Mobilization of workers in primary prevention, a condition for the efficiency of hospital-level intervention

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Abstract: Research in ergonomics and work psychology has been interested in the way to prevent musculo-skeletal and psycho-social risks in companies for many years. Globalization of an efficient approach is not easy to find. This is why research turns towards understanding the social construction of a preventive approach with workers. It would be necessary to have workers take an active part in the deployment of a preventive approach to make its effects lasting (Coutarel α Daniellou, 2007). In this way, the concept of the mobilization of stakeholders is being used more and more. Mobilization of stakeholders during a prevention process is a fundamental condition for the efficacy of an intervention. The aim of this paper is to show the conditions favoring the mobilization of stakeholders in a preventive approach. To understand this issue, we explore three hypotheses: the influence of the practitioner in the mobilization process (hypothesis 1), the role of the individual activity of each worker (hypothesis 2) and the construction of collective work (hypothesis 3). The contribution of this article is to improve intervention practices by encouraging the diagnoses and actions that must be carried out to facilitate the stakeholders’ mobilization, which is an important issue for the efficacy of prevention.

Practitioner summary: After her studies in work psychology at Grenoble University (France), the author is preparing a PhD thesis in the ergonomics of communication. Her research interests include the efficacy of ergonomic interventions, interdisciplinarity and professional risk prevention.

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1. Research context

French hospitals are subject to new economic constraints akin to those of businesses (Michel α al., 2007), substantially altering the organization of the caring work and practice of nurses (Bressol, 2004; Brémont, Mick, Robert, Pascal α Claveranne, 2013). These evolutions have implications on the nurses’ health: musculo-skeletal disorders (Estryn-Behar α Fouillot, 1990; Caroly, Moisan, Juret α Roquelaure, 2011) and mental disorders (Estryn-Behar, 1997; Safy-Godineau, 2013). Maintaining employment resulting an increase in absenteeism and inabilities to work. Preventive approaches thus are more oriented towards primary prevention (Brun, 2003). However, their success depends on which internal workers are concerned (Baril α al., 2001) in this type of preventive approach. To do this, workers must make connections between the intervention deployed and their individual and collective activity (Clot, Faïta, Kerguelen α Scheller, 2001, Caroly, 2010). The concepts of intervention in professional risk prevention (Guérin, Laville, Daniellou, Duraffourg α Kerguelen, 2006; Jobert, 2007;
Querelle, 2008) and mobilization (Vézina & Tougas, 2008; Chadoin et al., 2013; Brunet, 2014) held our attention.

2. The issue of the relationship between intervention efficacy and the stakeholders’ mobilization

Health care facilities facing difficulties in maintaining care nurses in employment, the National Pension Fund Officials’ local government asked us to study the resources that promote sustainable preventive actions for professional risks in health units. We chose to deal with this issue through the dynamic of stakeholders who, directly or indirectly, are in charge of prevention actions carried out in health care facilities (institutional stakeholders, work medicine, stakeholders in situ and nurses). This research aims at identifying levers for the mobilization of stakeholders during the deployment of a prevention process.

Our research question is the following: how to create conditions for the mobilization of stakeholders in a company in order to enable a social construction of musculo-skeletal and psychological risk prevention? Regarding mobilization as a key to the social construction of prevention, we suggest the following definition for this concept: *mobilization of stakeholders in a preventive approach is a dynamic and temporal process, introduced by a third party, permitting collective work with different stakeholders in order to carry out socially a common object (here, the ORSOSA approach) in a capacitating context (given work context) to manage the project and the individual activity of each person.* To understand the mobilization process, we explore three hypotheses: the influence of the practitioner in the mobilization process (hypothesis 1), the role of the individual activity of each worker (hypothesis 2) and the construction of collective work (hypothesis 3).

3. Method

Our methodology is based on the observation of the implementation of a primary prevention approach called ORSOSA (ie French Organization of care for nurses and health care) (Bonneterre, Liaudy, Chatellier, Lang & De Gaudemaris, 2008) in three geriatric units (fields 1, 2 and 3) in different hospitals. We chose this kind of health unit because several specialists agree to say that these units have the most difficult work conditions: patients needing palliative care, considerable physical constraints, negative representations of these units (Hugonnet, 1999; Estryn-Behar, 2004; 2013; Loriol, 2004; Ravallec, Brasseur, Bondéelle & Vaudoux, 2009).

