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**ORGANIZATIONAL SUPPORT FOR MITIGATING WORK-RELATED
STRESS AMONG EMERGENCY DEPARTMENT STAFF: A CROSS-
SECTIONAL STUDY OF LEVEL 5 HOSPITALS IN NAIROBI
COUNTY, KENYA**

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**SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION
IN HEALTHCARE MANAGEMENT AT STRATHMORE UNIVERSITY**

**STRATHMORE BUSINESS SCHOOL
STRATHMORE UNIVERSITY
NAIROBI, KENYA**

JUNE, 2026

DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made in the dissertation itself.

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Mary Goretti Mukai Kaseve

APPROVAL

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ABSTRACT

The Work-related stress among emergency department staff is a global concern, yet little empirical evidence exists on how organizational support and staff perceptions shape stress outcomes in African emergency care settings. Prior studies in Kenya have focused mainly on clinicians, overlooking non-clinical cadres, and have rarely compared hospital ownership models. Moreover, the mediating role of staff perceptions, central to Organizational Support Theory, has not been systematically tested in resource-constrained emergency departments. This study addressed these gaps by investigating work-related stress and the adequacy of organizational support among clinical and non-clinical staff in three Level 5 hospitals in Nairobi County (public, private, and faith-based). Using a cross-sectional convergent parallel mixed-methods design, quantitative data from 133 respondents were analysed in IBM SPSS, while qualitative data from open-ended responses and nine key informant interviews were thematically analysed in NVivo 14. Findings showed that 90.2% of staff experienced moderate to high stress (mean = 4.75/7.00), driven by heavy workload (57.9%), staffing shortages (44.4%), and resource inadequacy. Organizational support significantly predicted stress outcomes ($\beta = 0.550$, $R^2 = 0.349$, $p < .001$), yet emotional support and resource adequacy scored below the midpoint, and 60.2% of staff rated existing support as ineffective. Staff perceptions partially mediated the support–stress relationship, transmitting nearly half (49.6%) of the total effect, with management responsiveness and support effectiveness rated lowest. Counselling was underutilized due to confidentiality concerns, while informal peer networks emerged as the primary coping buffer. The study contributes novel evidence by extending Organizational Support and Job Demands–Resources models into African emergency care, incorporating non-clinical cadres and hospital ownership comparisons, and empirically confirming the mediating role of staff perceptions. Practically, the findings underscore that occupational stress in Nairobi’s emergency departments is structurally embedded and requires systemic interventions. Recommendations for healthcare administrators include annual staffing needs assessments, externally contracted employee assistance programs accessible across shifts, and equitable recognition frameworks to strengthen workforce resilience and retention. By integrating clinical and non-clinical cadres across hospital ownership models, the study advances methodological inclusivity and provides context-specific evidence to guide organisational reforms in African emergency care.

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DEDICATION

I dedicate this research document to my beloved family, my spouse, Dennis, and our children, Michelle, Maurice, and Matilda, for your unwavering support, patience, and love throughout my entire period of study, especially during the compilation of this document. Your encouragement and inspiration gave me the strength and determination to successfully complete this study.

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Background of the study

Work-related stress is progressively recognised as a global public health challenge, especially in high-acuity environments such as emergency departments where the intensity, unpredictability, and complexity of clinical demands are exceptionally high (World Health Organization & International Labour Organization, 2022). Evidence consistently shows that emergency clinicians experience significantly higher stress levels than most other health professionals, resulting in burnout, emotional exhaustion, and reduced job satisfaction (Adriaenssens, Gucht, & Maes, 2015). Stress in emergency care settings is further compounded by overcrowding, trauma exposure, critical incidents, and the pressure to make rapid, life-saving decisions (McAllister, McKinnon, Andrews, & Wright, 2019). These conditions compromise patient safety, weaken staff morale, and diminish overall service quality, underscoring work-related stress as a critical determinant of health system performance (Swancott, Armstrong, Roland, Walters, & Kirk, 2024).

Globally, chronic exposure to work-related stress among healthcare workers is associated with burnout, mental health challenges, cardiovascular problems, reduced attentiveness, and compromised clinical performance (Rathnayake & Ekanayaka, 2022). In emergency departments, persistent stress contributes to increased medical errors, low productivity, reduced empathy, and poor decision-making (Molina-Rivas, García-Herrero, Herrera, & López-García, 2020). Stress also disrupts teamwork and interprofessional collaboration, both of which are essential in fast-paced emergency environments. At the organisational level, these effects culminate in absenteeism, high staff turnover, and increased operational costs (Rhoades & Eisenberger, 2002).

