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A mixed method research project, investigating healthcare professional's perception of the worth of participating in an 8-week Mindfulness-Based Stress Reduction programme, and the perceived correlation it has with increased work satisfaction and ability to self-manage stress within the working environment.

By Deirdre Congdon

Master of Arts in Human Resources Management

National College of Ireland

Submitted to the National College of Ireland, August 2017

Abstract

Work-related stress, burnout and compassion fatigue are an increasing concern for healthcare professionals within their working environment. In order to combat the onset of work-related stress, burnout and compassion fatigue it is necessary for both management and employees to take responsibility for identifying resolutions to address these concerns. The Mindfulness Based Stress Reduction (MBSR) programme is one strategy which has been introduced and researched in order to equip healthcare professionals with the appropriate tools and techniques to assist them in coping with and striving to overcome these issues. The research pertaining to this concept is predominantly quantitative thus presenting a gap in the literature as there is no exploration of participant perceptions of or beliefs about the benefits of engaging in the MBSR programme.

Participants coping strategies and level of work satisfaction are the focal points of this dissertation. A cross-sectional approach was taken in which a mixed method survey was developed and distributed to participants of a recent MBSR programme facilitated in Organisation X. The data was analysed using both descriptive and thematic analysis. The findings of this research project support the literature, that completion of the MBSR programme introduces additional adaptive coping strategies which participants find useful in both personal and professional stressful situations. The findings indicate that the MBSR programme leads to a greater sense of work satisfaction, participants commented that they are better equipped with techniques to self-manage themselves within their work environment. In addition it was identified that there is limited understanding of the MBSR programme amongst participants prior to engagement.

Whilst changes in stress levels were not captured, the findings in this research are advantageous as they provide an indication of the benefits which can be gained from participating in the programme and support the continuation of the MBSR programme in Organisation X. The limitations of this project and recommendations for future research are set out.

Dissertation Declaration

Name: Deirdre Congdon

Student Number: 13109502

Degree: Master of Arts in Human Resources Management

Material submitted for award

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(b) I declare that all verbatim extracts contained in the dissertation have been distinguished by quotation marks and the sources of information specifically acknowledged.

(c) My dissertation will be included in electronic format in the College Institutional Repository TRAP (thesis reports and projects).

(d) I declare that no material contained in the dissertation has been used in any other submission for an academic award.

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Acknowledgements

I would like to thank Ursula Bates, Senior Counselling Psychologist, and David Shannon, Principal Clinical Psychologist, for their support. I would like to extend my thanks to Dr. Philip Hyland, Senior Lecturer, for his time and guidance throughout this process.

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List of Abbreviations

MBSR: Mindfulness-Based Stress Reduction

ESRI: Economic and Social Research Institute

CSO: Central Statistics Office

CIPD: Chartered Institute of Personnel Development

HSE: Health Service Executive

TILDA: The Irish longitudinal study on ageing

NCHD: Non-Consultant Hospital Doctor

IMO: Irish Medical Organisation

QNHS: Quarterly National Household Survey

UK: United Kingdom

CSI-SF: Coping Strategies Inventory – Short Form

SWWS: Satisfaction with Work Scale

HSCP: Health and Social Care Professionals

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Introduction

Employment industries are encountering complex challenges as a result numerous changing circumstances, for example; demographics, economics, service demand, globalisation etc. In order to overcome these challenges an expectation has been placed on employees to identify new ways to work in order to increase efficiency and productivity. Coinciding with these increased pressures, the subjects of work-related stress, burnout and compassion fatigue have been brought to the fore (Eurostat, 2009; Zeller & Levin, 2013; Central Statistics Office (CSO), 2016; Chartered Institute of Personnel Development (CIPD), 2016). Work-related stress has been defined as "*when a person perceives the work environment in such a way that his or her reaction involves a feeling of an inability to cope. It may be caused by perceived / real pressures / deadlines / threats / anxieties within the working environment"* (Health & Safety Authority, 2016; p. 6). In a report issued in 2009, 14% of employees in Ireland reported experiencing work-related stress at least once throughout their career (Eurostat, 2009).

Research suggests in comparison to other employment industries those working in the healthcare sector are more inclined to experience work-related stress, burnout or compassion fatigue at some stage in their career (Marianetti & Passmore, 2009; Slocum-Gori, Hemsworth, Chan, Carson & Kazanjian, 2011; Russell, Maitre & Watson 2016). The literature explains burnout as a human response to continuous exposure to emotional and interpersonal workplace stressors and is categorised into inefficacy, fatigue and pessimism (Maslach, Schaufeli & Leiter, 2001; Maricutoiu, Sava & Butta, 2016). Compassion fatigue has been described as a response to stress as a result of the emotional cost of caring, this has led healthcare professionals to abandon their work whilst there are patients in their care. This emotional response can lead employees to isolation, confusion and feelings of helplessness (Slocum-Gori, et. al., 2011). The literature confirms that the experience of work-related stress, burnout and compassion fatigue can have a direct impact on patient care. This impact can result in decreased empathy with patients, increased medication errors and a reduction in treatment adherence.

The research also indicates that turnover of staff as a result of experiencing one of the aforementioned issues has a direct impact on patient care as it results in a lack of continuity of care and a gap in workforce resources pending recruitment of replacement healthcare professionals (Fortney, Lutcherhand, Zakletskaia, Zgierska & Rakel, 2013).

In 2013, the Health Service Executive (HSE) launched the 'Healthy Ireland' framework. The framework recognises employees as an essential component to the success of the healthcare system therefore introducing a variety of health and wellbeing initiatives to promote wellness at work (HSE, 2013). In response to increased reports of work-related stress, burnout and compassion fatigue a variety of health initiatives have been introduced nationally to promote health and wellbeing. Research has been conducted on the effectiveness of Mindfulness-Based Stress Reduction (MBSR) programmes on healthcare professionals with regards to developing coping mechanisms which can prevent the onset of work-related stress, burnout and compassion fatigue (Fortney, et. al, 2013). The MBSR programme introduces participants to mindfulness and to a variety of techniques to assist with the self-management of stress; it also supports participants through this process (Irving, Dobkin & Park, 2008; Hulsheger, Alberts, Feinholdt & Lang, 2013; Zeller & Levin, 2013).

The research regarding this concept is predominantly quantitative in nature therefore there is limited research which details participant perceptions of and beliefs about the benefit of engaging in the MBSR programme. This presents a gap in the literature which the researcher wished to explore. The objectives of this research project are:

1. To achieve an in-depth understanding of healthcare professional's perception of the MBSR programme and the reasons they choose to participate.
2. Gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopt through the use of the MBSR techniques within the work environment.
3. To identify and explore how participants perceive participation in and completion of the MBSR programme has impacted their level of work satisfaction.

Literature Review

The Healthcare Profession

The healthcare industry is one of the largest employers in Ireland incorporating various professions from medical practitioners, nursing professionals, administration and domestic staff to health and social care professionals (HSCP), such as Occupational Therapists, Physiotherapists, Social Workers etc. (CSO, 2017). The healthcare profession is unique in nature as it entails complex work-related stressors in comparison to other employment industries. Healthcare professionals are required to achieve and maintain a high standard of technical skill, with the necessity to remain up to date with research to ensure that both clinical practice and judgement is both informed and safe in line with best practice (Zeller & Levin, 2013).

The current services provided by the health sector are becoming increasingly difficult to access as a result of reduced budgets, lack of workforce engagement and decreased student interest and participation (Fortney, et. al., 2013; Smith, 2014). This has resulted in increased pressures on healthcare professionals within the working environment as their workload continues to increase as patients' needs become more complex, alongside the requirement to maintain a high standard of knowledge to provide quality care to patients within an ever-changing healthcare environment (Smith, 2014). In addition to attending to and supporting the needs of sick and dying patients, healthcare professionals also offer emotional support to patients families and continuously coordinate and engage in heavy administration for the purpose of care plans and to inform the metrics by which the industry is heavily monitored. These duties are classed as unique stressors as they are performed in an environment composed of emotional distress and loss (Bazarko, Cate, Azocar & Kreitzer, 2013; Zeller & Levin, 2013).

There is an ever-increasing demand for healthcare services throughout the country. The Irish longitudinal study on ageing (TILDA) (2013) published a report identifying various factors which influence the utilisation of healthcare services. The findings of the TILDA report are significant for future healthcare service planning as national changes in demographics suggest there will be a continued increase in the demand for healthcare services (McNamara, Normand & Whelan, 2013).

The predominant contributing factor to this is the increase in the national age population which has resulted in an estimated 79% increase in demand for residential care services between 2006 and 2021 (Layte, Barry, Bennett, Brick, Morgenroth, Normand, O'Reilly, Thomas, Tilson, Wiley, & Wren, 2009; Conefrey, Lawless & Linehane, 2014). Despite this estimated increase in demand for healthcare services, the workforce population has decreased by 8% since 2007, thus resulting in increased workloads and job demands for existing staff (Department of Health, 2015).

The unemployment rate in Ireland consistently fell between the 1990's and 2006, in 2006 the national unemployment rate was 4.3%. However, as a result of the economic downturn the unemployment rate increased to 12.5% in 2009 and to its highest in 2012 at 14.2% (CSO, 2016). Throughout this period many organisations across all industries engaged in downsizing and an expectation was placed on employees to identify new working efficiencies to enable increased productivity within a shorter time frame and by a smaller cohort of staff (Zeller & Levin, 2013). In turn, employer expectation and employee perception of the work environment altered. Due to the fear of unemployment, workers began to execute more tasks on a day to day basis with access to less resources (Rossy, 2013).

In recent years, the unemployment rate has continuously decreased reaching its lowest point in almost a decade, recorded at 6.2% in April 2017 (CSO, 2017). However, whilst nationally the unemployment rates have decreased, in the absence of sufficient supply, there is an ever-increasing demand to recruit and retain healthcare professionals. The healthcare industry is coming under increased pressure to respond to growing service demands placing increased pressure on the current cohort of staff to work at a faster pace, for example; in January 2017, there was a record high of 612 patients on trolley's awaiting admission to hospital for treatment (Pollak & Clarke, 2017).

The last year has witnessed an increased level of work dissatisfaction and disengagement within the healthcare industry particularly amongst nursing, medical and domestic professionals. A tense industrial relations climate developed in 2016 throughout the health sector in response to perceived staff shortages, increased work demands and access to increased pay and restoration of allowances (Wall, 2016; RTE, 2017; Irish Medical Organisation (IMO), 2017).

