

Work-Overload and Work-place Stress on Hospital Staff in Ugep-Urban of Yakurr Local Government Area, Cross River State, Nigeria

Etim, John John. (B.PH)^{1*} Okoi, Nta Obono. (MBBS, FWCP)² Ndep, Antor O. (Dr.PH, M.PH, B.Sc., CHES)¹, Ibiang, Obeten Eno. (B.PH)³.

1. Department of Public Health, Faculty of Allied Medical Sciences, College of Medical Sciences, University of Calabar, Calabar, Nigeria.
2. Department of Family Medicine, University of Calabar Teaching Hospital, Calabar, Nigeria.
3. National Teachers' Institute (NTI), Bayelsa State Office, Yenagoa.

* E-mail of corresponding author: etmjhn@gmail.com

ABSTRACT

Work-overload in hospital settings has contributed to poor work performance and poor job satisfaction. Selye's Theory of Systematic Stress and Person-Environment Fit Theoretical Model were used to design a cross sectional descriptive study to determine the relationship between work-overload and work-place stress among hospital staff. A semi-structured self-administered questionnaire and an interview guide were used to collect data from 198 staff in 11 hospitals in Yakurr. Data were coded and analyzed using SPSS version 20 and results were presented using descriptive statistics. Results show 151 (76.3%) female and 47 (23.7%) male staff. However, 34 (72.3%) males and 119 (78.8%) females affirmed that they 'very often' feel stressed resulting from work-overload. Women are also more likely to be vocal about stress than men and better at applying coping strategies that work (55.6%) when compared to males (19.1%). The Chi-square (X^2) analysis, testing the relation between work-overload and work-place stress among hospital staff, was significant at 0.05 with calculated $X^2=8.505$. There was a significant relationship between work-overload and work-place stress at critical $X^2=7.82$. Result of hypothesis tested showed that there is a statistically significant difference between work-overload and increase in work stress on hospital staff. Following the results and findings of the study, it is recommended that work-place stress among hospital staff can be reduced and managed by considering and maintaining a balance between the following variables: (i) the task requirement (patient influx, proportion of ailments, etc) and staff ability (technical-no-how, skills, etc), and (ii) staff ability (technical-no-how, skills, etc), needs, expectations and satisfaction with resources provided (both human and material).

Keywords: Work-overload, work stress, hospital staff, Presenteeism, Key Informant Interview.

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

"If you feel stressed, give yourself a break and if you feel too relaxed, then get back to work"- Etim, J. J.

It is no doubt that stress is inevitable for every individual. It is worth knowing that stress is not bad either for individuals or for a work-force in the healthcare setting. Often, stress helps to bring out the best in the individual (Steven, 2010). However, this is dependent on how the stress events are addressed or interpreted (Etim, Bassey, Ndep, Ekpenyong & Otung, 2015). This is because, Etim et al. (2015) argued that every event has a potential of being a stress or strength depending on how it is handled. It is important to state clearly that despite efforts over the past last half-century by experts in stress to define the term, no satisfactory definition of stress has been in existence. This is because defining stress is much like defining happiness and what may be seen as stress to one person may not be seen as stress to another person. Globally, the genesis of stress research was in 1914, when Walter Cannon – a noted physiologist and an early pioneer of stress – for the first time described the body's reaction to stress by identifying stress reaction as "fight or flight," to imply an involuntary response that occurs in an emergency situation in which an individual must either confront or escape from a dangerous situation. However, the US National Institute for Occupational Safety and Health (NIOSH) in 2008 and Paul (2013) argued that stress may have different effects on the healthcare provider which may be: psychological problems (e.g.; change of mood, defying attitude, non-compliance with office order, disrespect to the superior, dissatisfaction on the job, etc.); behavioural problems (e.g.; tiredness, absenteeism, presenteeism, inability to

work in a group with harmony, individual outlook, turnover, unmindfulness, accident, etc.) and physical problems (e.g.; heart disease, pressure, exhaustion, etc.).

“Presenteeism is worse than absenteeism. Presenteeism is when a staff is at work or performing his/her duties but his/her mind is not in the work. This may lead to near misses and mistakes because of absences of concentration. All these can be a resultant effect of work-overload”- Etim, J. J.