Organisational support structures play a vital buffering role in mitigating work-related stress among healthcare workers. According to Organizational Support Theory, employees experience lower stress when they believe that their organisation values their contributions and prioritises their wellbeing (Eisenberger, Fasolo, & Davis-LaMastro, 1990). In emergency care settings, organisational support includes leadership responsiveness, adequate staffing, resource availability, emotional support, effective communication structures, equitable workload management, and opportunities for professional development (Shanafelt, Ripp, & Trockel, 2020). Both formal supports such as supervision systems, employee assistance programs,

debriefing sessions, and standard operating procedures, and informal supports such as peer relationships and collegiality, contribute significantly to staff resilience. However, inconsistencies in support systems, particularly in low- and middle-income country healthcare settings, limit the effectiveness of these protective structures (Muchiri, 2022).

Regional evidence from Sub-Saharan Africa suggests even higher levels of stress due to heavy workloads, chronic understaffing, resource shortages, and limited emergency care infrastructure (Ndejjo, Musinguzi, & Wekesah, 2021). In Kenya, several studies report high rates of burnout and occupational stress among healthcare staff, particularly nurses and emergency care personnel (Kwobah E. K., et al., 2021). Contributing factors include surging patient volumes, resource inequities, demanding work schedules, and insufficient psychosocial support mechanisms (Ojakaa, Olango, & Jarvis, 2014). Workplace violence against emergency nurses has also been documented as a compounding stressor in Kenyan hospitals (Kibunja, Musembi, Kimani, & Gatimu, 2021). Yet most Kenyan studies remain descriptive, focusing on burnout prevalence without examining organisational support as a determinant or moderator of stress within emergency departments.

Staff perceptions significantly shape how employees respond to job demands and stress. Perceived organisational support, defined as the degree to which staff believe the organisation cares about their wellbeing and values their contributions, is strongly linked to resilience, job satisfaction, and coping ability (Rhoades & Eisenberger, 2002). Research indicates that perceptions of support often exert stronger influence on psychological outcomes than the actual support provided (Eisenberger, Shanock, & Wen, 2020). In emergency departments, perceptions related to fairness, recognition, respect, resource availability, autonomy, and leadership communication play pivotal roles in determining stress levels (Adriaenssens, Gucht, & Maes, 2015). Despite this evidence, few Kenyan studies investigate staff perceptions as a mediating mechanism between organisational support structures and work-related stress outcomes.

Kenya's healthcare system is structured into six service delivery levels, with Level 5 hospitals functioning as high-volume county referral facilities providing specialised and emergency services. Nairobi's Level 5 hospitals are analytically distinct because they serve a densely populated metropolitan catchment with limited referral options, and uniquely combine public, private, and faith-based ownership models within a single county. This convergence creates a natural comparative setting not replicated elsewhere in Kenya. These varied ownership models demonstrate significant differences in organisational culture, management practices, resource availability, and staff support mechanisms (Kirigia, Emrouznejad, & Sambo, 2016).

Emergency departments within Level 5 hospitals in Nairobi handle large, diverse urban populations and respond to complex medical and trauma-related cases under intense operational pressure. Differences across these ownership models may create distinct organisational support environments, influencing stress experiences among emergency department personnel. Yet comparative research in these settings remains limited.

This study is theoretically anchored in Organizational Support Theory (Eisenberger, Huntington, Hutchison, & Sowa, 1986) and the Job Demands–Resources model (Bakker & Demerouti, 2007). Organizational Support Theory emphasizes how employees’ perceptions of organisational care and recognition influence resilience and stress outcomes, while Job Demands–Resources explains how job demands and available resources interact to shape occupational stress and burnout. Alternative frameworks such as the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), the Effort–Reward Imbalance Model (Siegrist, 1996), and Conservation of Resources theory (Hobfoll S. E., 1989) also offer valuable insights, but they foreground individual appraisal or resource loss. Organizational Support Theory and Job Demands–Resources were selected here because they emphasise organisational structures and perceptions, which are central to this study’s focus on institutional support. Together, these frameworks provide the foundation for examining how organisational support and staff perceptions influence stress experiences in Nairobi’s Level 5 emergency departments.

Despite widespread recognition of emergency care as a high-stress environment, significant knowledge gaps exist regarding how organisational support influences work-related stress among emergency department staff in Kenya. Most studies focus on burnout prevalence without analysing organisational determinants. Variations in organisational support across public, private, and faith-based hospital settings are rarely explored. Existing studies seldom include both clinical and non-clinical emergency personnel, despite their shared exposure to emergency workflows. Staff perceptions of organisational support, though theoretically central, are rarely examined as mediating variables in local empirical models. Finally, few studies employ robust mixed-methods designs that integrate quantitative and qualitative insights.