Strike action within the health sector would lead to cancellation and postponement of procedures, increased waiting lists and further increased numbers of patients on trolleys awaiting medical treatment. Following the intervention of the Workplace Relations Commission the industrial action did not proceed. Throughout the negotiation period the HSE advised that the cost of additional incentives requested to recruit and retain nursing professionals alone would be an estimated €180,000,000 per annum (RTE, 2017). Whilst the total cost for the restoration of the living-out allowance for Non-Consultant Hospital Doctor's (NCHD) has not yet been confirmed, it has been confirmed that this will entitle each NCHD to an additional €3,193 gross salary per annum (IMO, 2017). The impact this increased cost is likely to have on recruitment, work satisfaction and role engagement of healthcare professionals is unknown and therefore an accurate prediction of the health sector workforce in the coming years cannot be concluded.

The above literature details the continued increase in demand for healthcare services and the decreased level of workforce engagement. Given the conflicting position of healthcare services in contrast to that of staff engagement levels it is imperative staff are equipped with the right resources to assist them in maintaining a reasonable standard of work satisfaction and to develop coping strategies which will assist them in responding to the increased pressures they are experiencing within the work environment.

Work-related Stress, Burnout and Compassion Fatigue

Work-related stress, burnout and compassion fatigue have been brought to the forefront in recent years with a greater national awareness of mental health and an increased focus on employee wellbeing, promotion of work-life balance and satisfaction within the work environment. The promotion of wellness at work has been found to have a direct impact on efficiency, staff engagement and productivity levels (CIPD, 2016). Work-related stress, burnout and compassion fatigue have a direct financial impact on organisations as they can lead to absenteeism, presenteeism, staff turnover, loss of productivity and work-related injuries. Research recognises that workplace stressors can be as a result of a variety of factors; environmental, interpersonal or role specific (Zeller & Levin, 2013).

The Economic and Social Research Institute (ESRI) identified health sector employees as one of the most likely group of workers to suffer from stress, anxiety or depression as a work-related illness (Russell, Maitre & Watson, 2016). Numerous contributory factors can lead to this, for example; long working hours, shift work, increased job demands and the level of skill and attention to detail required to ensure optimum patient care, manage challenging behaviour of patients, managing family expectations etc. (National Institute of Occupational Safety and Health, 2009: Irving, Dobkin & Park, 2009; Marianetti & Passmore, 2009; Zeller & Levin, 2013). Whilst this ESRI report presents interesting findings, it is important to note that the data was gathered from the Quarterly National Household Survey (QNHS), the QNHS gathers data by requesting participants to disclose personal information, thus there is a possibility of self diagnosis. Therefore further research is required to ensure the data is both valid and reliable (Russell, et al., 2016).

Statistics released in 2013 confirmed the Irish health sector lost an average of 4.7% of working days at a cost of €176,500,000 due to absenteeism over a 12 month period (Department of Public Expenditure and Reform, 2013). More recent reports issued by the HSE disclose less detail on percentage rates of absence and causes for absenteeism however it has been documented that there was a drop in the absence percentage figure in 2015 to 4.19%, with an overall national target of 3.5% set throughout the sector (HSE, 2015). Following an extensive review of the absenteeism statistics available in Ireland there is limited statistical evidence which details the causes and percentage rates of workforce absences on an annual basis however a research study identified work-related stress as the most commonly reported occupational illness amongst nurses (Bernal, Campos-Serna, Tobias, Vargas-Prada, Benavides & Serra, 2015). Similarly, Eurostat released a report in 2009 which states that work-related stress was the second highest health and safety issue for organisations in Ireland and across Europe, with 14% of workers reporting that they experienced stress in the workplace (Eurostat, 2009). Whilst this report is of statistical significance regarding the reasons for workforce absenteeism, in the context of this dissertation the data is included cautiously as the report draws on information dating back to 2007.

Given the significant changes which have occurred within the economy and the challenges faced by the health sector, the figures presented in the Eurostat report are out of date and cannot be accurately applied to the current workforce therefore further research in the area is required.

A report released by Mercer in 2015 provides some guidance to employers as the findings state that 82% of employees questioned advised that they have experienced stress at work as a result of both personal and professional pressures. The quantitative study had a representative sample of 1,500 participants across Ireland and the United Kingdom (UK). The findings suggest that stress has resulted in decreased concentration, decreased work satisfaction and reduced productivity levels (O'Callaghan, 2015). This research did not focus on one employment sector in isolation, therefore further research is required in order for the findings to be generalised to the health sector. Stress has been found to have a direct impact on patient care as research has found nurses report a reduced ability to focus on their patients needs, this research also found that patients of the nurses who admitted experiencing work-related stress reported dissatisfaction with the level of care provided to them (Smith, 2014).

Similarly to work-related stress, burnout is more common within the health sector in comparison to other employment industries, with front line workers being the most likely to be exposed to experiencing this. Burnout in healthcare professionals arises as a result of continued exposure to work-related stress which can lead to reduced energy, this can be classed as a loss of emotional, mental, physical or spiritual energy. Research has shown that up to 60% of healthcare professionals have admitted to experiencing burnout at least once throughout their career (Fortney, et al., 2013). A recent quantitative study, supported by the Royal College of Physicians of Ireland, had a 55.3% response rate (1,749 medical doctors), this study found that one in three doctors reported experiencing burnout, four out of five doctors stated they had experienced work-related stress and only half of the respondents self rated themselves with a normal level of psychological wellbeing (Hayes, Walsh & Prihodova, 2017).

Research has been conducted specific to healthcare professionals regarding work-related stress and opportunities to cope with and manage stress levels within their work environment.

The research states that work-related stress within the healthcare environment is multi-factorial. Factors include; increased workload, management structures, lack of resources available, professional conflict, emotional demand of caring, supporting patients through loss, sleep deprivation as a result of shift work and reduced work-life balance (Irving, Dobkin & Park, 2009; Marianetti & Passmore, 2009; Zeller & Levin, 2013).

Compassion fatigue is a relatively new concept in the research domain, however continuous exposure to work-related stress has been found to lead to the onset of compassion fatigue in healthcare professionals. This phenomenon has been related to emotional exhausation, depersonalisation and an inability to perform effectively and efficiently in work. Similarly to stress, symptoms of compassion fatigue, such as anxiety, depression, low self-esteem, avoidance behaviours etc, build over time and have been found to result in the loss of work satisfaction, reduced quality of patient care provided, risk to patient safety and attrition levels within the health sector (Hooper, Craig, Janvrin, Wetsel & Reimels, 2010; Drury, Craigie, Francis, Aoun & Hegney, 2013).

The promotion of health and wellbeing for staff within the health sector is essential, as healthcare professionals are exposed to acute and chronic stressors within a demanding work environment. Research identifies experiencing work-related stress, burnout or compassion fatigue can have a negative impact on patient care, resulting in increased medication errors, lower treatment adherence and decreased levels of empathy with patients (Drury, et al., 2013; Fortney, et al., 2013). Therefore, the onset of symptoms as a result of work-related stress, burnout or compassion fatigue will not only impact the health and safety of the staff member, it will also have a direct impact on the health and safety of the patients in their care.

The above research demonstrates that there are multiple contributing factors to work-related stress, burnout and compassion fatigue and individual perception and coping mechanisms are key to how each of the above present and are managed. As detailed above the demand on healthcare services will continue to grow as the average population age increases. In the absence of sufficient workforce resources this is likely to lead to continued increased workload and additional pressures on existing healthcare professionals (Fortney, et al., 2013).

Whilst the elimination of work-related stress, burnout and compassion fatigue in their entirety is unrealistic, in order to ensure employee safety and optimum quality patient care is provided, it is imperative healthcare professionals are equipped with the right tools and resources to manage and combat the onset of work-related stress, burnout and compassion fatigue.

Coping Strategies

Coping strategies are the behavioural and psychological efforts individuals adopt in order to manage themselves within a situation. Efforts are adopted by individuals within stressful situations in order to minimise, reduce and tolerate stressful events. Coping is defined as a process which is receptive to changing circumstances and therefore responds to stressful situations and adapts to different contexts. Research suggests the use of adaptive coping strategies reduces the experience of burnout within healthcare professionals. The literature indicates that healthcare professionals are more inclined to experience work-related stress, burnout and compassion fatigue if they engage in disengagement behaviours such as avoidance and denial (Cheng, Kogan & Hin-man Chio, 2012; Subramanian & Kumar, 2012).

Whilst the literature pertaining to the use of coping strategies for the management of work-related stress identifies various approaches dependent on the context and environment in which the stress arises, the literature concludes that the use of coping strategies can determine the impact the stress will have on an individual (Fortes-Ferreira, Peiró, Gonzaléz-Morales & Martín, 2006). The use of coping strategies within the work environment is likely to reduce turnover, increase wellbeing and have a direct impact on patient care (Koeske, Kirk & Koeske, 1993; Holton, Barry & Chaney, 2016). In general, coping strategies have been distinguished into adaptive and maladaptive strategies. Adaptive coping is a constructive strategy, for example; use of exercise, massage, discussing the source of stress with a family member or friend, etc. Maladaptive coping is a passive strategy which can result in the use of avoidance behaviours, for example; increased food or alcohol consumption, drug use, etc. (Subramanian & Kumar, 2012). Research findings indicate that adaptive coping strategies are more influential for managing and reducing stress levels than maladaptive coping strategies.

There is no evidence to support that maladaptive coping strategies lead to reduced work-related stress unless combined with the use of adaptive coping strategies (Koeske, et al., 1993; Dewe, 2003).

Within this context, it has been stated that the promotion of adaptive coping strategies in isolation will not omit stress levels experienced by employees, rather the introduction of tools and resources which incorporate adaptive coping strategies in to the work environment are more inclined to assist employees with the self-management of stress (Holton, et al., 2016). As coping levels have been found to have a direct impact on the level of stress experienced within a given situation, research suggests that the introduction and promotion of adaptive coping strategies to the working environment can have a direct impact on the level of work-related stress, burnout and compassion fatigue experienced (O'Driscoll & Cooper, 1994; Cheng, et al., 2012; Subramanian & Kumar, 2012).

Mindfulness

Mindfulness can be classed as both an old and a new construct. Whilst mindfulness originates from Buddhist meditation practice, dating back over 2,500 years, it is in recent decades that the construct has begun to be empirically examined (Krishnakumar & Robinson, 2015). Mindfulness has been defined as the awareness which arises by purposefully paying attention in the present moment. The practice recognises that the present moment is the only moment we live in and therefore encourages practitioners to intentionally remain, non-judgmentally, aware within the present moment (Williams & Kabat-Zinn, 2011). Whilst there are a multitude of definitions for this phenomenon the core components of each definition are: the present moment, awareness and acceptance (Hede, 2010; Teper & Inzlicht, 2014; Dane, 2015).