Work-overload occurs when an individual simply has more work than he or she can handle. That is, beyond one’s capacity or capability. According to Amalu, Abang and Odigwe (2013), the overload can be either (i) quantitative (the person has too many tasks to perform or too little time to perform them) or (ii) qualitative (the person may believe he or she lacks the ability to do the job). The first implies that the staff knows how to do it but limited time to do the overload while the later implies that the staff do not even know how to do it even if given the whole year to do it, the work or task would still not be done. This can best be described using the self-efficacy theory. That is, perceived barriers to action where an individual feel inability to manage or cope with stress. The physical demands of a job are its physical requirements on the worker; these demands are a function of the physical characteristics of the setting and the physical tasks the job involves.

2.0 THEORETICAL FRAMEWORK

The following two theories were adopted as a guide for the study: Selye’s Theory of Systematic Stress and Person-Environment Fit Theoretical Model. In a series of animal studies, Selye (1976) observed that a variety of stimulus events (e.g., heat, cold, toxic agents) applied intensely and long enough are capable of producing common effects. Besides these nonspecific changes in the body, each stimulus produces, of course, its specific effect. Heat, for example, produces vasodilatation, and cold vasoconstriction. According to Selye, these nonspecifically caused changes constitute the stereotypical, i.e., specific, response pattern of systemic stress. Selye (1976) defines this stress as ‘a state manifested by a syndrome which consists of all the nonspecifically induced changes in a biologic system’.

This stereotypical response pattern, called the ‘General Adaptation Syndrome’ (GAS), proceeds in three stages or constructs: (a) The *alarm reaction* comprising an initial shock phase and a subsequent counter shock phase. The shock phase exhibits autonomic excitability, an increased adrenaline discharge, and gastro-intestinal ulcerations. The counter shock phase marks the initial operation of defensive processes and is characterized by increased adrenocortical activity. (b) If noxious stimulation continues, the organism enters the *stage of resistance*. In this stage, the symptoms of the alarm reaction disappear, which seemingly indicates the organism’s adaptation to the stressor. However, while resistance to the noxious stimulation increases, resistance to other kinds of stressors decreases at the same time. (c) If the aversive stimulation persists, resistance gives way to the *stage of exhaustion*. The organism’s capability of adapting to the stressor is exhausted, the symptoms of stage-(a) reappear, but resistance is no longer possible. Irreversible tissue damages appear, and, if the stimulation persists, the organism dies. The implication of Selye’s theory and its construct to this study lies in the fact that it outlines the stages a healthcare provider would undergo if stressed as a result of work-overload and as such serves as a guide to the authors in the formulation of research questions for the study.

The early proponents of Person-Environment Fit Theoretical Model were Lewin (1935) and Murray (1938) who conceptualized the interaction between the person and environment ($P \times E$) as the key to understanding people’s cognitive, affective and behavioural reactions. The theory states that optimal fit between the person and his/her environment is needed for effective human functioning. Relating this to this study implies that optimum fit between the healthcare providers and their healthcare work environment is needed for effective healthcare delivery to consumers of healthcare services as well as the patients. In occupational stress research, the fit concept has been characterized as having two components or constructs: (a) the degree of match, congruence, or correspondence between the demands people confront at work and their abilities to meet those demands, referred to as *demands-ability fit*; and (b) the match, congruence or correspondence between the worker’s needs (including physical and psycho-social needs) and the resources available to him/her.

3.0 STATEMENT OF THE PROBLEM

In the hospital settings, just like every other work settings, work-overload has been a major contributing factor to increase in stress levels of workers and has contributed to accidents at work sites, near misses, poor job satisfaction, poor attitude to work, breakdown of equipment, breakdown of staff, slumping of staff, sudden death of staff in the workplace, reoccurring episodes of migraine, body aches, fluctuations in appetite by affecting

workers psychology and Gastro-Intestinal Tract, absenteeism, presenteeism, sick-leave, poor work inputs/outputs, Cardio Vascular Disease, Blood Pressure issues, Stroke, etc. The rate at which hospital staff complain of work-overload in the study area has been very alarming. Public Health Professionals complaining of poor working relationship among hospital staff, Doctors complaining of limited hands, Nurses and Pharmacists complaining of understanding doctors hand writing, laboratory scientists complaining of power failure, Radiographer and Radiologists complaining of poor work environment, Health Information Managers complaining of non-adherence of colleagues to shifts, just to mention a few. Above all these complains as sources of stress to hospital staff, the highest frequency reflected that work-overload has been the major complains and has resulted into poor job satisfaction, poor inputs and outputs and hospital staff breakdown in health. It is upon these complains and authors field observations for the study the researchers were interested in investigating the relationship between work-overload and increase in work stress among hospital staff.

