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Research protocol

Prevention of psychosocial risks: Strategies for a healthy work environment

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ABSTRACT

Introduction: There is a wealth of data on the prevalence of psychosocial risk factors and their consequences, which can provide an idea of the magnitude of the problem and guide preventive measures. The occupational health field is an emerging and relevant area for the early detection of signs and symptoms in workers when faced with inadequate exposure to these types of factors. Objective: To detect individual situations of people affected by psychosocial risks, where general risk assessment could mask, and to analyse the effectiveness of educational interventions.
Methods: Quasi-experimental, longitudinal, and prospective study (for two years). All hospital workers who meet the inclusion criteria will be included. The project is being developed in 2 phases. In the first phase, data will be collected using the "MindSAFE" tool, and screening questionnaires will be filled out. After analysing the results, the second phase will begin, where the worker will be summoned to a nursing office for a more exhaustive individual assessment or, alternatively, a telephone consultation will be carried out. After analysing the worker's situation, various educational interventions will be carried out according to their needs. Follow-up will take place in 3 and 6 months.
Data analysis: Absolute and relative frequencies will be calculated for qualitative variables and the mean and standard deviation for quantitative variables. The relationship between variables, according to their nature, will be determined using Pearson's Chi-square and analysis of variance.

Keywords: Occupational health nursing; occupational risks; psychosocial risk.

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Introduction

1. PSYCHOSOCIAL RISK FACTORS.

GENERAL CONCEPTS

Professionals face risks caused by various agents throughout their workday, including psychosocial risks. The psychosocial concept is used to refer to the interaction between socio-occupational factors (content, management and organisation of work) and the skills and needs of workers (1, 4-7). Table 1 shows the main risk factors.

Table 1. Psychosocial risk factors

Content of the work	Lack of variety (repetitiveness) or short work cycles, fragmented or meaningless work, little use of skills, high levels of uncertainty, etc.
Workload and pace	Underload or overload, high or imposed or inadequate pace, inflexible deadlines that are poorly planned or maladjusted, levels of concentration/continuous attention, interruptions, etc.
Working hours	Shift work, night work, inflexible schedules, unpredictable hours, insufficient rest, hyperconnectivity, etc.
Participation and control	Little participation in decision-making, lack of temporal autonomy, difficulty in taking initiative, etc.
Environment and equipment	Inadequate availability, suitability or maintenance of equipment; poor environmental conditions, etc.
Organizational structure and culture	Poor communication, little support for problem solving and personal development, etc.
Interpersonal relationships at work	Social or physical isolation, poor relationship with superiors, harassment, etc.
Role of the organization	Role ambiguity, role conflict, responsibility for others, etc.
Professional development	Professional stagnation and uncertainty, inadequate or insufficient promotion, low salaries, job insecurity, etc.
Work-life balance	Conflict between work and personal needs, etc.

The large number of elements that interact in these factors, such as working conditions (environment, tasks and organization) and the characteristics of the worker (lifestyles, social environment, capabilities, needs, expectations, and extra-work conditions)

(4, 5, 8, 11), can negatively influence the health status of the individual, causing psychological or physical damage (1, 2, 10) and among the areas of greatest impact are education, health, social work, public administration, call centers, construction, commerce, transportation, hospitality and industry (2, 9, 11).

However, all of this has a series of conditions. Generally, psychosocial factors are not negative or positive by themselves, but rather their capacity to promote a positive health status or pose a risk will be determined by how they are structured in organizations (4, 6). They do not act independently of each other, that is, they have a multi-causal origin and not all risk factors are present in the same way and intensity in the working population (9, 10).

EVALUATION AND MANAGEMENT

The differential characteristics of these risk factors require taking into account several assumptions in their assessment. On the one hand, there is the difficulty involved in establishing a direct causal relationship between exposure and the damage caused, given the nature of these and the multicausality factor (1, 4, 6, 7, 10).