Mindfulness is a form of mental training which encourages a person to be present with their thoughts and acknowledge them in a nonreactive way, thus leading to a greater sense of equanimity (Hede, 2010; Fortney, et. al., 2013).

The practice teaches those who regularly engage in it to focus their attention in the present moment in order to successfully perceive events as and when they occur, to regulate the mind and to allow distressing thoughts and feelings to pass by as they are fleeting in nature, thus in turn resulting in clarity, compassion and open heartedness (Anicha, Ode, Moeller & Robinson, 2012; Fortney, et al., 2013).

Kabat-Zinn (2012; 2013) makes the point that mindfulness is not a technique, rather it is a way of being. Mastering the art of mindfulness allows the practitioner to experience life as it is, in the present moment, in the absence of judgement and personal bias. The practice prevents rumination, encouraging practitioners to let go of past negative thoughts, experiences and regrets (Mars & Oliver, 2016). During the practice participants are prompted to engage with the art of mindful meditation by witnessing what is occurring in the present moment. Once this is achieved participants are encouraged to engage in the process openly, acknowledging distracting thoughts and feelings however not fixating on them, allowing them to pass by. Participants are guided in this way to inspire them to create space between thoughts and the reaction one has to them (Kabat-Zinn, 2005).

In addition to the above, the state of mindfulness has been described as an attitude which is both accepting and caring, resulting in practitioners being perceived as less defensive in nature. Research has identified broader benefits of mindfulness practice such as increased self-esteem, self-compassion, self-control, greater sense of wellbeing, a sense of equanimity and a reduction in reactivity and exposure to negative emotions (Anicha, et al., 2012; Krishnakumar & Robinson, 2015).

As a direct result of time pressures and uncertainty, dynamic work environments have a tendency to be related to high levels of emotion and stress. Scientific research on the impact of mindfulness on health and wellbeing has increased over the years. The research has identified that '*mindfulness positively relates to judgment, accuracy, insight related problem solving and academic performance. Such findings resonate with research indicating that mindfulness enhances cognitive flexibility and promotes executive functioning – qualities instrumental to performance across a range of tasks'* (Erik & Brummel, 2013: pp.106).

Research has found that mindfulness training amongst healthcare professionals reduces stress within the work environment and reconnects employees to the emotional and relational components of care (Hunter, 2017).

Mindfulness-Based Stress Reduction

The MBSR programme is an evidence based intervention beneficial for those experiencing stress. MBSR is a structured 8-week programme which incorporates mindfulness based meditation, breathwork, Hatha Yoga and other relaxation methods. The programme requires participants to attend a two hour session per week, assign 45 minutes to mindfulness practice per day and to attend a once off full day of mindfulness. The programme teaches participants that they are not defined by their thoughts and emotions (Praissman, 2008; Bazarko, et al., 2013).

The MBSR has been taught and its impact evaluated dating back to the early 1990's. The programme was taught in the Stress Reduction Clinic at the Univeristy of Massachusetts Medical Centre to more than 8,000 people over a seventeen year period. Participant outcomes were evaluated to identify the impact MBSR has had on their lives. The evaluations concluded that stress will impact humans continuously throughout their life for a variety of reasons and intensities (Santorelli, 1996). Participants of this MBSR programme acknowledged they had increased self-esteem, better understanding of themselves and of others and a deeper sense of self-trust leading to a greater ability to cope with stressful situations and interactions thus allowing the person to be more present and attentive in the moment (Santorelli, 1996). Longitudinal quantitative research conducted with 30 healthcare professionals identified engagement with the MBSR programme improved mood and decreased emotional exhaustion throughout the programme and up to 9 months post intervention. The research found that MBSR had a positive impact on healthcare professionals resulting in decreased stress levels within the work environment (Fortney, et al., 2013).

Interestingly, a study was conducted which investigated the impact of mindfulness on employees in jobs which required them to engage in regular emotionally charged encounters in their work environment (Hulsheger, et al., 2013). This quantitative study aimed to identify whether the introduction of mindfulness could reduce emotional exhaustion and increase work satisfaction.

The study was conducted in two parts, one was a five-day longitudinal study and the second was an experiment. Both components of the study identified that mindfulness led to a greater sense of work satisfaction and reduced emotional exhaustion for employees. Whilst this study is of statistical significance it is important to note that the research limitations lie in the focus of the study, it was conducted over a variety of service industries and not specifically the health sector. In addition, the research focused on emotion regulation through the use of mindfulness. The research does not provide any evidence of coping strategies or increased quality of life (Hulsheger, et al., 2013).

A mixed method research project was conducted by Wasylkim, Holton, Azar and Cook (2015) to investigate the impact mindfulness had on the effectiveness of leadership within the healthcare environment. This research identified that as a result of increased pressure in the work environment, healthcare professionals refrained from discussing personal issues regarding their own health and wellbeing as they felt it was inappropriate within the context of limited resources available to them and their colleagues.

An experimental study was conducted on trainee therapists to identify the impact MBSR can have on care-givers. This study supports the literature that healthcare professionals experience unique stressors as their roles require them to witness and support patients and families through suffering and loss causing emotional distress. The study found no changes to the control group however the findings suggest that MBSR participants detailed the benefits gained from the programme as an increase in attentiveness, awareness and self-compassion, and a decrease in levels of stress and anxiety experienced. Convenience sampling was the method used for this study as access to potential participants was cohort controlled, therefore resulting in a significant limitation as it was not possible for the researchers to screen for participant motivation which may have had an impact on their perception and experience of the programme (Shapiro, Brown & Biegel, 2007). Similarly, a qualitative study conducted by Irving, Dobkin and Park (2009) found the MBSR programme reduced stress, anxiety and emotional exhaustion in healthcare professionals.

Zeller and Levin (2013) specifically investigated the impact the use of mindfulness and MBSR can have on nursing personnel. The researchers comment on the increased sense of attentiveness amongst participants, the ability to be free from distraction and a greater ability to manage emotions in distressing situations. Whilst the study presents interesting findings relevant to this research project, it displays limitations as the findings are presented in an unstructured manner and in the absence of any reference to the validity and reliability of their findings (Zeller & Levin, 2013). The findings are included due to their relevance to this project and as a component for the basis of this research however the limitations are acknowledged.

As detailed above the MBSR programme is demanding with regards to time and the expectation that participants will continue to practice mindfulness on a daily basis. As discussed throughout this literature review, time pressures placed on healthcare professionals and their increased workload can make it increasingly difficult for them to engage in a programme of this nature. Considering this Fortney, et al., (2013) created an abbreviated version of the MBSR. Through this programme the researchers encouraged participants to view their patient interactions as a time to practice mindfulness thus incorporating it into their work environment. This research was conducted with 30 participants using 4 surveys that measured baseline and 1 day, 8 weeks and 9 months' post intervention. The data collection methods were three validated surveys focusing on work satisfaction, quality of life and compassion. The research findings indicated that an abbreviated MBSR programme can ease the onset of work-related stress, burnout and compassion fatigue through to 9 months' post intervention. These findings are significant as they suggest that short introductory programmes can have a positive effect on healthcare professionals following their successful completion of the programme. The findings of the study are concerning in relation to healthcare professionals baseline which identified high scores of emotional exhaustion and depersonalisation. Whilst there is no denying the significance of these research findings it must be noted that this research was conducted in the absence of a control group therefore further research is required on the use of an abbreviated MBSR programme and the possible impact it can have on healthcare professionals within the working environment.

Smith (2014) conducted an indepth analysis of the literature available in the area of MBSR relevant to healthcare professionals. The outcome of this analysis clearly articulates the benefits of MBSR categorised into themes of decreased stress, burnout and anxiety, improved focus and mood and increased empathy towards patients and their families in their time of need. The article identifies limitations in the research and areas for further exploration, it also confirms the findings of multiple studies and the positive impact MBSR has had on healthcare professionals within the work environment (Smith, 2014).

Whilst there is research available detailing the impact the MBSR programme can have on work-related stress, burnout and compassion fatigue within the work environment, there is minimal research conducted relevant to the impact participating in the MBSR programme can have on organisational outcomes, for example; absenteeism, productivity levels, leadership etc. (Jamieson & Tuckey, 2016). In addition, the research in this field varies regarding the length of the MBSR programmes provided to participants within the studies. Some of the research indicates that MBSR has been adapted to a shorter programme, therefore further research is required to ensure the data produced by the research is both valid and reliable. As the length of engagement with the programme varies throughout the literature, further research is required in order to identify what the minimum required level of engagement within the MBSR programme is in order for individuals to experience positive outcomes (Smith, 2014).

Research Rationale

As healthcare professionals become increasingly more pressurised due to increased organisational and service demands and a reduction in the supply of the workforce resources available, it is imperative that healthcare professionals are equipped with tools and resources which provide effective ways to cope with and manage stress within the work environment (Praissman, 2008).

Based on the researchers review of the literature there is a hypothesis made that healthcare professionals who engage in an MBSR programme will report lower levels of work-related stress, compassion fatigue and burnout and when experienced, engagement in the MBSR programme better equips healthcare professionals to reduce and manage the onset of these issues.

Whilst the available literature pertaining to this phenomenon suggests engagement in the MBSR programme will prevent the onset of work-related stress, burnout and compassion fatigue the research does not acknowledge changes to participant circumstances which may have arisen over the 8 week period.

The majority of literature available regarding this phenomenon discusses the benefits of mindfulness from a quantitative perspective. As a result this has left gaps in the literature regarding individual perceptions, thoughts and experience of engaging in the MBSR programme (Smith, 2014). As the majority of research is quantitative further investigation using a qualitative methodological approach would be beneficial in order to better understand healthcare professionals experience of the MBSR programme and the impact they feel the MBSR has had on them within the work environment.

Research Question

A mixed method research project investigating healthcare professional's perception of the worth of participating in an 8-week Mindfulness-Based Stress Reduction programme and the perceived correlation it has with increased work satisfaction and ability to self-manage stress within the working environment.

Based on the review of the literature the main objectives of this research project are to achieve an in-depth understanding of healthcare professional's perceptions of MBSR and the reasons they choose to participate in the programme and gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopt through the use of the MBSR techniques within the working environment. The researcher worked to identify how participants perceived participation and completion of the MBSR programme has impacted on their work satisfaction and explore their perception of this.