4.0 OBJECTIVE OF THE STUDY

To determine the relationship between work-overload and work-place stress among hospital staff.

5.0 RESEARCH QUESTIONS

How does work-overload affect work-place stress among hospital staff?

6.0 RESEARCH HYPOTHESES

There is no statistically significant difference between work-overload and work-place stress among hospital staff.

7.0 SIGNIFICANCE OF THE STUDY

This study was found to be very important to respondents as the study exposed them to how they can understand when they are stressed, when to have a break/relax without endangering the lives of patients and without putting the hospital into losses as well as know when to return back to work. This study would be of great relevance to her readers, the scientific world, researchers, scholars, government, Non-Governmental Organizations (NGOs), health facility managers and staff globally. This is true because it will serve as a reference material to the listed groups when considering stress reduction and management for individuals, agencies, companies and government.

8.0 LIMITATIONS OF THE STUDY

The major limitation is timing for the study. This is because as at the period and season for this study, it could be that the researchers collected data from respondents in a period when they were having high influx of patients and some staff just been retired and relinquished of their hospital roles without replacement yet. Therefore, the researchers suggest a similar study be carried out in a different season and region to authenticate the findings of this study. Another limitation is that, the sample size may not permit for generalization therefore a similar study can be conducted globally (either as a state or regional project) for easy comparison of results and generalization.

9.0 LITERATURE REVIEW

Occupational stress can be perceived to have effect on workers. It was established in a research carried out on 153 nurses in two public hospitals in Ibadan Metropolis in Nigeria that, job stress has significant effect on physical and mental health of nurses and can result in diagnosis and treatment error (Mojoyinola, 2008 ; Teasdale, Drew, Taylor, & Ramirez, 2008). Research has clearly documented that people who smoke or drink tend to smoke or drink more when they experience stress (Hirokawa, Taniguchi, Tsuchiya & Kawakami, 2012). According to the authors, there is also evidence that alcohol and drug abuse are linked to stress, although this relationship is less well documented. Other possible behavioral consequences are accident proneness, violence, and appetite difficulties (Hutagalung & Gustomo, 2013). The psychological effects of stress relate to a person's mental health and well-being. When people experience too much stress at work, they may become depressed or find themselves sleeping too much or not enough (Wyatt, 2008).

The medical effects of stress affect a person's physical well-being. Heart disease and stroke, among other illnesses, have been linked to stress (Hirokawa, Taniguchi, Tsuchiya & Kawakami, 2012). Other common medical problems resulting from too much stress include headaches, backaches, ulcers and related stomach and intestinal disorders, and skin conditions such as acne and hives (Wyatt, 2008). Clearly, any of the individual

effects just discussed can also affect the organization. Other results of stress have even more direct consequences for hospitals. These include decline in performance, withdrawal, and negative changes in attitudes.

Burnout as another effect of stress has clear implications for healthcare providers, the organizations and patient (Craig Hospital, 2013). Burnout is a general feeling of exhaustion that develops when an individual simultaneously experiences too much pressure and has too few sources of satisfaction. Burnout generally develops in the following way. First, people with high aspirations and strong motivation to get things done are prime candidates for burnout under certain conditions. They are especially vulnerable when the organization suppresses or limits their initiative while constantly demanding that they serve the organization's own ends. In such a situation, the individual is likely to put too much of himself or herself into the job. In other words, the person may well keep trying to meet his or her own agenda while simultaneously trying to fulfill the organization's expectations. The most likely effects of this situation are prolonged stress, fatigue, frustration, and helplessness under the burden of overwhelming demands (Amalu & Uche, 2012). The person literally exhausts his or her aspirations and motivation, much as a candle burns itself out. Loss of self confidence and psychological withdrawal follow ultimately as observed in the case of presenteesm (Etim et al. 2015).