The ORSOSA approach aims at initiating a discussion about the organization of care units with various stakeholders of the institution (doctors, care management, human resources management, executives, doctors, nurses etc.) and at improving work organization (Pavillet et al., 2013). The implementation of the approach in the care units is made by an external organizational practitioner. This approach is declined in several stages (from the presentation of the approach, meetings with the head of care, to the support of recommendations). To carry out an assessment, the practitioner presents a questionnaire to nurses and nurses’ auxiliaries in the chosen health units, in order to evaluate the risk of stress and musculo-skeletal risks. The stakeholders can use the data collected to debate on the real activity of the carers and find solutions for these units.
To observe the implementation of this approach in hospital facilities, we used a qualitative method (interviews of stakeholders (41 interviews), brief interviews (85 interviews), observation of meetings (6 observations), diary of the consultant (103 logbooks) and self-confrontation (3 interviews...)). Data obtained has been categorized to reflect the mobilization of workers in relation to the strategies involved by the practitioner: do people make links between their own activity and their collective activity in the implemented process, do they make links with outstanding institutional projects and the organizational context of the hospital; do stakeholders ask questions on the deployment of the approach?

4. Monographs of the three sites

The deployment of the ORSOSA approach was different in the three geriatric units and had different outcomes on the efficacy of professional risk prevention.

In the site n°1, initially the head of the unit and the doctor were skeptical about the interest of the approach in their care unit (head of unit suffering, fusion of two units, work overload, important absenteeism of the nurses, etc). The practitioner asked the ergonomist, the head supervisor and the executive team of care to help the head of the unit to face the difficulties. This point was particularly crucial given the alarming results of the questionnaire administered to the carers which showed a unit in sufferance. Debates on work organization and the way to face the difficulties took place and lead the stakeholders to find solutions. All the stakeholders discovered new resources that enabled them to further their individual and collective activity. An assessment six months after the end of the deployment showed that most of the recommendations were followed (working group for task breaks, ergonomic observations on workload in the unit, establishment of places dedicated to communication between head of unit and carers).

In the site n°2, the deployment of the approach was delicate. Effectively, the head of unit, the doctor and the head supervisor were against the deployment of the approach because they perceived it as an attempt of instrumentation coming from the executive team and because they were afraid of the results of the approach. This resistance was amplified by the fact that the results of the questionnaire were not alarming, thus reinforcing the uselessness of the approach. Few debates about activity in the care unit took place, material issues were pointed out. Institutional stakeholders did not come in to the site and carers did not participate much in the approach. The effects of the approach six months after are negligible because centered on material issues.

In the site n°3, site stakeholders, institutional stakeholders and work medicine were very active from the beginning of the deployment of the approach, perceiving the interest for the improvement of work organization in their unit. Results of the questionnaire showed several warning signs like in the site n°1. However, these warning signs did not discourage the stakeholders. Inversely, they deployed a collective activity to find solutions to the daily issues (lack of communication among the staff, lack of material, lack of training of the nursing auxiliaries). They managed to develop new resources that enhance collective and individual activity. All the recommendations were applied six months after the deployment, mainly by the stakeholders of the hospital.
5. Results
The results of this research identified several conditions for the mobilization of stakeholders in the implementation of a primary preventive approach.

5.1. Strategies used by the practitioner
First, the practitioner uses five main strategies to engage stakeholders in the preventive approach (hypothesis 1): strategies related to research involving stakeholders (the practitioner focuses on the needs of the stakeholders and tries to engage the team in the intervention process), temporal strategies (the practitioner tries to optimize duration in the deployment of the approach in the hospital), strategies to create links between the implementation process and organizational context observed in hospitals (the practitioner makes links between the approach and several institutional instances), strategies to justify the relevance of the approach (the practitioner insists on the background, the interest of the tool, financing, the timetable of the approach, etc.), and finally strategies to make connections between the approach and the organization of care service (the practitioner makes links between the unit and the difficulties faced by the internal stakeholders and carers). The practitioner adapts to the organizational context of the care service in which it he operates. We observe that the less mobilized the stakeholders are, the more strategies the practitioner uses (site n°2 (233 strategies used) > site n°1 (230 strategies used) > site n°3 (148 strategies used). When the work environment is receptive to facilitating the implementation of the approach, the practitioner relies on strategies creating links between the process side and the operational side of the service to allow workers to develop their skills (sites n°1 and 3). Whereas, when the service is reluctant to apply the approach, the practitioner uses strategies to justify the relevance of the approach and to involve workers in transforming their own representations so they can find an interest in the process and to invest in it (site n°2).