The aforementioned objectives will be explored using the following research sub-questions:

1. What are healthcare professionals perceptions of the MBSR programme and what benefits do they think it might have?
2. Are healthcare professionals better equipped with coping strategies following the completion of the MBSR programme?
3. Do healthcare professionals experience greater levels of work satisfaction upon completion of the MBSR programme?

Methodology

The volume of research conducted in the area of mindfulness and the work environment has steadily increased in the last three decades, however this has predominantly been quantitative based research (Jamieson & Tuckey, 2016). The research makes limited reference to individual perception, understanding and experience of mindfulness and the impact the use of mindfulness can have on ones' own ability to cope within the work environment. This has left gaps in the literature which the researcher wished to investigate relevant to staff participation in the MBSR programme facilitated within Organisation X.

As detailed above the research objectives of this project relate to individual's understanding and perception of mindfulness, therefore the ontological perspective of this research project is constructivism. Constructivism observes reality as a creation from one's own experience of the social world and therefore is subjective in nature (Collis & Hussey, 2009). As discussed in the literature review mindfulness is a unique experience to all individuals, therefore the epistemological consideration for this research project is interpretivism. Interpretivism differs to positivism as it claims meaning is constructed by individuals, therefore this perspective acknowledges that individuals can experience and understand the same reality in a completely different way thus resulting in the possibility of the researcher identifying a number of contradictory viewpoints as individuals construct their own understanding of the phenomenon in question (Gray, 2014; Aswathy & Gupta, 2015).

Sample

Taking in to account the time and sample access available for this study an inductive approach was deemed most appropriate. The researcher was less concerned with the generalisability of the data collated, rather the primary focus of the study was to identify whether participants of the MBSR programme in Organisation X perceive value in attending the programme and whether they feel better equipped to cope within the work environment once the MBSR is completed (Saunders, Lewis & Thornhill, 2009).

Organisation X is a healthcare facility based in Dublin with approximately 600 employees across two sites. The organisation specialises in both Care of the Elderly and Palliative Care. The organisation is staffed with a multidisciplinary team comprising of nursing staff, medical staff, HSCP, complementary therapists, domestic staff, etc. The MBSR programme was facilitated within Organisation X between February and April 2017. 15 staff members voluntarily applied to participate in the programme, interviews were conducted by the programme facilitators and 12 applicants were approved to participate in the programme. 2 participants did not complete the programme and 10 staff members completed the MBSR programme. The timeline for completion of this research project was confined and the project required participants to have engaged in the MBSR programme therefore access to an appropriate sample was limited. As a result, participants were sourced through the use of non-probability sampling (Collis & Hussey, 2009; Quinlan, 2011).

There was a 90% response rate to the survey. Gender and occupation were the demographics assessed at the outset of this survey. All participants were female and the occupational breakdown of participants was: 45% Nursing, 11% Support Services, 22% HSCP and 22% Management and Administration. The researcher recognises that whilst the sample is not representative of healthcare professionals as a whole, the sample was sufficient for the purposes of investigating the phenomenon in question within Organisation X (Quinlan, 2011).

Procedure

Prior to undertaking this project, the researcher prepared and submitted a research proposal and sought ethical approval from both the National College of Ireland and Organisation X in order to gain consent to progress with this research project.

This research project was cross-sectional in design. Whilst a longitudinal approach was the preferred research design, a cross-sectional approach was used as timelines and resources available were limited. The sample was comprised of a variety of healthcare professions i.e. nursing professionals, HSCP etc., therefore a cross-sectional study was used to enable the researcher to identify common themes which may arise across the professions (Collis & Hussey, 2009).

In addition, the MBSR programme was facilitated in Organisation X from February to April 2017, therefore the researcher did not have an opportunity to gather baseline data prior to the commencement of the programme for the purposes of having comparable data upon completion of the MBSR programme.

The researcher is a staff member of Organisation X. Due to the sensitive nature of this topic the researcher had concerns regarding confidentiality and ethical implications which may arise for participants engaging in the research project. Following careful consideration, a mixed method survey was the chosen approach for the purposes of data collation (Appendix 1). Whilst this was not the preferred method of data collation the researcher contemplated the size of the organisation and the fact that the researcher was internal, therefore it was concluded that in order to facilitate anonymous responses which allowed participants to be honest within the context of this phenomenon it was essential the researcher did not engage directly with participants.

The MBSR programme facilitators discussed this research project with participants and sought consent to contact them regarding the research project. Participants were invited to engage in this research project through the use of written invitation. In order to protect the anonymity of all participants the survey was created online using Survey Monkey. The researcher sent the survey weblink to the programme facilitators for circulation to MBSR participants (Appendix 2). The use of the weblink enabled participants to engage in the research project in the absence of having to provide any personal or identifiable information. The cover page of the survey provided a clear overview of the objectives of the project, the potential benefits and risks of participating in the research project, a confidentiality clause and contact information. Prior to accessing the survey participants were required to provide consent, in order to access the survey participants were required to select a tick box confirming they had fully read and understood the contents of the informed consent page (Appendix 3). In the event participants wished to engage in the research project however were not computer literate or they did not have access to a computer, the survey was made available to the programme facilitators in hard copy format. Two weeks after the invitation to participate in the research project was sent, participants were sent one reminder by the programme facilitators.

Ethical Considerations

As the topic in question is sensitive in nature there were several ethical considerations which needed to be addressed prior to the commencement of the research project (Collis & Hussey, 2009):

- **Participation in the MBSR programme:** all programme participants voluntarily applied to participate in the programme. This MBSR programme was facilitated by two internal Clinical Psychologists who are qualified to teach the programme. All applications were submitted directly to the Psychology department and an interview was held to ensure all participants were deemed suitable to participate in the programme safely. The researcher had no involvement in this process or in the development of the selection criterion for participants to be approved to participate in the programme (Jamieson & Tuckey, 2016).
- **Confidentiality:** as the researcher is internal to the organisation the data was collated through the use of a survey to ensure participants remained anonymous throughout the process. The data is stored on a private Survey Monkey account which only the researcher has access to. The data was printed for the purpose of analysis, this documentation is kept in a locked filing cabinet which is only accessible by the researcher. The data collated will be destroyed in a shredder and disposed of in a confidential waste bin upon receipt of grade for this research project.
- **Participation in the study:** the MBSR programme facilitators discussed this research project with the MBSR participants on the final evening of the programme, the facilitators gained verbal consent to contact MBSR participants regarding the survey. To protect the anonymity of the participants the invitation to engage in the research study was circulated by the MBSR facilitators, the invitation contained a weblink to the online survey. The survey contained a cover page providing an overview of the purpose and aims of the study to ensure participants were fully informed prior to engaging in the research project. The cover page advised participants that the survey was anonymous with a view to receiving rich, plentiful and honest data which the researcher could analyse to establish themes.

- **Right not to participate in the study:** participants of the MBSR programme were advised of their right not to participate in this research study. To alleviate any fears or pressure MBSR participants may have been feeling, the invitation to participate in the research project stated that there would be no penalization for non-participation in the study. MBSR participants were also made aware that the survey was completely anonymous and therefore did not have to feel pressurised to complete the survey in fear that the researcher may be able to identify who did / did not participate in the study.
- **Informed consent**: in order to access the survey, it was compulsory for participants to select a tick box advising they had fully read and understood the informed consent document prior to accessing the survey.
- **Sensitivity:** the topics of work-related stress, burnout and compassion fatigue are sensitive in nature therefore participants were notified that the Human Resources department, Occupational Health department, Employee Assistance Programme and Employee Wellbeing initiatives were available to them for the duration of the research project and throughout their employment.

Measures

The survey was divided in to three sections:

1. **Healthcare professional's perception of the MBSR programme**: open-ended questions were used to gain an in-depth understanding of healthcare professional's perception of MBSR and their opinion of the worth of participating in an 8-week MBSR programme. These questions were developed by the researcher upon completion of an in-depth review of the available literature.

2. **Coping strategies**: both open and closed ended questions were used to gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopt through the use of the MBSR techniques within the working environment.

The Coping Strategies Inventory - Short Form (CSI-SF) was used to collate this data. This scale has been widely validated and has a Cronbach's Alpha ranging from 0.72 to 0.94 (Cano Garcia, Rodríguez Franco & García Martínez, 2007; Addison, Campbell-Jenkins, Sarpong, Kibler, Singh, Dubbert, Wilson, Payne and Taylor, 2007). This scale asked participants to rate the frequency in which they use each of the listed coping strategies using the following responses "1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Almost Always".

The CSI-SF distinguishes coping in to two froms of approaches; engagement strategies and disengagement strategies (Addison, et al., 2007). The 16 items of the CSI-SF were analysed and separated into engagement and disengagement behaviour related phrases. In order to interpret the results accurately, recoding of the CSI-SF Likert Scale was used for the disengagement behaviour related phrases. As a result, the scale ranged from 16 (very poor coping strategies) to 80 (excellent coping strategies). The scores of each phrase were added together to identify the participant's level of coping.

The open-ended questions were developed by the researcher in order to encourage respondents to reflect on the coping strategies they use, both past and present.

3. **Work satisfaction**: in order to identify how participants perceive participation and completion of the MBSR programme has impacted their work satisfaction and to explore their perception of this both open and closed questions were used. The Satisfaction with Work Scale (SWWS) was developed based on the Satisfaction with Life Scale (SWLS) and has been used to measure participants work satisfaction. This scale is a short survey consisting of five questions focusing on individuals' wellbeing with their work and has been proven to signify levels of work-related mental health. This scale has been widely validated and has a Cronbach's Alpha of 0.87 (Bérubé, Donia, Gagné, Houlfort & Koestner, 2007). The scores of each of the 5 phrases were added together.

The total score of each participant was categorised as follows: extremely satisfied (31-35), satisfied (26-30), slightly satisfied (21-25), neutral (20), slightly dissatisfied (15-19), dissatisfied (10-14), extremely dissatisfied (5-9) (Pavot & Diener, 2008). Each category was interpreted using Pavot and Diener's (2013) explanation method (Appendix 4).

Analytical Strategy

In order to clearly illustrate the development of the survey and the analysis of the data, the quantitative and qualitative aspects of the survey are discussed separately below.

Quantitative Aspect

Two of the key objectives of this research project were to identify the coping mechanisms healthcare professionals use to self-manage stress within the work environment and to identify the level of work satisfaction they have upon completion of the MBSR programme. As there are a number of healthcare professional roles within Organisation X demographic data relevant to the working environment was collated in order to identify themes which may arise in the data relevant to any one discipline.