Studies have shown that much of what one knows about stress today can be traced to the pioneering work of Dr. Hans Selye. Among Selye's most important contributions were his identification of the general adaptation syndrome (GAS) and the concepts of stress and distress (Selye, 1976). The GAS begins when a person first encounters a stressor. The first stage is called 'alarm'. At this point, the person may feel some degree of panic and begin to wonder how to cope. The individual may also have to resolve a 'fight-or-flight' question: Can I deal with this, or should I run away? For example, suppose a healthcare provider is assigned to write a lengthy report overnight. His/her first reaction may be 'How will I ever get this done by tomorrow'? If the stressor is too extreme, the person may simply be unable to cope with it. In most cases, however, the individual gathers his or her strength (physical or emotional) and begins to resist the negative effects of the stressor. The healthcare provider with the long report to write may calm down, get back home and gets the work started. Thus, at stage two of the GAS, the person is resisting the effects of the stressor. Often, the resistance phase ends the GAS. If the healthcare provider completes the report earlier than expected, may get tired but will be happy. On the other hand, prolonged exposure to a stressor without resolution may bring on phase three of the GAS: exhaustion. At this stage, the person literally gives up and can no longer fight the stressor. For example, the healthcare provider may fall asleep and fail to finish the report.

Using the 3Rs (Rethink, Reduce and Relax), one can also manage stress and prevent stress-related illness (Hirokawa, Taniguchi, Tsuchiya & Kawakami, 2012). That is;

- i. **Rethink:** one under stress needs to think really seriously about it and talk with others to identify the causes of the stress and take steps to remove the stressor. Understand the type of stressor affecting them and the contributors to the stress.
- ii. **Reduce:** reduce toxin intake – obviously tobacco, alcohol, especially – they might be seen to provide temporary relief but they are working against the balance of the body and contributing to stress susceptibility, and therefore increasing stress itself (Selye, 1976).
- iii. **Relax:** explore and use relaxation methods – they do work if given a chance – Yoga, Meditation, Self – Hypnosis, massage, a breath of fresh air, etc. (Craig Hospital, 2013). Listening to motivational songs, reading motivational books, or use of motivational words can also help. Relaxing and reducing negative thoughts can help regulate the body temperature as it will reduce the secretion of certain hormones in the body that could result into rise in body temperature.

10.0 METHODOLOGY

The study adopted a descriptive cross sectional studies. The study setting was all the 11 hospitals (1 public and 7 private) in Ugep-Urban. The scope of the study was centers on work-overload and increase in work stress among hospital staff. The study population comprised of all hospital staff in the study area as at the time of this research. The sample size determination was done through an all-inclusive technique where all the respondents in the study area are used since the study population was small. Therefore, the sample size was 198 hospital staff (175 respondents from the public and 23 from the privates). By this, all the departments in each facility was represented or covered. Instruments for data collection was researcher administered questionnaire and Key Informant Interviews (KIIs) guide. The instruments used for data collection were pre-tested among 40 hospital staff outside the study area. Data from the respondents were coded, scored, and analyzed. In analyzing the data from the pilot test, its reliability coefficient using Person Product Moment Correlation was 0.76 which

indicates that the instrument was reliable. As regards data collection procedure, data was collected from each hospital/department to the other before moving to the next hospital/department in no particular order within one month. Method of data analysis was done through SPSS version 20, test of hypothesis was done using Chi-square statistical test tool within 95% CI with a df of 3. In ensuring ethical consideration, verbal informed consent was sort from respondents before data collection commenced. Respondents were assured of confidentiality, voluntary participation and freedom to opt out at any point of the study.

11.0 RESULTS AND DISCUSSION

A total of 198 staff were used for the study. The gender distribution of respondents showed that 151 (76.3%) were females and 47 (23.7%) were males. Among these, respondents aged 18 – 27 were 35 (17.7%), 28 – 37years were 85 (42.9%), 38 – 47years were 62 (31.3%), 48 – 57years were 13 (6.6%), and 58 – 67years were 3 (1.5%). This study shows that respondents between the ages of 28-37 had the highest counts of 85 (42.9%). This is in conformity with the study findings of Sukumar and Kanagarathinam (2016) that studied 120 respondents on occupational stress and observed that respondents between the ages of 31-40 had the highest counts of 55 (45.8%). Marital status of respondents shows that 111 (56.1%) were married, 79 (39.9%) single, 3 (1.5%) divorced, and 5 (2.5%) were widowed. At the time of this study, 98 (49.5%) respondent had between 1 – 5 children, 10 (5.1%) had 6 – 10 children and 90 (45.5%) had no children.

Table-1: Respondents (by gender, age, marital status, and number of children) who perceive work-overload as major source of stress at work.