On the other hand, its reading is indirect and subjective as it includes the individual perception of the worker throughout the use of various tools, mainly questionnaires, which is why specialized training in the subject is required and, finally, said evaluation is a process that consists of several phases and requires prior planning (1, 4).

All of this has required the development and research of specific assessment methodologies, which include new perspectives and relevant factors (gender, age, personality, work skills, etc.), complying with appropriate criteria of reliability and validity (2, 4, 9). Among the instruments used in their assessment, a wide range is available. Of all of them, at a national level, the INSST FPSICO psychosocial factors assessment method and PSICOVS2023 protocol stand out.

2. CONSEQUENCES OF EXPOSURE IN THE WORKPLACE

Throughout history, various studies on the subject have referred to the possibility of an indirect impact that these risk factors can have on workers and the organization, since

establishing how and when certain factors lead to these effects is a task currently under research (1, 7).

Repeated exposure to an inappropriate psychosocial situation can be reflected in the worker through physiological changes (cardiac arrhythmias, palpitations, increased cortisol, irritable bowel syndrome, muscle tension, etc.), psychological and emotional changes (anxiety, depression, irritability, attention deficit, lack of motivation, etc.) or behavioral changes (addictions, sedentary lifestyle, sleep disorders, etc.); and in the organization through an increase in absenteeism, presenteeism, conflict, voluntary resignations, low productivity or increased temporary disability (TD), accidents, etc. (1, 6, 7, 8, 10, 17).

We must consider that there are the characteristics of the worker, including extra-work factors (social class, lifestyles, etc.), who will mainly determine the magnitude and nature of the consequences of these factors (1, 7, 18). All these situations are of great importance, not only because of the effects on the state of well-being and the psychological, physical and social functioning of work; but also because of the direct and indirect economic impact on organizations, management systems and health services due to high costs and productivity losses (4, 7, 10).

Justification

Thanks to the published literature, there is a big amount of data regarding the incidence and prevalence of the main psychosocial risk factors and extensive scientific evidence on the consequences both at the individual and organizational level; however, due to the characteristics of the studies (type of population and factors analyzed, tools used, nature of the factors, etc.) it is difficult to extrapolate these results to the global population, although they all reach the conclusion that psychosocial risks affect this group and the organization, which can give an idea of the magnitude of the problem and guide preventive measures in the area of Occupational Health (4).

However, in recent years, there has been a constant increase in certain indicators related to the demands derived from psychosocial factors (longer working hours, greater pressure and mental load, among others), leading to questions about the mistakes or failures committed in terms of prevention (4). The lack of information on the effects on workers'

health, the lack of awareness and cultural prejudices considering those professionals who report psychosocially unfavorable situations as "weak" or "predisposed", the business culture: promotion of the idea of considering such situations as inherent to the job and that prevention and treatment is the sole responsibility of the worker, through self-control techniques, all encouraged by the attitude of disbelief in the impossibility of controlling or eliminating psychosocial factors, could be the main problems in this area.

The field of Occupational Health is a relevant place for the early detection of signs and symptoms in workers due to inadequate exposure to psychosocial risk factors. As occupational nursing specialists, we can carry out high-quality actions following evidence-based practice, facilitating decision-making and more suitable health monitoring, all from a multidisciplinary perspective, with contributions from occupational medicine, the technical side and the psychosociology of organizational health.

For the reasons mentioned before, a study is proposed in which, through various strategies in the area of Health Surveillance, unfavorable psychosocial problems and situations are addressed prematurely, avoiding the development of consequences (work accidents, TD, etc.) and pathologies in the health of workers, improving their quality of working life.

Objectives

GENERAL OBJECTIVE

To detect individual situations of people affected by psychosocial risks, where the general risk assessment could mask, and to analyze the effectiveness of educational interventions, in preventive matters in the occupational nursing consultation.

