatives in selection processes** (interviews and assessments).

4. **Standardise leave time rules: Publish and distribute**, in a transparent manner, **workers' rights as regards leaves of absence** and other types of leave so that they do not depend on the approval of people in middle management roles.

5. **Develop and publish standards for the assignment of salary supplements based on meeting targets, productivity, etc.**, including workers' legal representatives in the process.

6. **Eliminate individual salary agreements.**

7. Apply standard, fair criteria for **assigning workloads, working hours, public holidays, schedule changes, etc.**, as discussed in the previous sections on high quantitative demands and work-life conflict.

Increase compensation:

1) **Increase base salaries** across all categories.

2) **Increase career progression supplements** in the nursing and healthcare assistant (HCA) categories. Reduce the large gap between their supplements and those of medical staff.

Enhance professional recognition:

1) **Use participatory methods and ensure that time is set aside during the workday**: develop forms of delegative and consultative direct participation in groups during working hours (see measures under "Low control").

2) **Avoid personnel management practices based on the threat** of dismissal in response to complaints or the **disregard for workers' professional judgement** as a result of process standardisation or authoritarianism.

3) **Implement the recommendations in this document** to avoid or reduce work-related psychosocial risks across different jobs and to eliminate or reduce shortcomings in the design, management and organisation of work to create a healthy workplace, which means putting the focus on nurses and healthcare assistants.

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