Question: How often do you perceive work-overload as a major source of and contributor to your stress at work?					
S/N	Variables	Sub-variables	Very often (%)	Not often (%)	Total (%)
1	Gender	Males	34 (72.3)	13 (27.7)	47 (100)
		Females	119 (78.8)	32 (21.2)	151 (100)
		Total	153 (151.1)	45 (48.9)	198 (200)
2	Age	< 28 Years	14 (40.0)	21 (60.0)	35 (100)
		28 – 47 Years	121 (82.3)	26 (17.7)	147 (100)
		> 47 Years	7 (44.0)	9 (56.3)	16 (100)
		Total	142 (166.3)	56 (134.0)	198 (300)
3	Marital status	Married	74 (66.7)	37 (33.3)	111 (100)
		Single	59 (74.7)	20 (25.3)	79 (100)
		Divorced	3 (100)	0 (0.0)	3 (100)
		Widowed	5 (100)	0 (0.0)	5 (100)
		Total	141 (341.4)	57 (58.6)	198 (400)
4	Number of children	1 – 5	83 (84.7)	15 (15.3)	98 (100)
		6 – 10	2 (20.0)	8 (80.0)	10 (100)
		No Child	67 (74.4)	23 (25.6)	90 (100)
		Total	152 (179.1)	46 (120.9)	198 (300)

The analysis in Table-1 following the question on how often respondents perceived work-overload as a major source or contributing factor to their stress at work shows that, of the 47 males and 151 females in the study, 34 (72.3%) males and 119 (78.8%) females affirmed that it is ‘very often’ they attribute their stress at work to work-overload as against 13 (27.7%) males and 32 (21.2%) females who ‘not often’ attribute their stress at work to work-overload. This is by implication that they all experience stress resulting from work-overload but not very often. This corroborates with the study of Vyas (2014) who studied stress level among nurses and found that they all attest that they experience stress resulting from load at work.

Even though all respondents admitted that they feel stressed resulting from work-overload, as regards age; 121 (82.3%) respondents who were 28 – 47 years admitted it ‘very often, followed by 14 (40.0%) respondents who were below 28 years then by 7 (44.0%) respondents who were 47 years and older. This result

could be attributed to the fact that people found within the age range (28-47) are likely to express their feelings when they are confronted by challenges or tasks that requires hard work while those < 28 and > 47 tend to keep their feelings to themselves. The study of Sukumar and Kanagarathinam (2016) affirms this results as it is shown in their study that respondents within 31-40 years recorded more stress.

The married 74 (66.7%) admitted stress very often. This could be presumed that domestic stress contributes to the perceived workplace stress. However, it was also found that respondents who were single 59 (74.7%) admitted stress very often. This could be attributed to the fact that they formed the bulk of respondents in the studied sample size. On the other hand, all the 3 divorced and 5 widowed respondents in the study admitted stressed very often at workplace. This can be attributed to the psychological/emotional stress resulting from divorce and loss of partner. Domestic stress as a confounder to workplace stress cannot be over emphasized as the study shows that 83 (84.7%) respondent who had children admitted stressed very often. Though contrary to this, 67 (74.4) respondents who were single as at the time of this study also admitted stressed at work (Table-1). This can be attributed to the fact that some respondents who were single may have psychological stress resulting from several expectations as regards; life partners, better remuneration, convivial workplace environment, improved staff-staff relationship, relinquishment from adhoc duties, etc. as corroborated by Etim et al. (2015).

Table-2: Respondents ability to manage or cope with stress.

Question: How likely can you manage or cope with stress?				
Variables	Sub-variables	More likely (%)	Less likely (%)	Total (%)
Gender	Males	9 (19.1)	38 (80.9)	47 (100)
	Females	84 (55.6)	67 (44.4)	151 (100)
Total		93 (74.7)	105 (125.3)	198 (200)

Despite the analysis in Table-1 shows that women are more likely to express stress than men. Considering the coping ability of women and men to stress, the analysis and data in Table-2 shows that females (55.6%) are still more likely to cope with stress and manage it as compared to their male (19.1%) counterparts.