SPECIFIC OBJECTIVES

1. Analyze the main characteristics of the psychosocial risks to which the working population is exposed and recognize the needs and influence on their health.

2. Evaluate and understand coping styles and strategies for dealing with psychosocially unfavourable situations, including the resources used.

3. Identify areas for improvement and reduce preventable psychosocial risk factors that affect worker symptoms.

4. Establish priorities and improve communication through preventive planning in the affected disciplines.

Methods

STUDY DESIGN

This is a quasi-experimental, longitudinal and prospective study over a two-year period.

POPULATION AND AREA OF STUDY

The study population will be those workers who have an active contract during the study period, belonging to the centre and who meet the inclusion criteria in the follow-up period. The population will be monitored at the Occupational Nursing clinic.

Given the characteristics of the study, the sampling will be total and the method of recruitment will be through posters and information notes distributed throughout the centre, including information in each health examination.

INCLUSION AND EXCLUSION CRITERIA

INCLUSION CRITERIA

1. Professionals in active status during the study period.
2. Professionals who voluntarily agree to join the study and sign the required informed consent.
3. Professionals who have completed the initial questionnaires.

EXCLUSION CRITERIA

1. Professionals with diagnosed and uncontrolled mental illness.
2. Professionals in follow-up with mental health specialists in the event of suspected mental illness.
3. Professionals who have been in a TD process during the study.

4. Lack of follow-up and/or inability to attend the Occupational Nursing consultation.

5. Transfer of workplace that makes monitoring impossible.

6. Language barrier, cognitive or sensory disabilities that impede the development of the study.

STUDY VARIABLES

See Table 2 and Table 3.

Table 2.*Independent variables*

Variables		Categories
Sociodemographic and personal	Sex	*Man – Woman*
	Age	*Years*
	Nationality	*Country*
	Place of residence	*City*
	Socioeconomic level	*Low - medium - high*
	Marital status	*Single - Married - Divorced - widowed*
	Number of children and age	*Number – years*
	Level of education	*No studies – 1st year studies – 2nd year studies – university studies*
	Medical history of mental illness	*Yes - no*
Labor	Professional category	-
	Belonging Service	*Emergencies – Operating Room – Hospitalization – Others*
	Seniority in the job	*≤ 3 years – 4 to 10 years - >10 years*
	Working mode	*Teleworking - In-person - Hybrid*
	Type of contract	*Fixed – temporary*
	Type of workday	*Complete - Half - One third - One fourth - One fifth*
	Schedule	*Morning - Afternoon - Night - 12 hours*
	Previous positions	*Category and service*
	Risk assessment	*Low - moderate - high - very high*
Intervention	Impact in the last year	*TD - accidents - absenteeism*
	Rating health surveillance	*Yes - no*

Table 3.Dependent variables

Variables	*Categories*
10QFRP Basic Questionnaire	*0 – 4*
Langer-Amiel Total Health Test (TST) Questionnaire	*Yes – no* *Often – Sometimes – Never*
Psychological Well-Being Scale (EBP)	*1 – 5*
Type of intervention	*Primary – Secondary – Tertiary*

DATA COLLECTION INSTRUMENTS

"MindSAFE" tool

The main objective of this tool is to establish a means of support, indirect and individual, to all professionals who need it through the platform "*Google Forms*". Being an online format, cultural and work-related prejudices are avoided as far as possible, since the worker does not initially need to request an appointment for an assessment at the service, and therefore be absent from the workplace. In addition, it will allow the Occupational Health service to evaluate specific situations and locate sources of possible psychosocial problems, being able to design changes and prioritize actions.

This tool will allow the data obtained for each worker (individual assessment) to be compared with the psychosocial risk assessments (global assessment) carried out by the Occupational Health technical area, in all jobs and professional categories.