Descriptive analysis was used to articulate clear summaries about the sample and the data collated in order to reach conclusions. The mean, mode and standard deviation were calculated from the data collated in order to clearly articulate the findings (Saunders, Lewis & Thornhill, 2009).

Qualitative Aspect

This survey incorporated a qualitative aspect with an aim to achieve an in-depth exploration of the thoughts and perceptions individuals working within a healthcare environment have of the impact and value of engaging in the MBSR programme, and the impact they perceive it has had on them within the work environment. Open questions were used to explore participants understanding and perception of the value of participating in the programme relevant to their work environment.

Given the exploratory nature of this aspect of the study, the research was conducted through an inductive process. The inductive process observes empirical social reality allowing the researcher to explore individual thoughts and perceptions leading to the development of themes and perspectives from the data collated (Gilbert, 2008; Collis & Hussey, 2009). As this project was conducted as cross-sectional research it resulted in there being no pre-engagement data. Following a thorough review of the literature the open questions were developed to encourage participants to reflect on their thoughts, perceptions and behaviours prior to engaging in the MBSR programme. The researcher recognises that retrospective reflection is not a valid unbiased articulation of participants views prior to engaging in the MBSR programme, however the researcher wished to identify whether participants recognised a change in their own thoughts, perceptions and behaviours upon completion of the programme.

The qualitative data was analysed through the use of thematic analysis. This method of data analysis was chosen as it is particularly useful for research questions that seek to investigate an individual's understanding of a phenomenon. The use of thematic analysis identified themes and patterns in the data collated from the survey. Throughout the data analysis process the researcher was cognisant that the data could be manipulated through the use of thematic analysis depending on how the data was approached. For example, the researcher may be empathetic to the content or alternatively may be suspicious of the data, therefore it was imperative the researcher approached the data in an unbiased fashion (Quinlan, 2011; Willig, 2013).

As discussed above, the research in this field is predominantly quantitative, therefore this aspect of the data was analysed through an inductive approach identifying themes emerging from the data. This approach prevented the data being manipulated through the use of a predetermined coding and themes (Collis & Hussey, 2009; Quinlan, 2011; Willig, 2013).

Analysis of Results and Main Findings

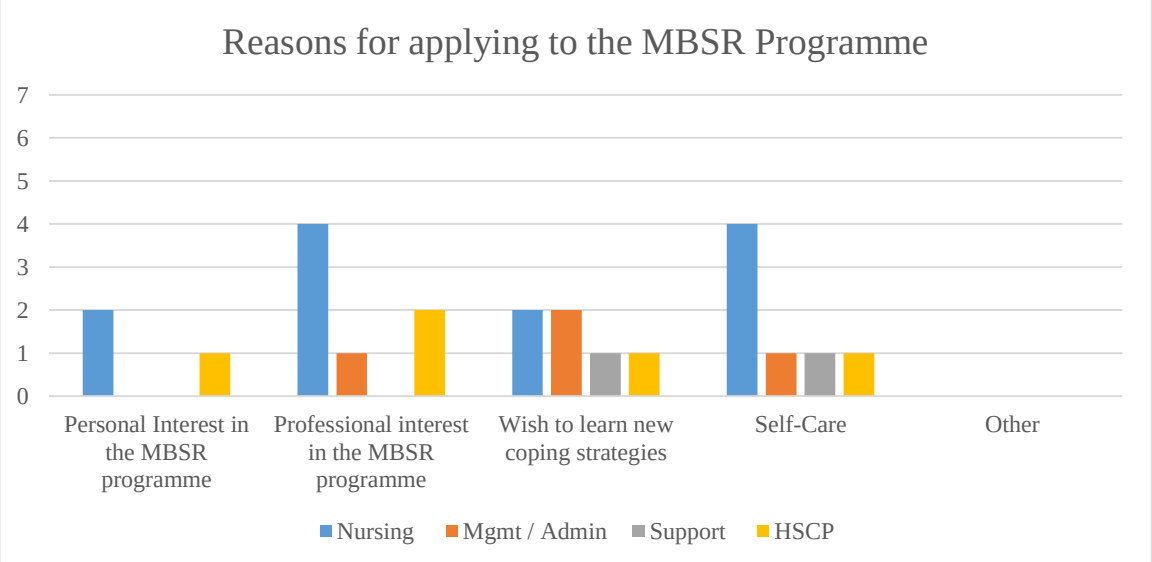
Throughout the survey each of the respondents described the benefits of engaging in the MBSR programme. Respondents detailed a greater sense of self-awareness when managing stress in both their personal and professional lives. Each of the respondents demonstrated a variation in their self-reported coping strategies pre-and post-engagement in the MBSR programme.

Some respondents disclosed that they did not feel their satisfaction within the work environment increased as the programme outcomes were personal to them, however their interactions within the work environment demonstrated improvement due to increased self-awareness. The analysis and graphs below outline the statistical data and main themes which emerged through the examination of the survey responses.

1. **What are healthcare professional's perceptions of the MBSR programme and the benefits that it may have?**

Whilst 33% of respondents had some experience of short mindfulness courses prior to participation in the MBSR programme, 22% of respondents disclosed that they had no understanding of the MBSR programme prior to engagement. The results suggest that respondents hoped to experience reduced levels of stress, relaxation and to gain greater self-awareness. Predominantly all respondents (89%) engaged in the full programme, 11% of respondents did not complete this question in the survey.

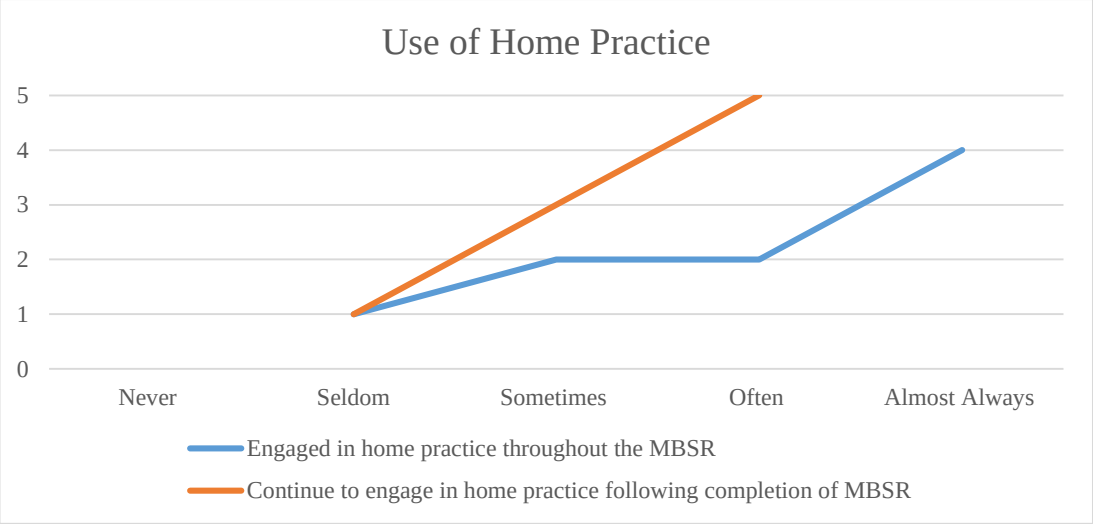
Figure 1 - Reasons for applying to the MBSR Programme



All respondents advised that the MBSR programme met their expectations, emphasising that the MBSR helped respondents to deal with stressful situations by introducing new strategies resulting in greater levels of self-management and self-awareness. Respondent 9 stated: *"learning about 'living or being in the moment' increasing moment to moment awareness, using this to assist in the reduction of stress".*

Whilst the respondents detail the benefits of using MBSR techniques the findings, displayed in figure 2 below, suggest following completion of the MBSR programme respondent's engagement with home practice techniques reduced.

Figure 2 - Use of Home Practice



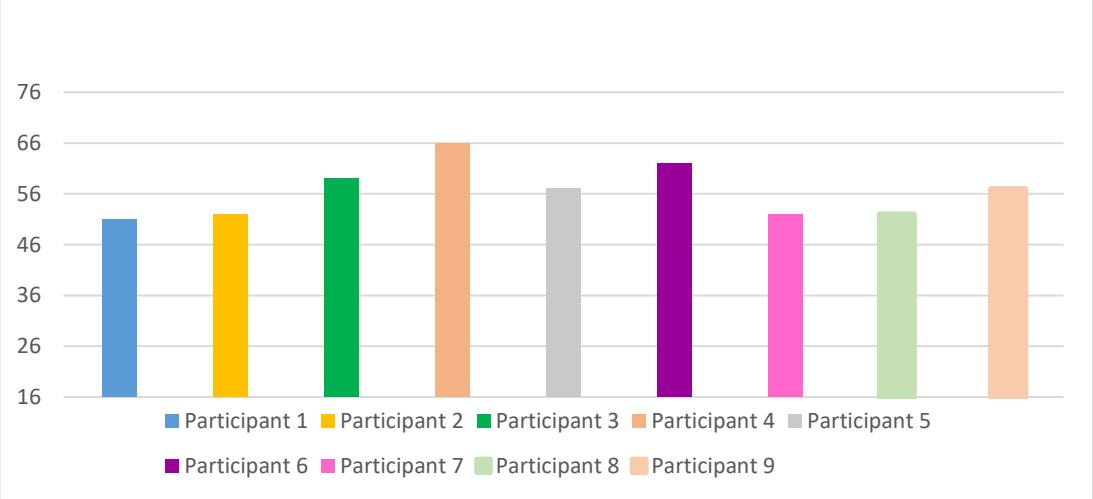
Efficiency:

A number of respondents disclosed that they now experience a greater sense of calmness resulting in a greater ability to focus on work-related tasks as they arise. Due to a self-reported increased ability to focus, respondents advised that they now feel more efficient with their work, getting more done in a shorter time frame resulting in a greater sense of accomplishment. Respondent 2: *"My concentration and focus is much clearer, when I have a heavy workload I get through the work quicker and feel a nice sense of accomplishment".*

2. **Are healthcare professionals better equipped with coping strategies following the completion of the MBSR programme?**

The range of the CSI-SF measure is 64, 16 being the lowest level of maladaptive coping versus 80 being the highest level of adaptive coping, 48 is the minimum score to indicate use of adaptive coping strategies within this measure. Amongst the 9 participants the mean self-reported use of coping strategies was calculated at 57, the minimum score was 51 and the maximum was 66. The mode was calculated at 52 and the median was 57. The standard deviation of the results was 5.22. Approximately 67% of the sample fell within one standard deviation and 100% of the sample fell within two standard deviations of the mean.