The null hypothesis was stated as: there is no statistically significant difference between work-overload and increase in work stress among hospital staff. The independent variable was work-overload while the dependent variable was increase in work stress among hospital staff. To test the hypothesis, the test statistical technique used was the Chi-square (X^2). This result is presented in Table-3. The result of the analysis in table-3 reveals that the calculated Chi-square (X^2) value is 8.505 and the critical value of Chi-square at 95% confidence interval (X^2_{95}) is 7.815 at degree of freedom (df) of 3. Since the test statistic (X^2) is greater than the critical value (X^2_{95}), the researchers rejected the Null Hypothesis (H_0) in favour of the Alternative Hypothesis (H_a). This implies that, work-overload contributes to hospital staff level of stress. This is by implication shows that there is a statistical significant relationship between the two variables studied.

Table-3: Test of hypothesis – there is no statistically significant difference between work-overload and increase in work stress among hospital staff [Chi-square (X^2)]

Variables	f_o	f_e	f_o	f_e	Cal. X^2 -value
Work-overload	52	49.5	34	49.5	8.505*
Increase in work stress	47	49.5	65	49.5	
Totals	99	99	99	99	

*significant at 0.05; df=3; Critical $X^2 = 7.82$

The result of the key informant interviews (KIIs) as the qualitative data source affirms that hospitals staff in all the health facilities studied attested that work-overload contributes to stress within the workplace. This was also observed as some key informants reported that they are not comfortable working more than their strength can carry or working above the resources provided. Lack of resources needed to work was a recurrent theme associated with increased work-place stress;

“It won’t be fair when we work more than our strength or the resources provided to do the hospital job. Those of us in private hospitals work so hard, knowing too well that one is closely supervised because any negligence to work or duty will cost you your remuneration”. (Key informant from one of the private hospitals)

“I feel uncomfortable when I discover that the hospital management does not seem to understand that hospital staff are over working themselves and as such requires break or rest. Because of limited staff you will find one person doing the job that would have been done by more than one staff”. (Key informant from one of the private hospitals)

“Government expects you to work more than the resources provided, it’s not possible. Sometimes you know what to do but in the absence of equipment or basic drugs, you seem not to go further but refer a simple case that could have been handled in this secondary facility. Cases like this have been source of stress to me”.

(Key informant from one of the public hospitals)

“To me, the basic source of stress is when there are no drugs in the facility. Sometime I have finished prescribing only to discover that there are no drugs even as common as paracetamol as one may think. It is always, really, and very frustrating”. (Key informant in one of the public hospitals)

However, based on authors field observations, it is here asserted that stress among hospital staff can be reduced and manage by considering and striking or maintaining a balance between the following variables: (i) the task requirement (patient influx, proportion of ailments, etc) and staff ability (technical-no-how, skills, etc), and (ii) staff ability (technical-no-how, skills, etc), needs, expectations and satisfaction and Resources provided (both human and material). This includes how sufficient and up to date the resources are, maintenance culture and training of staff in its operation. This is pictorially presented and explained in fig.-1 & 2.

		Staff ability (Technical-know-how, skills, etc).	
		High	Low
Task requirement (Patient influx, expectations, and satisfaction, ailment proportion, etc.)	High	Low stress	High stress*
	Low	Low stress	Low stress

Fig.-1: Authors rendition for stress reduction and management by matching task requirement and staff ability variables.

Resources provided (both human and material), management care.		
	High	Low
High	Low stress	High stress*
Low	High stress*	Low stress

Fig.-2: Authors rendition for stress reduction and management by matching staff ability and resources provided variables.

It implies that, when staff ability and skills to address health issues is high while task requirement is low, there will be low stress on the staff, where staff ability is high and task requirement is high there will be low stress because the staff is equal to the task but stress will be high if task requirement is high where staff ability is low (Fig.-1). This explanation goes same for staff expectations and resources provided. If resources are low and staff expectation is high, there will be high stress for the staff but if resources provided are high and staff skills are high there will be low stress (Fig.-2).

12.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

If you feel stressed, give yourself a break and if you feel too relaxed, then get back to work. One of the tenets for safety is ensuring safety to the rescuer first, safety to the victim or patient and then ensuring safety to others too. The healthcare providers are to be safe in order to safe others. Stress is not healthy for hospital staff because if they breakdown the patient will definitely not have the care and treatment anticipated. It can be deduced from this study that work-overload increases stress levels of hospital staff. Therefore, following the results and findings of this study, it is recommended that:

- i. hospital staff can rest when over stressed so as to avoid exhaustion and breakdown. This will restart the healthcare worker into a state that would enable them work more effectively and efficiently;
- ii. before taking a break, the patient should be stabilized and another healthcare provider called to take over before the break;
- iii. hospital management should value human resources as well as equipment by ensuring that hospital staff do not over work themselves out. This can be made possible by ensuring there are workable three shifts and that staff adheres to it;
- iv. government and organizations should assist healthcare facilities with the provision of material and human resources in order to ameliorate the problem of occupational stress in health facilities resulting from work-overload.