5.2. Carrying out individual work
Our results of hypothesis 2 show that stakeholders get mobilized in a preventive approach when it is relevant and it supports their individual activity. When the stakeholders see the sense between what they do in their activity and the ORSOSA approach, they engage in it. The stakeholders of site n°1 meet up with the head of unit and each stakeholders finds elements of solutions from their own activity: the ergonomist brings tools for analysis, the executive team gives institutional answers, the head supervisor brings answers related to politics and the hospital. Site n°2 suggests that when stakeholders do not link their own activity to the deployment of the approach, they cannot engage and tend to oppose the approach: they think that the approach will disturb their work. They make few references to their individual activity and develop a defensive collective strategy. Their participation focuses on their knowledge and existing inconsistencies in the organization of care units or of the hospital, in terms of the lack of carers, resources, etc. Finally, site n°3 shows that when stakeholders can make the link between the approach and their individual activity, they are mobilized and deploy their individual activity. The stakeholders share the difficulties of the unit and are mobilized into finding solutions.
5.3. Carrying out the collective work of the stakeholders

The results of hypothesis 3 show that stakeholders are mobilized for the preventive approach when the approach enables them to develop collective work. Several ways are possible for carrying out efficient collective work with the stakeholders of a hospital. Sites n°1 and 3 suggest different constructions of collective work but they share a common point between the stakeholders. For the site n°1, stakeholders met up with the head of the unit who was facing difficulties (collective work related to help) and for site n°3 they met up with the intention and the willpower to improve the organization of the care unit (cooperative collective work). The stakeholders collaborated more to improve the work organization. Moreover, we noticed that their professional network expended. Our results show that collective work enables the stakeholders’ mobilization for the deployment of the prevention approach. Furthermore, some stakeholders have more organizational abilities for meetings than the head of unit and the executive team for example. Thus, the head of the unit has a critical function because this position is directly connected with the carers and the doctor of the unit: he can intervenes directly in favor of the approach (sites n°1 and 3) or on the contrary in its disfavor. Additionally, the three sites demonstrated the main role of the executive team of care administration. Its presence legitimizes the approach as regards to the carers and the head supervisors (lack of implication on the part of the head supervisor in site n°2).

The executive team guarantees the implementation of recommendations (site n°3).

It seems that the more different stakeholders invest in the preventive approach, the more solutions are found by the care unit for its functioning. So the stakeholders make their abilities and knowledge available in a safe setting represented by collective work. Debating difficulties on the site, co-interventions in the units had an impact on well-being at work and on the development of the resources of the stakeholders. These stakeholders can consider new ways of proceeding and share the “tricks of the inter-trade”. This is how collective work helps the individual work of the stakeholders to develop.

6. Discussion

Mobilization of stakeholders in a primary prevention approach appears essential for effective prevention. When stakeholders are mobilized, they are able to find organizational solutions and make connections between different projects of the institution, which contribute to better working conditions (Vezina α Tougas, 2008 ; Chadoin α al., 2013 ; Brunet, 2014) and to the preservation of the health of nurses. But mobilization requires several conditions.

6.1. A capacitating organizational context

Context of intervention is not rigid, it can evolve. The goal of the stakeholders is to develop “new abilities, knowledge, enhance their possibilities of actions, their level of control on the task and on the way to carry out this task, that is to say their autonomy” (Fernagu-Oudet, 2012, p.7).

As part of our research, deployment of the approach contributed to the implementation of a dynamic between the stakeholders of site n°1 to develop their environment. Stakeholders discover (site n°1) or develop (site n°3) new resources that enable them to expand their individual and collective work. This collaboration-enables professional risks prevention in an establishment to be carried out for the social
good. Indeed, the head of the unit, the ergonomist and the doctor of the unit of site n°1 identified new possibilities in their activity that enabled them to intervene on the work organization, thanks to the approach. However, faced with the collective opposition of the site stakeholders and the head supervisor in site n°2, the intervention context was considered threatening. They were not able to manage to turn this context into a capacitating environment, due to the lack of mobilization on the part of the site stakeholders and the head supervisor.