Figure 3 - Coping Strategies Inventory - Short Form



Activities to manage stress:

The results suggest following completion of the MBSR programme 100% of participants engage in adaptive coping strategies. Participants were asked to list the coping strategies they used prior to engaging in the MBSR programme, each participant listed various activities, the most predominant activities used were talking with a friend or family member and exercise. Whilst the results of the survey suggest 100% of respondents engage in adaptive coping strategies, one respondent disclosed that prior to engaging in the MBSR programme they also drank alcohol on occasions to help manage stress.

MBSR techniques to manage stress:

Following completion of the MBSR programme each of the participants referenced a shift towards utilising MBSR techniques for the purposes of coping in order to self-manage stress within the work environment. Participants referenced the use of meditation, breathing exercises, body scan technique etc. for the purposes of managing stress and experiencing a greater sense of relaxation. Respondent 9 stated: *"I manage stress in a calmer manner and hopefully other staff and service users will feel the benefit of this',* Respondent 6 stated: *"...the course provided very good accessible techniques which mostly work when practiced regularly."* and Respondent 3 stated: *"I have learnt improved ways of managing stress and that has contributed to feeling more satisfied with my work environment".* In addition to the use of MBSR techniques two participants referred to walking and reading as coping strategies they continue to use.

Self-Care:

The responses indicate there is an increased understanding of the requirement and personal responsibility of self-care within the work environment upon completion of the MBSR programme. Respondent 3 stated: *"...I am conscious that I should see where I feel stress in my body when I'm experiencing it..."*, Respondent 4 stated: *"More aware of my own self-care and that then has a more positive impact on my work."* and Respondent 5 stated: *"I am learning to be kinder to myself."*

3. **Do healthcare professionals experience greater work satisfaction upon completion of the MBSR programme?**

The range of the SWWS is 30, 5 being extremely dissatisfied versus 35 being highly satisfied. Amongst the 9 participants the mean satisfaction level was calculated at 24.89, the minimum score was 17 and the maximum was 29. The mode was calculated at 27 and the median was 25. The standard deviation of the results was 3.48. Approximately 78% of the sample fell within one standard deviation and 100% of the sample fell within two standard deviations of the mean.

Interpreting the results in line with Pavot and Diener's measurement instrument (2013) Appendix 4), the results suggest that 1 respondent's work satisfaction level is below average, 3 respondents have an average satisfaction level and 5 respondents have a high satisfaction level.

Figure 4 - Results of the Satisfaction with Work Scale – Pavot and Diener's measurement instrument

Satisfaction Level	Range	Participants
Highly Satisfied	30-35	0
High Score	25-29	5
Average Score	20-24	3
Slightly Below Average	15-19	1
Dissatisfied	10-14	0
Extremely Dissatisfied	5-9	0

Upon completion of the MBSR programme 78% of respondents advised they felt more satisfied within their work environment, respondents disclosed they now feel better equipped to seek the positives in all situations. Respondent 2 stated: *"Am more centered and happier within myself. Enjoying my working environment and my communication with my co-workers and the patients".* Some respondents (22%) advised they are neither more nor less satisfied within their work environment following completion of the MBSR programme. Respondent 6 stated: *"I don't think I am more or less satisfied with my work place but I am better able to acknowledge the positives and appropriately deal with the negatives."* In contrast to this, 100% of respondents advised they have a greater sense of work satisfaction as they feel better equipped with techniques to self-manage themselves within their work environment. References were made to a greater sense of calmness, communication and self-awareness.

Self-awareness:

Respondents suggested that they have a greater sense of self-awareness, are better equipped to seek the positives and have a greater understanding of the impact their behaviour and interactions can have on their colleagues within the work environment.

Respondent 6 advised that increased self-awareness has altered their interactions with colleagues and service users and now is more aware of the impact she can have on others, stating: *"I am also more aware of the impact of how I am on colleagues so try not to be unduly negative…".*

Respondents disclosed that they are more aware of how they experience stress within their body and discussed their new-found ability to recognise this feeling and to manage it before it has an impact on their wellbeing and environment. Respondent 7 stated: *"….it is my own ability to be aware of what is happening within me and deal with it."*

Communication:

The findings indicate that respondents feel better equipped to communicate with colleagues as they have an increased ability to remain calm and control their reactions in stressful situations. Respondent 4 stated: *"It allowed me to become aware of my reactions and to be more mindful in certain situations."* and Respondent 5 advised that "*a key learning from the programme was all individuals experience stress, the ability to now recognise this assists with self-management and interactions in stressful situations"*.

Positivity:

As a result of greater awareness respondents referred to an increased ability to acknowledge the positives in life and to better manage the negatives. Respondent 8 stated: *"I feel more positive."* and Respondent 6 stated: *"…look for strengths and positives so there is a more balanced perspective when dealing with issues."* One respondent commented that as a result of more relaxed thoughts they now experience a greater sense of physical and emotional wellbeing.

Following the review and analysis of the data collated the researcher did not identify any contrasting themes arising amongst the different professions which participated in the survey. As discussed above the themes arising throughout the responses were consistent amongst respondents regardless of their professional discipline.

Discussion and Recommendations

The majority of literature available pertaining to the concept of mindfulness discusses the benefits of mindfulness from a quantitative perspective. Based on the researchers' review of the literature there was an assumption made that healthcare professionals who engage in the MBSR programme will report lower levels of work-related stress, compassion fatigue and burnout. When these are experienced, engagement in the MBSR programme better equips healthcare professionals to reduce and manage the onset of these issues. As this phenomenon has been predominantly explored from a quantitative perspective, this research project aimed to further explore participant perceptions and experiences of the MBSR programming in order to better understand the impact healthcare professionals feel the MBSR has had on them within the work environment. The main objectives of this research project were to achieve an in-depth understanding of healthcare professional's perceptions of MBSR and the reasons they choose to participate in the programme, gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopt through the use of the MBSR techniques within the working environment and to identify how participants perceive participation and completion of the MBSR programme has impacted on their work satisfaction and explore their perception of this. The aforementioned objectives were explored using the following research sub-questions:

1. What are healthcare professionals perceptions of the MBSR programme and the benefits it may have?
2. Are healthcare professionals better equipped with coping strategies following the completion of the MBSR programme?
3. Do healthcare professionals experience greater work satisfaction upon completion of the MBSR programme?

The research findings indicate:

1. 88% of participants did not have a clear and precise understanding of the MBSR programme prior to engagement, however 78% of respondents applied to participate in the programme for the purposes of self-care and 67% of respondents wished to gain new strategies for coping.

2. The MBSR programme introduces new alternate adaptive coping strategies which participants find useful in stressful situations, in both a personal and professional context.
3. The MBSR programme leads to a greater sense of work satisfaction as participants are better equipped with techniques to self-manage themselves within their work environment.

1. **What are healthcare professionals perceptions of the MBSR programme and the benefits it may have?**

Whilst the literature pertaining to this phenomenon suggests engagement in the MBSR programme is beneficial for participants resulting in reduced levels of stress, anxiety and emotional exhaustion, it is imperative to note that participant motivation and progress throughout the programme are not discussed resulting in significant gaps in the literature (Shapiro, et. al, 2007; Hulsheger, et. al., 2013; Fortney, et. al., 2013). As the available research is predominantly quantitative there is no exploration of changes to individual participants circumstances over the 8-week period of the programme, this factor may have impacted on the level of stress, anxiety etc. experienced, nor is there any exploration of the reasons why attendees chose to participate in the MBSR programme.

The MBSR programme is demanding of participants time as there is an expectation that they engage in mindfulness practice on a daily basis over an 8-week period (Fortney, et. al., 2013). Similarly to the literature, the findings of this research project suggest prior to participation there was a lack of in-depth understanding amongst participants of the aims of the programme and the level of engagement which was required in order to achieve the benefits associated with participation. However, taking this factor in to account it is significant that 83% of participants completed the programme in full.

The findings of this research project support the existing literature with regards to participant outcomes. All respondents in this research project disclosed that engaging in the MBSR programme has supported them in dealing with stressful situations through the introduction of new coping strategies which promote increased levels of self-management and self-awareness (Praissman, 2008).

The findings of this research project are supported by the in-depth analysis of the literature conducted by Smith (2014). Similarly to Smiths review, one of the themes identified in this project was 'efficiency', respondents disclosed that their level of focus increased following completion of the MBSR programme enabling them to complete more work within a shorter time frame.

Following completion of the MBSR programme respondents disclosed they now have a better sense of wellbeing and reduced stress levels within the work environment. These findings support the findings of Fortney, et. al., (2013) as respondents advised they continue to use the techniques learnt on the programme as they find them accessible and useful, resulting in decreased levels of stress experienced within the work environment.

The literature identifies that the MBSR programme is demanding of participants time, the findings of this research project support this conclusion as a selection of participants disclosed that the MBSR programme is 'intense' and a 'big commitment'. In response to this conclusion Fortney, et. al., (2013) developed an abbreviated version of the MBSR programme, this programme was analysed and positive outcomes were identified. Considering these findings, the introduction of an abbreviated MBSR programme could be considered for ease of access and integration to the work environment of healthcare professionals.

The above findings indicate that there is a positive perception and response to MBSR engagement however there is limited understanding of the programme aims prior to engagement, this suggests that more education regarding programme objectives is required to encourage people to apply to participate in the programme and manage their expectations of what is involved in it prior to commencement.

2. **Are healthcare professionals better equipped with coping strategies following completion of the MBSR programme?**

Similarly to the findings of this research project the literature acknowledges that the 8-week MBSR programme has a direct positive impact on healthcare professionals resulting in decreased stress levels within the work environment up to 9 months post intervention (Fortney, et al., 2013).

However, whilst the literature suggests participants experience reduced stress levels it does not detail levels of continued engagement with the MBSR techniques. In contrast, the findings of this research project demonstrate that 89% of respondents continue to engage in MBSR techniques post participation in the programme. The findings suggest that 33% of respondents engage in home practice MBSR techniques more often upon completion of the programme.

This research project aimed to identify whether the MBSR techniques introduced to participants throughout the 8-week programme were used as coping strategies when encountering stressful situations. This research project identifies that participants of the programme utilise the MBSR techniques as coping strategies. Respondents to the survey acknowledged MBSR techniques as accessible tools which can be utilised for the purposes of coping with stressful situations. Participants disclosed that upon completion of the programme they felt better equipped to cope in stressful situations. In contrast, the literature does not discuss the topic of coping, rather the literature states participants experience lower stress levels following MBSR engagement, further research in to the area of coping and MBSR is required (Zeller & Levin, 2013; Fortney, et. al., 2013).