When the professional scans the QR code, a page will open with a detailed explanation of the use and reason for it, including your acceptance and signature of the informed consent for entry into the study. Once you have accepted your inclusion in the study and signed your consent, you will move on to page number two, where you will have to fill in several details:

- DNI
- Age (years)
- Sex (male - female)
- Category and service to which it belongs
- Time worked (years)
- Characteristics of the work (modality, type of contract, type of workday, schedule)

- Diagnosis of psychiatric pathology (yes - no)
- Method of contact with the worker: e-mail or telephone

After completing all these sections, they will be combined with the database according to the category and service indicated, being able to determine and classify which are the psychosocial risks to which the professional is inherently exposed to. This classification will be based on what is indicated in NTP 926, psychosocial factors: evaluation methodology: "Very high (Percentile ≥ P85), high (P75 ≤ Percentile < P85), moderate (P65 ≤ Percentile < P75) and adequate/low situation (Percentile < P65)" (13).

Finally, the worker will complete and record the questionnaires included as screening, with the aim of obtaining an initial individual assessment of its psychosocial situation and allowing for the establishment of actions in terms of health surveillance through preventive measures (primary, secondary or tertiary) according to the variables analysed.

The professional will receive as *feedback* a comment indicating the notification and registration of the case, along with the waiting period (48h - 72h) that may occur before the Health Surveillance area can contact him/her.

10QFRP Basic Questionnaire

This tool is designed as a rapid screening tool for identifying psychosocial factors whose exposure may be perceived as a risk. It is a self-completed questionnaire, consisting of 10 items, with a Likert-type response (0-4), and a score between 0 and 40 points can be obtained (15).

The cut-off point is the total sum ≥ 12 points, although it will be considered positive if any item scores ≥ 3 points are obtained. According to the PSICOVS2023 protocol, the questionnaire does not constitute an assessment of psychosocial risks, although it can serve as a guiding tool (4, 15).

Langner-Amiel Total Health Test (TST) Questionnaire

It is a screening tool used to assess the symptoms and/or degree of frequency in situations related to working conditions. It is not used as a diagnosis or prognosis. According to studies developed by the National Center for Working Conditions of the INSST, correlations have been found between this scale and psychosocial aspects at work such as role definition, mental load, work content, etc. (21).

It consists of 22 items and the response are yes/no or the degree of frequency. Three groups are distinguished according to the score obtained: less than or equal to 4 (low), between 5 and 7 (intermediate) and greater than or equal to 8 (extreme group). A high score does not necessarily indicate the certain existence of alterations, but that these are probable without indicating the cause (21).

Psychological Well-Being Scale (PWB)

This tool is designed to assess subjective psychological, material, occupational and relationship well-being. It is a self-administered scale and consists of 65 items, divided into 4 subscales, with scores ranging from 1 to 5. The first two subscales (subjective psychological well-being and material well-being) must be applied together, and independent or global results may be obtained. The rest of the subscales can be included depending on the objectives of the study (22).

o Subjective psychological well-being subscale. It consists of 30 items and refers to happiness or well-being. Its maximum possible score is 150, so the higher the score, the greater the subjective perception of well-being. This subscale must be assessed by the stage of life that the person being assessed is going through (adolescence, middle age, old age, etc.).

o Material well-being subscale. It consists of 10 items and measures a person's subjective perception of their economic situation. Its maximum score is 50.

o Occupational well-being subscale. It consists of 10 items and is considered an important component for the overall satisfaction of the overall and complete state. Its maximum score is 50.

o Relationships with partners subscales. It is evaluated using 2 questionnaires according to gender and consists of 15 items. Its maximum score is 75.

Depending on the score, it can be obtained in 3 ways:

o Sum of each subscale: subjective psychological well-being + material; work well-being and well-being with one's partner).

o Addition of the total scale.

o Addition of the weighted scale (items in shaded boxes).

Once the scores for each scale have been collected, the percentile in which the worker is located according to sex and age will be determined (22).