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Appendix

Stress Assessment/Workload Analysis Questionnaire for Hospital Staff

Serial #. _____

Date: _____

Department of Public Health
Faculty of Allied Medical Sciences
College of Medical Sciences
University of Calabar
Calabar

Informed Consent Form for Hospital Staff

Dear Respondent/Participant,

I am a researcher of the above mentioned institution, presently undertaking a research on work-overload and increase in work stress on hospital staff in Ugep-Urban of Yakurr Local Government Area, Cross River State, Nigeria.

Please respond to all items herein sincerely as the data generated from this study will be used for academic purpose only and I assure you of strict confidentiality of information elicited. I would be happy to have you complete this material and in anticipation, I say thank you for participating in this study.

Etim, John John.
Research Team Leader.

For Participant/Respondent (Staff)

I hereby confirm that, after receiving the above information, both by word-of-mouth and by writing, I agree to participate in this survey. My information would only be used only for research purposes by the Etim John (Researcher). I am informed that participation is voluntary, and that I can withdraw my participation at any time.

Signature or mark of the respondent _____ Date: _____

Section-A: DEMOGRAPHIC DATA

Please tick (✓) in the column provided below the answer which is most appropriate to you.

1. **What is your gender:** Male , Female
2. **What is your age:** 18-27 , 28-37 , 38-47 , 48-57 , 58-67 , 68-77 , 78 & older .
3. **What is your marital status:** Single , Married , Divorced , Widowed , Others _____
4. If Married, Number of children?

5. **What is your religion:** Christianity , Islam , Traditional , Others _____
6. How long have you worked in this hospital?

Section-B: WORK ASSESSMENT

7. What are your qualifications?

8. What is your position/designation in this hospital?

9. What work do you do in this hospital (Work Description)?

10. Apart from your regular work, do you do any other duties? Yes , No . If Yes, please state down

11. How much is your salary? #18-50,000 , #51-100,000 , #101-250,000 , >#250,000
12. Are you satisfied with your salary? Yes , No .
13. Is your salary commensurate with your job description? Yes , No .
14. Do you have approved days off? Yes , No .
15. Do you operate on shifts? Yes , No .
16. If Yes, do staff adhere to it? Yes , No , Not Often .
17. How long do you stay before the next staff takes over?

18. In the past month, how often have you felt over worked?	Never <input type="checkbox"/>	Almost Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Fairly Often <input type="checkbox"/>	Very Often <input type="checkbox"/>
19. Do you receive support from the management?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Does the management respond to staff issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Do you go on annual leave? Yes , No .

22. Are you comfortable with your work facilities/equipments? Yes , No .

Section-C: STAFF PERCEPTION OF STRESS

23. What do you consider to be hospital Work Stress?

24. Do you feel stressed in your work? Yes , No .

25. What do you really think are the major sources of your stress in the work place?

26. What are the signs you feel when stressed at work?

27. Does your family care or other responsibility affect your work performance? Yes , No .

Section-D: STAFF RESPONSE TO STRESS/ATTITUDE TO PATIENT

28. Have you felt angry or upset at patients' situation or question?	Never <input type="checkbox"/>	Almost Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Fairly Often <input type="checkbox"/>	Very Often <input type="checkbox"/>
29. Have you ever felt stressed at work as a result of your workload?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you ever felt stressed at work as a result of caring for patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever felt stressed at work as a result of the attitude of your co-workers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. What do you do when you feel stressed?

Section-E: STAFF SELF EFFICACY/HEALTH BELIEFS

33. Do you really think the stress you are passing through at work can negatively affect your patient?
 Yes , No , Not Sure .

34. Has the stress you have been passing through influenced your attitude? Yes , No , Not Certain .

35. Do you think your attitude can affect the patient's confidence on your services? Yes , No , Not Sure .

36. Does attitude of your fellow staff towards you affect your productivity at work? Yes , No , Not Sure .

37. Can you please put down the stress factors you think have negatively influenced your attitude at work?

38. What are the possible ways you think hospital Work Stress can be prevented, reduced or managed?

39. What general comment do you have about your work environment in this facility?

THANK YOU