This study therefore investigates how organisational support influences work-related stress among staff in Level 5 emergency departments in Nairobi County, incorporating staff perceptions as a mediating factor. By addressing these gaps, it contributes to academic knowledge, informs policy, and provides practical insights for strengthening staff resilience and healthcare system performance in Kenya’s urban emergency care settings.

1.2 Problem definition

Emergency departments in Kenya's Level 5 hospitals face increasing patient loads, resource constraints, and complex emergencies, exposing healthcare workers to high levels of work-related stress. Stress in these settings is consistently linked to long working hours, inadequate staffing, and limited psychosocial support. For instance, a study at Kenyatta National Hospital documented rising workloads against declining staff numbers, leading to heightened risk of burnout (Muchiri, 2022). Similarly, research at Nakuru Level 5 Hospital highlighted that weak occupational safety and health practices negatively affected staff commitment (Ndejjo, Musinguzi, & Wekesah, 2021).

At the national level, reports indicate that work-related stress affects nearly one-third of Kenyan employees (31.6%), with consequences including hypertension, anxiety, and reduced productivity (Kenya National Bureau of Statistics, 2020). Among healthcare workers, stress prevalence is even higher, with studies across Sub-Saharan Africa reporting depression rates ranging from 4.8% to 96.5% and post-traumatic stress disorder symptoms from 11.7% to 78.3% (Adriaenssens, Gucht, & Maes, 2015). These regional figures illustrate the scale of the problem but were not generated within Kenyan emergency care settings, and should therefore be interpreted as indicative rather than directly transferable.

Despite this burden, organizational support systems in emergency departments remain fragmented and underdeveloped. Reports highlight inadequate infrastructure, training, and psychosocial support, leaving staff vulnerable to stress and burnout (Emergency Medicine Kenya Foundation, 2021). While organizational support is recognized as a critical buffer against work-related stress (Eisenberger, Shanock, & Wen, 2020), limited empirical evidence exists on how such support functions within Kenyan emergency departments. Existing studies tend to focus broadly on burnout or job dissatisfaction, without analysing specific organizational support structures such as leadership responsiveness, staffing adequacy, communication systems, and psychosocial support.

Although interventions such as counselling and wellness programs have been introduced in Kenyan hospitals, their fragmented and inaccessible nature has limited effectiveness (Kwabah B. , Othieno, Ndeti, Mutiso, & Mwayo, 2023). Counselling uptake remains low due to confidentiality concerns (Bii, 2023), while wellness initiatives often fail to reach night-shift staff or emergency personnel. Conversely, informal peer networks such as collegial check-ins and departmental support groups have provided some relief (Agarwal, Brooks, & Greenberg, 2019) but remain fragile without institutional resourcing (Ojakaa, Olango, & Jarvis, 2014). This

pattern illustrates why stress levels remain persistently high despite the presence of interventions.

Furthermore, staff perceptions, central to Organizational Support Theory, remain underexplored in the Kenyan context. Employees' beliefs about whether their organization values their contributions and prioritizes their well-being significantly shape resilience and stress responses (Rhoades & Eisenberger, 2002). Without examining these perceptions, interventions risk being misaligned with frontline realities and may fail to achieve meaningful impact.

The problem is compounded by Kenya's diverse hospital ownership models. Public, private, and faith-based Level 5 hospitals operate under different governance structures, resource allocations, and organizational cultures, which likely influence the availability and effectiveness of support (Muchiri, 2022). Yet comparative evidence across these models is scarce, constraining policymakers and hospital administrators from designing tailored interventions that strengthen workforce resilience and improve patient outcomes.

These unresolved gaps highlight the need for empirical investigation into how organizational support and staff perceptions shape stress outcomes in Kenya's Level 5 emergency departments. Prevalence, organizational support gaps, staff perceptions, and ownership-model variation are treated not as four separate problems but as four empirically necessary components of this single, central question. The desired state is one where staff are adequately supported through structured organizational mechanisms that mitigate stress and enhance resilience. The existing gap is the mismatch between this ideal and the current reality of overstretched, under-supported staff. This study therefore investigates the influence of organizational support on work-related stress among clinical and non-clinical emergency department staff in Nairobi County, examining staff perceptions as a mediating factor and comparing across hospital ownership models to inform targeted strategies. What remains unknown is how organizational support structures and staff perceptions interact to shape stress outcomes across Kenya's diverse Level 5 hospital ownership models, a gap this study directly addresses.