Semi-structured interview

The interview will compare the information in the questionnaire that the worker has filled out. The objective of the interview is to find out the main cause or reason for which the questionnaire has been filled out and why the professional believes he or she is in this situation, assessing his or her personal resources to deal with the work situation and what measures he or she proposes to eliminate this stressful situation.

Among the questions we will ask the worker are:

• How would you rate the relationship between the demands of your job, the offers, your capabilities and expectations/aspirations?

• Does your job meet the expectations you had when you joined? Why?

• Do you consider the personal and professional resources available to you to be adequate?

• Symptoms that may be associated with work and frequency: stress, anxiety, insomnia, job dissatisfaction, lack of motivation, boredom at work, palpitations, abdominal pain, lack of appetite, irritability, difficulty relaxing.

PROCEDURES AND INTERVENTIONS

The project is developed in 2 phases: first phase, data collection and results, second phase, interventions and monitoring.

PHASE 1.

- Data collection: For the start of the project and data collection we will use the new tool, "*MindSAFE*". The main objective of this phase is to analyse the psychosocial situation of the worker as objectively as possible, using the psychosocial risk assessment of the technical area.

First of all, the professional will have to fill out the **10QFRP questionnaire.** This tool will inform us of the psychosocial risk factors that have the greatest impact or importance on the professional ´s health.

Secondly, the subjective state or consequences will be analyzed through the **Langner-Amiel Total Health Test (TST) questionnaire**, responsible for assessing the state of well-being and functional capacity.

- Results: The main objective of this phase is to assess who needs care as soon as possible and who may be delayed. The results of the screening are shown in Table 4.

Table 4.*Screening results*

Intervention	**10QFR Questionnaire**	**TST Questionnaire**	**risk assessment**
In-person appointment at the Nursing consultation	≥ 12 points total or score 3-4 some item*	≥ 8 points*	It is not in line with what was stated by the technical area.
Intervention	**10QFR Questionnaire**	**TST Questionnaire**	**risk assessment**
Telephone consultation	≤11 points total or 1-2 points per item	≤ 7 points	There are no changes in your workplace.

*** The results of both questionnaires will be essential elements to determine the type of initial intervention to be carried out. In those cases where only one of them is shown to be altered, it will not be an initial reason for a face-to-face appointment.**

PHASE 2.

In this phase we will find two assumptions:

1. Any worker who has not obtained high scores in the questionnaires and/or is in line with the risk assessment (primary and secondary prevention).

2. A worker whose subjective state varies greatly from what he or she could develop according to his or her risk assessment and/or presents high scores in the questionnaire (tertiary prevention).

Generally speaking, it is known that there is no manual for psychosocial intervention that describes the type of programs and actions indicated for each situation. Each conflict situation will require a tailored intervention, with solutions for both the organization and the individual.

- Primary and secondary prevention:

In the first case, an initial assessment will be carried out by nursing staff in the Occupational Health Surveillance service, based on a semi-structured telephone interview.

The objective of the interview is to find out the main cause or reason for which the questionnaire has been completed and why the professional believes that he or she is in that situation, assessing his or her personal resources to deal with the work situation and what measures he or she proposes to eliminate this stressful situation.

It is important to know that not in all cases it is possible to act at the source (primary prevention), since there are factors that are inherent to the workplace. In these cases, action will be taken through secondary prevention.

Main objectives of the interventions:

- Promote information and awareness among workers and managers about psychosocial risk factors.
- Improve communication between professionals and managers regarding psychosocially unfavorable situations.

- Implement seminars and workshops that promote coping techniques and skills development in workers (stress management techniques, training activities for conflict situations, etc.), improving response capacity.

- Tertiary prevention:

For those workers who present high risks, an appointment will be made in person at the Occupational Nursing consultation and the form will be filled out **Psychological Well-Being Scale (PWB)**, with the aim of assessing possible extra-work-related changes that may affect the worker's situation.

