01 / RESEARCH AND QUANTITATIVE ANALYSIS

Healthcare workforce wellbeing

Workload, recovery time and the intention to leave

PY3202 Applied Psychology Project · James Cook University (Singapore) · 2026

THE RESEARCH QUESTION

Which working conditions were linked to burnout and plans to leave, and how could teams respond?

My contribution

I ran all group analyses in SPSS, conducted two consultations and organised the Chinese records and English versions. I presented the Job Demands–Resources (JD–R) model, our intervention plan and my critical review of the evidence.

5,000	44.4%	66.7%
COURSE-PROVIDED RECORDS	REPORTED BURNOUT "OFTEN"	INTENDED TO LEAVE

Why we focused on these working conditions

We chose three of eight categories for their high stress, frequent burnout and low job satisfaction.

WORKPLACE FACTOR	MEAN STRESS (1–10)	MEAN SATISFACTION (1–5)	BURNOUT "OFTEN"	INTENDED TO LEAVE
Heavy workload	8.20	1.97	54.6%	74.1%
Work–life imbalance	8.02	2.00	49.4%	78.5%
Safety concerns	8.01	2.02	54.7%	69.6%

Mean stress differed by at most 0.19 points across these three groups. For this exercise, the lecturer advised assuming a 1–10 stress scale and specified a 1–5 job satisfaction scale.

ASSOCIATIONS ACROSS ALL 8 CATEGORIES

Burnout frequency (V = .207)

Intention to leave (V = .209). Both $p < .001$.

EMPLOYEE ASSISTANCE PROGRAMME (EAP)

Intention to leave by reported access

No significant association (V = .017, $p = .235$).

Cramér's V measures association strength from 0 to 1. The course dataset recorded EAP access only. Programme use and effectiveness remain unknown. These cross-sectional findings show associations.

How I analysed the data

01 / CATEGORICAL OUTCOMES

I used cross-tabs and chi-square tests to examine links between workplace factors, burnout and intention to leave.

02 / GROUP MEANS

I compared mean stress and job satisfaction across the eight categories using Welch's ANOVA and Games–Howell pairwise tests.

03 / SUPPLEMENTARY MODEL

I ran a binary logistic regression on intention to leave. Comparing predicted and observed rates showed poor fit, so I interpreted the estimates cautiously.

The JD–R model guided our next question. Which demands could teams reduce, and what would help staff recover?

02 / STAKEHOLDER CONSULTATION

How two consultations changed the proposal

I asked two professionals where our early ideas might break down. Their responses changed how we thought about manager check-ins, confidentiality and cover for breaks.

A / MENTAL-HEALTH PRACTICE

Oral interview

A mental-health practitioner discussed screening, targeted support and the pressures that employers can address.

B / HEALTHCARE PROJECT MANAGEMENT

Seven-question written consultation

A healthcare project manager in a non-clinical role considered staffing, privacy and the time managers could spare.

What to prioritise with limited resources

MY QUESTION TO THE PROJECT MANAGER

With resources for only one or two measures, which would you choose first? Which would be hardest to put into practice?

The four options were manager training, brief workload checks, protected rest, and clearer information on confidentiality and referrals.

How the feedback shaped the design

IDEA	WHAT I HEARD	WHAT WE TOOK FROM IT
Protected breaks	The project manager put rest first. Staff still need someone to cover their duties.	Agree on cover before asking staff to take a break.
Regular staff check-ins	Staff may read questions about their mental health as a performance assessment.	Tell staff who can see their answers and how those answers will be used.
Manager-led support	Recognising strain takes time and skill. A manager may see a problem but lack authority to fix it.	Keep check-ins brief and give managers a route to someone who can act.

Asking for help privately

The practitioner saw value in screening to identify staff who needed support. The project manager warned that a check-in could feel like a performance review. We needed a way for staff to raise concerns and understand who could see their answers.

MY REFLECTION

Next time, I would start with “Tell me about the last time someone on your team missed a break.” Hearing what happened before offering options would give the interviewee more room to challenge my assumptions.

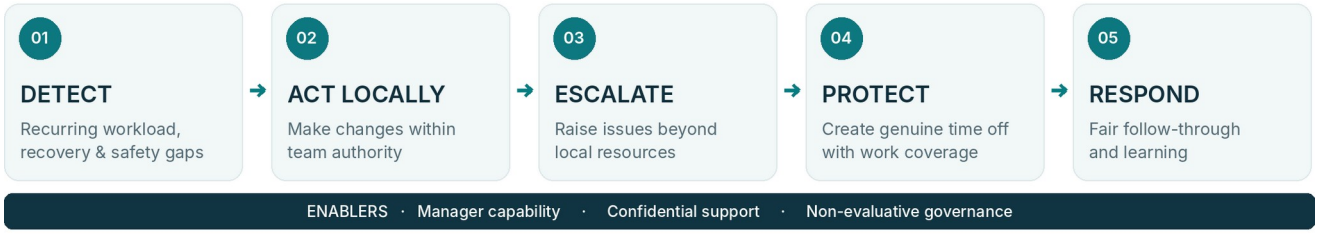
These are two professional perspectives. Our group also considered a separate written response from a healthcare academic.

03 / GROUP PROPOSAL AND FEASIBILITY

Workforce Recovery and Safety Initiative

WRSI · Group proposal for a feasibility pilot · Not implemented

Our group proposed a way for teams to address recurring problems with workload, recovery and safety. For example, a team repeatedly missing breaks would first try to rearrange cover. If staffing prevented that, a manager with authority to change the roster would review the issue and report back.



Staff and managers would agree on who covers a break, when an issue needs escalation and who must respond.

A 12-week pilot in one clinical service

WEEKS 01–02	WEEKS 03–04	WEEKS 05–10	WEEKS 11–12
Map current practice	**Design with staff**	**Run the pilot**	**Review with staff**
Record baseline measures and map how teams manage workload, breaks and safety.	Agree on escalation routes, prepare managers and explain data privacy.	Track participation, break cover and whether managers respond to concerns.	Ask what worked, what added work and whether staff felt safe speaking up.

What we would measure

DELIVERY

Who took part, who covered breaks, how managers responded and how much time it cost.

STAFF EXPERIENCE

Could staff step away, influence their work and raise safety concerns with confidence?

WORKFORCE OUTCOMES

Changes in stress, burnout, job satisfaction and intention to leave would be exploratory.

WHEN AN INDICATOR CAN MISLEAD

More recorded breaks could hide work pushed past the end of a shift. More safety reports could mean more incidents, greater trust in reporting, or both. We would ask staff what changed before interpreting either trend.

How the service would decide whether to continue

Staff and managers would review the findings together. The service could continue or adapt the pilot, or pause or stop it if the extra workload, risks to privacy or disruption to care outweighed the benefits.

How I weighed the evidence

In the research I reviewed, training improved managers' knowledge and self-reported supportive behaviour. The pooled evidence showed no significant improvement in employee psychological symptoms (Gayed et al., 2018). I presented training as a way to help managers respond and refer staff.

PROJECT SOURCES PY3202 course dataset, SPSS Final Output v8, consultation records and translations, and group presentation. Theory and intervention evidence included Bakker et al. (2023), Lesener et al. (2019), Panagioti et al. (2017), Gayed et al. (2018), O'Neill et al. (2022) and Boskma et al. (2025).