In support of Santorelli's (1996) research this project also identified self-awareness as a key theme which developed across all respondents following completion of the MBSR programme. Respondents disclosed, upon completion they have a greater level of self-awareness and an increased awareness of the impact their behaviour can have on situation outcomes, thus encouraging the individual to be present and attentive in the moment. The findings indicate that participants have an increased ability to manage their reactions to stressful situations and have an increased ability to feel stress in their body as it arises. Respondents disclosed this new-found level of awareness supports them in preventing the onset of stress as it can be managed prior to impact.

As a result of limited evidence pertaining to coping strategies used by healthcare professionals, when encountering work-related stress, burnout and compassion fatigue, the literature does not discuss changes to participants coping strategies upon completion of the MBSR programme.

As a result, further research is required in order to draw conclusions as to whether a change in coping strategies and a greater sense of self-awareness following completion of the MBSR programme contribute to reduced stress levels.

The literature clearly demonstrates that there is a continuous increase in pressures within the work environment throughout the health sector. Given the reduced levels of workforce engagement it is imperative current staff members are encouraged to maintain a high standard of wellbeing so that they can meet the demands of their job and that management facilitate and support them to do this. To this regard, the above findings are significant as respondents disclose the MBSR introduced accessible coping strategies.

3. Do healthcare professionals experience greater work satisfaction upon completion of the MBSR programme?

The literature investigating the MBSR programme and its correlation with work satisfaction is limited. However, the findings of this research are consistent with the findings of Hulsheger, et. al. (2013) as respondents were found to have a greater sense of work satisfaction upon completion of the programme. The responses to this section of the survey vary as 100% of respondents disclosed their level of work satisfaction increased upon completion of the MBSR programme. However 22% of respondents stated they do not feel more nor less satisfied within the work environment as the MBSR programme is personal to them, predominantly relating to how they conduct themselves and respond to situations within the work environment. Respondents disclosed they had a greater sense of work satisfaction as a result of feeling calmer, enhanced communication strategies and increased levels of self-awareness.

In contrast to the literature, the findings of this project provide an insight into how participants of the MBSR programme integrate the techniques learnt on the programme into their daily lives and in turn the impact this can have on them within their work environment. Communication is a predominant theme identified throughout the responses. Respondents disclosed the benefits enhanced communication skills have on their interactions with others thus resulting in improved relations. In addition, the findings indicate increased levels of positivity amongst respondents.

Respondents disclosed that they now strive to seek the positive in situations to achieve a balanced perspective to which they can then respond.

Whilst the findings of this research project are consistent with that of the relevant literature available, it must be noted that the literature discusses varying approaches to the MBSR programme. Therefore further research is required in order to identify what minimum course content is required to ensure positive outcomes for participants. Throughout the analysis of the research it is evident that participants in the programme achieved positive outcomes, however the longevity of the benefits need to be explored post intervention in order to identify the level of commitment required by participants when the programme concludes to maintain the benefits experienced.

The qualitative findings of this project were analysed using thematic analysis, in contrast the available literature is predominantly quantitative based therefore the findings reflect different aspects. This research explored participants perceptions of the programme, its benefits and the impact MBSR had on participants within a professional context.

Research Limitations

Following the completion of the research project limitations to the research were identified. As the epistemological perspective of this research project is interpretivism the collated data cannot be generalised across the health sector or the organisations cohort in its entirety (Gray, 2014). In addition, inductive reasoning proposes theory is developed through the analysis of observations made on a given phenomenon. This form of research is exploratory in nature and relevant to each individual, whilst this approach provided individual perceptions pertaining to this phenomenon the outcome is not definitive and can be interpreted in many ways depending on the researcher's internal bias (Gilbert, 2008; Collis & Hussey, 2009).

Demographics of this project identified 100% of respondents were female, whilst this presents a limitation in the application of this research topic from a male perspective it must be noted 90% of Organisation X staff cohort is female. As a result of the small sample size the findings are not representative throughout the organisation and further research would be required to draw valid conclusions.

In addition, the small sample size prevented the researcher from calculating the internal reliability of the surveys therefore the researcher was required to rely upon previous calculations of the validated surveys in published literature.

As this research was cross-sectional in design it did not have data collated prior to participants engaging in the MBSR programme and therefore lacked comparable data to identify whether there were valid changes to thoughts, perceptions and behaviours following completion of the programme. Cross-sectional research can identify that a correlation exists however it cannot explain why, therefore this research project was unable to make definitive conclusions, rather recommendations were made in relation to areas for further research (Collis & Hussey, 2009).

The sample was selected using convenience sampling. The participants of the MBSR programme applied voluntarily to participate in the programme therefore it was likely they each had an interest in mindfulness. The researcher acknowledges that the findings could significantly change if a probability sampling method was used, however enabling staff to voluntarily apply to participate in programmes is the current approach in Organisation X in line with best practice.

As the researcher is internal to the organisation, in order to preserve participant anonymity, it was essential data was collated through the use of surveys. In comparison to interviews this method prevented the researcher developing participants perceptions in detail. In an attempt to minimise the potential for vague responses, the invitation to participate in the project detailed the purpose of the study in full and the expectation of participants in the study.

The responses to the open questions in the survey were short and therefore provided limited information to interpret, therefore interviews or focus groups would need to be conducted in order to achieve an in-depth understanding of MBSR participants views of the programme and the benefits they perceive in participating in the MBSR programme. In order to protect participant anonymity it may be worthwhile using a facilitator external to the organisation.

Recommendations

All participants disclosed the benefits they identified, both personally and professionally, upon completion of the programme. These findings are consistent with that of the literature therefore the findings of this research project indicate that it is valid to recommend that the 8-week MBSR programme continue to be made available to employees of Organisation X.

The findings indicate that there is limited understanding regarding the programme prior to participation therefore education of the purpose, content and aim of the 8-week MBSR programme is required. The education should be conducted with management participation in order to promote the programme amongst staff throughout the organisation. In addition, a leaflet should be drafted and made available to all employees to ensure applicants can make an informed decision to apply to participate in the programme.

Should the research be conducted again the researcher recommends a longitudinal approach is adopted to enable an accurate comparison of pre-and post-intervention. The use of an independent researcher would reassure participants of confidentiality, thus enabling the researcher to conduct interviews or focus groups, facilitating a more in-depth exploration of participant perceptions.

This research project investigated coping strategies and the impact participation in the MBSR programme had on participants work satisfaction. Research in this field is limited therefore further research is required to explore the phenomenon from this perspective.

Costing

The above recommendations will incur the following costs for implementation:

1. The MBSR programme is provided in house by two Clinical Psychologists therefore this will be cost neutral with the exception of manpower costs. In order to advertise the programme, host pre-engagement interviews, facilitate and evaluate the programme, on average the facilitators will invest a minimum of 43.5 hours each per 8-week programme. This incurs an organisational Manpower cost of €3154.62 (appendix 5).

2. The leaflet will be drafted by the programme facilitators in conjunction with the internal Communications department. The leaflet will be reviewed and printed by pre-existing external suppliers. The cost of professionally reviewing the leaflet to include images is €200. The cost of printing 300 leaflets is €150.

Timeline for implementation

- The programme is currently facilitated twice a year. In order to facilitate continuity in the programme it is recommended that there are consistent dates annually for the facilitation of the programme. The programme is currently facilitated in February to April and September to November annually.
- The information in the current MBSR staff advertisement can be adapted for use in the leaflet. This will take a maximum of 1 week to prepare and review. Based on current timelines with the pre-existing supplier the draft leaflet to include imagery will take 1 day to produce. Once proof read and confirmed the leaflets can be printed and delivered within 1 week. It is recommended this task is undertaken immediately to ensure the leaflets are distributed by the end of August 2017 to promote the programme scheduled to commence at the end of September 2017.

Conclusion

The aim of this research project was to achieve an in-depth understanding of healthcare professional's perception of MBSR and the reasons they chose to participate in the programme. It also aimed to gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopted through the use of the MBSR techniques within the working environment and to identify how participants perceived participation and completion of the MBSR programme had impacted on their level of work satisfaction and explore their perception of this. In order to achieve these aims a mixed method survey was developed and participants of a recently completed MBSR programme were invited to participate in the study.

The quantitative data was analysed through the use of descriptive statistics and the qualitative data was analysed using thematic analysis in order to draw conclusions.

Given the limited time frame and resources available this research project displays limitations. The limitations were identified in this chapter detailing recommendations for how they could be overcome in the event the research was to be replicated in the future.

The findings indicated participants had a limited understanding of the MBSR programme prior to engagement. Completion of the MBSR programme facilitates alternate adaptive coping strategies which participants found useful in stressful personal and professional situations. The MBSR programme led to a greater sense of work satisfaction as participants were better equipped with techniques to self-manage themselves within their work environment.

The findings were consistent with those presented throughout the literature however as the research project had a qualitative element it provided additional themes to those in the literature, for example; communication and positivity. The findings in this research are beneficial as they provide an indication of the benefits of the MBSR programme and support continuation of the programme in Organisation X.

Personal Learning Statement

This research project investigated healthcare professional's perception of the worth of participating in an 8-week MBSR programme and the perceived correlation it had with participants levels of work satisfaction. This was a mixed method research project which was conducted over a 5-month period. The experience of carrying out this research project has been both an enjoyable and informative one. Prior to engaging in this research project I had a general interest in the area of mindfulness however had limited knowledge in relation to the available research supporting the phenomenon.

Whilst I have previously researched the topic of wellbeing in the workplace, my in-depth review of the literature pertaining to the levels of work-related stress, burnout and compassion fatigue experienced by healthcare professionals has been eye opening. As Employee Wellbeing Group Lead within Organisation X the available literature pertaining to this phenomenon has further informed my belief in providing wellbeing initiatives in house to make resources available to staff in order to endorse both physical and mental wellbeing and promote a culture of work-life balance.

The low level of participation by staff from Organisation X in wellbeing initiatives is frustrating. In the past participation levels have been limited with concerns raised by managers that there is no time to release staff to attend the scheduled initiatives. Following my review of the literature I will introduce education sessions for managers regarding the promotion of wellbeing initiatives in order to create awareness of the consequences of staff not attending wellbeing initiatives.

One of the main challenges I experienced conducting this research project was the way in which I gathered the data. My preferred data collection method would have been interviews in order to gain an in-depth understanding of the participants thoughts and perceptions of the programme, the reasons they chose to engage in it and the benefits they achieved from the programme. The information collated in the surveys prompted so many questions to me as a researcher that I wished I could have explored the points further with participants.