To assess all the data obtained and guide subsequent actions, we will classify psychosocial risks following the UNE-ISO 45003 Standard in aspects of how work is organized (roles and expectations, control or autonomy of work, etc.) and social factors at work (interpersonal relationships, leadership, culture of the organization/work group, recognition and reward, etc.) (4).

Main objectives of monitoring:

- Mitigate the negative effects on the worker and the organization due to exposure to these psychosocial risk factors.
- Develop recovery and rehabilitation strategies for those workers with symptoms associated with psychosocial factors.
- Implement seminars and workshops that promote techniques and development of coping skills in workers, avoiding relapses (stress management techniques, training activities for conflict situations, etc.).

- Follow-up:

Workers included in the study will be monitored at 3 and 6 months to reassess their current situation. Workers who showed a need for action in response to psychosocial risk factors will be monitored in 3 stages: 1 – 3 – 8 weeks.

OVERALL EVALUATION.

Although the main objective of this assessment and monitoring is the control of individual psychosocial risk factors, the extent and characteristics of the problem must be taken into account, based on the epidemiological evaluation of the cases, since other assessments by the multidisciplinary Occupational Health team (technicians and doctors) could be included, allowing for better preventive actions to be applied.

- In cases where psychiatric disorders are detected or suspected, the patient will be referred to the Unit's Occupational Physician. The causal relationship between exposure to psychosocial factors and the possible development of pathologies will be assessed.
- In cases where an increase in the incidence of certain professional categories and/or services is observed, a re-evaluation by the Occupational Health technical area would be advisable to determine the nature of the adverse situation.

Data analysis

First, a descriptive statistical analysis will be carried out by calculating absolute and relative frequencies described in the qualitative variables, and the mean and standard deviation (M ± SD) for the quantitative variables with normal distribution and the median and Odds ratio (OR) for those that do not fit a normal distribution.

Regarding the inferential statistical analysis, if homogeneity of variances is assumed, the different variables will be related using Pearson's Chi-square in the case of qualitative data and analysis of variance in quantitative data. On the other hand, the Wilcoxon test will be used as non-parametric tests in qualitative data and the Kruskal-Wallis test in quantitative data. A statistical significance of $p<0.05$ and a confidence level of 95% will be taken into account.

All analyses will be performed using the IBM SPSS Statistics 29.0.1.0 statistical package.

Difficulties and limitations of the study

Limitations and difficulties that could be encountered in carrying out this study include:

- The characteristics of the study itself: type of study and sampling used, as well as the follow-up period.
- The questionnaires and type of interviews conducted may not encompass some psychosocial risk factors.
- Difficulty in generalizing the results obtained, since the sample is limited to the workers at the study centre.
- Factors that may influence your responses (culture, personality, age, etc.).
- The health self-reported by professionals is mainly assessed, and not the objective aspect of these effects (for example, through heart rate monitoring, monitoring of hours of nighttime rest, etc.).
- Lack of compliance with guidelines established by nursing staff.
- Loss of patient follow-up throughout the study.
- Difficulty in recruiting professionals, due to the nature of the risk factors analysed (cultural prejudices, experience, age, etc.), with the possibility that after the explanation of the study they may refuse to participate or not sign the informed consent.
- Possible biases in the answers to self-administered questionnaires and the guided interview itself in the nursing consultation.

Ethical and legal aspects

The proposed study will be submitted to the Ethics Committee for evaluation prior to its application for approval. Respect for the fundamental principles of the Declaration of Helsinki (2013 update: Fortalezas, Brazil) promulgated by the World Medical Association (WMA); the Council of Europe on Human Rights and Biomedicine; the UNESCO Universal Declaration on the Human Genome and Human Rights and the Oviedo Council on Human Rights and Biomedicine.

Confidentiality of all data will be guaranteed at all times. Participants must sign an informed consent form, in which they give their approval to participate in the study. Participation is completely voluntary and this consent may be revoked at any time.

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