6.2. Use of several strategies by the practitioner during deployment of the approach

Our results show that the practitioner adapts to the context in the hospital in which the intervention occurs in order to involve, mobilize stakeholders, on the long term. The role of the practitioner is to cope with the context of the hospital and to try and show the stakeholders that changes are possible (Daniellou, 2001, p. 122) in their organization. For instance, Daniellou (1998) demonstrated that the impossibility to imagine that we can act differently in a situation seems to generate musculo-skeletal disorders in companies. When deployment of a prevention approach lacks institutional support (as in site n°2), the practitioner has to apply lesser solutions to change the representations of the stakeholders. Bellemare α al. (2000) points out that “little projects are undertaken in a greater proportion than big ones during an ergonomic intervention”. Carrying out “little projects” allows stakeholders to become aware that improvements can be achieved (Daniellou, 2001, p. 122).

Moreover, our results demonstrate that the more mobilized the internal stakeholders of the hospital are in the deployment of the approach, the less the practitioner uses strategies. In this way, the practitioner mobilizes the power of thinking, debating and acting (Daniellou, 1998). Effectively, the practitioner helps stakeholders to react and to improve their working conditions in the care unit and implement preventive actions. His intervention aims at “expanding the social discussion between several logics or viewpoints, to transform representations on work, to answer work as strategic variable in change projects” (Coutarel α al., in press). The practitioner has to steer between positions of intervention, of support and observation, to make stakeholders use this kind of preventive approach in an autonomous way.

6.3. Levers to mobilize stakeholders during deployment of a preventive approach

It seems that an stakeholders is mobilized in a preventive approach if it makes sense with the goals he is set upon and what is possible to do in daily life (Clot, Faïta, Fernandez α Scheller, 2000; 2001). The ORSOSA approach does not prescribe the role of the mobilized stakeholders; each stakeholders becomes involved as he wishes (presentation during instances, giving analysis tools, finding out practical solutions, etc.). Our results, in line with the literature on it, point out that it is not possible to order the different stakeholders to work together, professional logics (as we saw in site n°2). Each stakeholders has to see a common interest: stakeholders in site n°1 meet up to help the head of the unit to cope with the difficulties facing him; for site n°2, stakeholders gather assemble to show their opposition and finally in site n°3, all assemble to improve working conditions in an ongoing fashion. Thus, it is necessary to find what connects bonds the stakeholders: quality of work, maintaining workers in employment, patients' well-being, etc. in order to provoke discussion among them so as to
be careful not to make the health question the sole preoccupation of the stakeholders in work medicine. By allowing stakeholders from different professional logics to get a share in the idea that solutions can be found to face difficulties: identifying methodological solutions, using analysis tools, using advice and resources related to real work, etc. Collective sharing as to work, difficulties met in the care unit enrich the acknowledgment (Dejours, 1993, Grenier & Zeller, 2014) of others' work (Caroly, 2010), which is the origin of collective work. According to Tremblay & Wils (2005) and Labelle, Guérin & Tremblay (2008), “acknowledgment is one of the post powerful levers of collective mobilization (...) to ensure the success of an organizational change”. Thus « transformation of work situations becomes an opportunity to carry out new ways, spaces, abilities rules where a debate on work takes place, and where alternatives become noticeable. Sustainable modification of the relationship with the professional environment in favor of a greater ability of individuals to influence the proceedings of work contributes to the development of the willpower to act. This development of the willpower to act affects individuals, who can live uncomfortable and critical moments (Coutarel & al., in press).

However, this is possible only if the stakeholders in situ express themselves on their activity and on the functioning of the health unit (sites n°1 and 3). So it is necessary to favor a debate in the health units by creating sustainable meeting places between stakeholders (creating participative approach). This debate needs a safe place where all the stakeholders can talk freely (sites n°1 and 3). As Sainsaulieu (2012) said: “common goals shared with workers of health units are few and insufficient” (p.486). The ORSOSA approach is considered as a tool that enables the creation of meet-ups for the different stakeholders about a subject in common favoring debate on work. Examining work organization from all sides and the frequency of contacts produced by the different ORSOSA meetings can make stakeholders aware of the wealth of collective work.

Conclusion
The ORSOSA approach is not only an ideal tool to carry out sustainable professional risk prevention. It is especially a way of deploying a preventive approach that makes transformations in the working environment and on internal stakeholders. We place the concept of mobilization as a factor in the efficacy of interventions, an essential lever to carry out socially, professional risk prevention in companies. A preventive approach can have sustainable effects on work organization by mobilizing its stakeholders on the questions of professional risk prevention.

References