Due to ethical considerations, it was not possible for me to engage with participants directly therefore to overcome this challenge I have recommended that an independent researcher facilitate this type of project in future to safe guard against potential confidentiality issues. In addition, if I was provided the opportunity to conduct the project again I would use a longitudinal approach in order to collate data pre-and post-intervention in order to have richer data to analyse. Alternatively, I would welcome the opportunity to use the research approach in an another organisation.

The completion of this research project has reinforced my belief in lifelong learning. It is imperative when striving to introduce and embed initiatives, such as the MBSR programme, into the working environment that the reasons for introducing the programme are evidence based outlining the benefits of participation.

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Appendices

Appendix 1 - Mindfulness-Based Stress Reduction mixed methods survey

Which department do you work in?

☐ Nursing department ☐ Support Services ☐ Management / Administration

☐ Other Patient & Client Care ☐ Health & Social Care Professionals

Gender

☐ Male ☐ Female

Why did you apply to participate in the MBSR programme? ***Choose all as applicable***

☐ Personal interest in the MBSR programme ☐ Wish to learn new coping strategies ☐ Other

☐ Professional interest in the MBSR programme ☐ Self-care

What was your understanding of the MBSR programme prior to commencement?

What outcomes did you expect to achieve through the MBSR programme?

How many sessions of the Mindfulness Based Stress Reduction (MBSR) programme did you attend?

☐ 1-3 ☐ 4-6 ☐ 7-9

How frequently did you engage in home practice throughout the programme i.e., diary entries; daily formal home practice; informal home practice; 3-step breathing spaces (regular/coping); etc.?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Almost Always

Are you still engaging in home practice since you have completed the programme i.e., diary entries; daily formal home practice; informal home practice; 3-step breathing spaces (regular/coping); etc.?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Almost Always

Did the MBSR programme meet your expectations?

☐ Yes ☐ No

Please elaborate:

Please rate the general frequency with which you use the below listed coping strategies. Please indicate your response using the following scale:

1 = Never 2 = Seldom 3 = Sometimes 4 = Often 5 = Almost Always

- I make a plan of action and follow it _____
- I look for the silver lining or try to find the bright side of things _____
- I try to spend time alone _____
- I hope the problem will take care of itself _____
- I try to let my emotions out _____
- I try to talk about it with a friend of family member _____
- I try to put the problem out of my mind _____
- I tackle the problem head on _____
- I step back from the situation and try to put things into perspective _____
- I tend to blame myself _____
- I let my feelings out to reduce my stress _____
- I hope for a miracle _____
- I ask a close friend or relative that I respect for advice _____
- I try not to think about the problem _____
- I tend to criticize myself _____
- I keep my thoughts and feelings to myself _____

Prior to participating in the MBSR programme what coping strategies did you use to relieve stress or to relax?

Upon completion of the MBSR programme please detail any coping strategies you have introduced to your daily work life to self-manage stress.

What benefits, if any, do you feel the MBSR programme has contributed to your working environment?

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line after each item.

7 = Strongly agree **6 = Agree** **5 = Slightly agree** **4 = Neither agree nor disagree**

3 = Slightly disagree **2 = Disagree** **1 = Strongly disagree**

In general, the type of work I do corresponds closely to what I want in life. _____

The conditions under which I do my work are excellent. _____

I am satisfied with the type of work I do. _____

Until now, I have obtained the important things I wanted to get from my work. _____

If I could change anything at work, I would change almost nothing. _____

Following your completion of the MBSR programme overall do you feel you are more satisfied within your working environment?

☐ Yes ☐ No

Please elaborate:

Do you feel the completion of the MBSR programme has had an impact on your overall work satisfaction?

☐ Yes ☐ No

Please elaborate:

Appendix 2 - Written invitation to participate in the research study

From: Facilitator B
Sent: 05 April 2017 15:57
To: A
CC: Facilitator C
Subject: Mindfulness Survey

Dear All,

I hope this email finds you well.

Please find a link below to the mindfulness survey, as mentioned in our final session.

Mindfulness Based Stress Reduction Programme Survey

If you have any questions in relation to this, or if you would prefer to complete a written copy of this survey, please don't hesitate to get back in touch.

Best Wishes,

Facilitator B

Appendix 3 - Informed Consent page

Following your recent completion of the Mindfulness-Based Stress Reduction (MBSR) programme you are invited to participate in a research study. The purpose of this research study is to:

- Gain an understanding of healthcare professional's perception of MBSR and the reasons why they choose to participate in the programme.
- Gain a deeper understanding of the coping mechanisms, if any, healthcare professionals adopt through the use of the MBSR techniques within the working environment.
- Identify whether participants believe they have a greater sense of work satisfaction upon completion of the MBSR programme and explore their perception of this.

This research study is being conducted by A (Manpower Manager) on behalf of Organisation X as part of a Masters in Human Resource Management through the National College of Ireland.

Please take your time to read the below information and to consider whether you wish to participate in this research study. Participation in the study is voluntary, you have the right not to participate or to leave the study. Deciding not to participate or choosing to leave the study will not result in any penalty and it will not harm your relationship with the organisation.

What is involved in the study?

If you decide to participate in this study you will be asked to complete an anonymous survey with a number of open and closed questions. This should take you a maximum of 20 minutes to complete.

Benefits to taking part in the study?

Published research details the benefits the MBSR programme can have on healthcare professionals.

The findings of this research will inform the future development of this programme; therefore, others may benefit in the future from the information found in this study.

Confidentiality

The survey will be completed anonymously. To ensure participants are unidentifiable this survey will be distributed to you by the MBSR facilitators. Therefore, please be assured I do not details of course participants and I will not contact you regarding this study. The MBSR facilitators will retain your contact information on file.

You can remove yourself from this research study at any time up until the completion and submission of the survey. As the survey, will be completed anonymously once submitted you will be unable to remove yourself from the study as the contents of your survey will be unidentifiable.

Risks

The topic of stress can be sensitive for participants, therefore should you agree to participate in this study please be aware that the services of the Occupational Health department, Employee Assistance Programme, Human Resources Services and Employee Wellbeing initiatives remain available to you.

Contact Information

- A (Manpower Manager): ph. XXXXXX or email XXXXXX
- Email Facilitator B (Senior Counselling Psychologist) at XXXX or Facilitator C (Principal Clinical Psychologist) at XXXX

Consent of Subject

Upon clicking the below 'Consent' button you are agreeing that you have fully read and understood the above information and you are agreeing to participate in this research study. Following your reading of the above information if you do not wish to participate in this research study please exit the web browser and email the MBSR facilitators to advise that you do not wish to participate in the study. Alternatively, you can ignore the email.

Appendix 4 - SWWS Measurement Instrument

Pavot, W. & Diener, E. (2013). The Satisfaction with Life Scale (SWL). Measurement Instrument Database for the Social Science. Retrieved from http://www.midss.org/sites/default/files/understanding_swls_scores.pdf [6 May 2017].

"30 - 35 Very high score; highly satisfied

Respondents who score in this range love their lives and feel that things are going very well. Their lives are not perfect, but they feel that things are about as good as lives get. Furthermore, just because the person is satisfied does not mean she or he is complacent. In fact, growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development.

25 - 29 High score

Individuals who score in this range like their lives and feel that things are going well. Of course, their lives are not perfect, but they feel that things are mostly good. Furthermore, just because the person is satisfied does not mean she or he is complacent. In fact, growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development. The person may draw motivation from the areas of dissatisfaction.

20 - 24 Average score

The average of life satisfaction in economically developed nations is in this range – the majority of people are generally satisfied, but have some areas where they very much would like some improvement. Some individuals score in this range because they are mostly satisfied with most areas of their lives but see the need for some improvement in each area. Other respondents score in this range because they are satisfied with most domains of their lives, but have one or two areas where they would like to see large improvements.

A person scoring in this range is normal in that they have areas of their lives that need improvement. However, an individual in this range would usually like to move to a higher level by making some life changes.

15 - 19 Slightly below average in life satisfaction

People who score in this range usually have small but significant problems in several areas of their lives, or have many areas that are doing fine but one area that represents a substantial problem for them. If a person has moved temporarily into this level of life satisfaction from a higher level because of some recent event, things will usually improve over time and satisfaction will generally move back up. On the other hand, if a person is chronically slightly dissatisfied with many areas of life, some changes might be in order.

Sometimes the person is simply expecting too much, and sometimes life changes are needed. Thus, although temporary dissatisfaction is common and normal, a chronic level of dissatisfaction across a number of areas of life calls for reflection. Some people can gain motivation from a small level of dissatisfaction, but often dissatisfaction across a number of life domains is a distraction, and unpleasant as well.

10 - 14 Dissatisfied

People who score in this range are substantially dissatisfied with their lives. People in this range may have a number of domains that are not going well, or one or two domains that are going very badly. If life dissatisfaction is a response to a recent event such as bereavement, divorce, or a significant problem at work, the person will probably return over time to his or her former level of higher satisfaction. However, if low levels of life satisfaction have been chronic for the person, some changes are in order – both in attitudes and patterns of thinking, and probably in life activities as well. Low levels of life satisfaction in this range, if they persist, can indicate that things are going badly and life alterations are needed. Furthermore, a person with low life satisfaction in this range is sometimes not functioning well because their unhappiness serves as a distraction. Talking to a friend, member of the clergy, counselor, or other specialist can often help the person get moving in the right direction, although positive change will be up the person.

5 - 9 Extremely Dissatisfied

Individuals who score in this range are usually extremely unhappy with their current life. In some cases, this is in reaction to some recent bad event such as widowhood or unemployment. In other cases, it is a response to a chronic problem such as alcoholism or addiction. In yet other cases the extreme dissatisfaction is a reaction due to something bad in life such as recently having lost a loved one.

However, dissatisfaction at this level is often due to dissatisfaction in multiple areas of life. Whatever the reason for the low level of life satisfaction, it may be that the help of others are needed – a friend or family member, counseling with a member of the clergy, or help from a psychologist or other counselor. If the dissatisfaction is chronic, the person needs to change, and often others can help."

Appendix 5 - Costing: Mindfulness-Based Stress Reduction Implementation

Action Required	Hours
Prepare advertisement	0.5
Review applications	1
Host interviews (30 minutes each | average of 20 applicants per programme)	10
Facilitate the evening sessions	20
Facilitate the full day session	7
Evaluation and follow up	5
Total Hours per Facilitator	**43.5**

- 1-hour costs €36.26
- 43.5 hours costs €1,577.31
- The cost to Organisation X for the manpower of 2 facilitators is **€3154.62**