1.3 Research objectives

1.3.1 General objectives

To examine the role of organisational support systems in mitigating occupational stress among emergency department staff in Nairobi's Level 5 hospitals, with the aim of generating evidence to strengthen workforce resilience and improve health system performance.

1.3.2 Specific objectives

- i. To assess the prevalence and sources of work-related stress among clinical and non-clinical emergency department staff, recognising that stress may be structurally embedded across cadres.
- ii. To examine how organisational support structures relate to work-related stress outcomes, with particular attention to the role of supervisor support as a potential buffer.
- iii. To analyse the mediating role of staff perceptions of organisational support, exploring how perceptions may transmit or reshape the support–stress relationship.

1.4 Research questions

- i. What is the prevalence of work-related stress among emergency department staff in Nairobi's Level 5 hospitals, and what structural sources contribute to this stress?
- ii. In what ways do organisational support structures relate to work-related stress outcomes among emergency department staff, and which forms of support appear most influential?
- iii. How do staff perceptions mediate the relationship between organisational support structures and work-related stress?

1.5 Scope of the study

The study focuses on three Level 5 hospitals in Nairobi County, representing the public, private, and faith-based sectors. These hospitals were randomly selected from the list of all eligible Level 5 hospitals within the county to minimize selection bias and ensure diversity of organisational structures and support systems (Kirigia, Emrouznejad, & Sambo, 2016). This design enables comparative analysis to identify variations in stress levels, the effectiveness of organisational support interventions, and institutional best practices (Adriaenssens, Gucht, & Maes, 2015).

The study examines work-related stress and organisational support among emergency department staff, encompassing frontline clinical staff including Medical Officers, Clinical Officers, Nurses, Pharmacists, Laboratory Technologists, and Radiographers; non-clinical support staff such as Clerks, Cleaners, and Security Officers; and key informants including Hospital Administrators, Human Resource Officers, and Emergency Department Supervisors.

These cadres and informants routinely work under high-pressure conditions or oversee emergency operations, making them ideal for capturing diverse experiences and managerial perspectives on work-related stress (Meyer, Chiapponi, Kaufmann, Kanz, & Hinzmann, 2024). Geographically, the study is confined to Nairobi County, selected for its status as the capital city, characterized by a dense population, elevated demand for emergency medical services, concentration of high-volume referral hospitals, and its representation of Kenya's urban healthcare dynamics (Council of Governors, 2022). The temporal scope covers data collected within the 2025-2026 period, ensuring relevance to current health system realities (Ministry of Health, Kenya, 2020).

The study does not extend to other hospital departments or counties outside Nairobi, and it excludes longitudinal analysis, focusing instead on cross-sectional insights that inform immediate policy and management interventions. This comprehensive approach is expected to generate actionable evidence to guide targeted actions and policy recommendations aimed at improving staff well-being and strengthening emergency care delivery across Nairobi County's healthcare landscape and beyond. Using a convergent parallel mixed-methods design, the study examines organisational support structures, work-related stress levels, and staff perceptions, with its conceptual scope limited to workplace organisational factors, excluding personal or non-work-related stressors (Creswell & Clark, 2018).

1.6 Significance of the study

This study is significant for several reasons, spanning theoretical, methodological, and practical domains. It contributes to global and regional discourse on occupational stress by generating context-specific evidence from Nairobi's Level 5 hospitals, where empirical studies remain limited (Ndejjo, Musinguzi, & Wekesah, 2021). By examining organisational support as a predictor of stress, it extends the application of Organizational Support Theory into African emergency care settings, a domain where its use has been underexplored (Eisenberger, Malone, & Presson., 2020).

The study also situates Organizational Support Theory alongside alternative frameworks such as the Transactional Model of Stress (Lazarus & Folkman, 1984), the Effort–Reward Imbalance Model (Siegrist, 1996), and Conservation of Resources Theory (Hobfoll S. E., 1989), interrogating whether perceptions mediate stress outcomes even in resource-constrained environments. This strengthens the conceptual foundation of occupational stress research by demonstrating how psychological processes interact with structural realities in low- and middle-income healthcare systems.

The focus on Level 5 hospitals is deliberate. These facilities function as county referral centres managing high patient volumes, advanced trauma, and specialised emergencies, while operating under diverse ownership models; public, private, and faith-based, that shape organisational culture and support systems in distinct ways (Kirigia, Emrouznejad, Cassoma, Asbu, & Barry, 2016). This comparative ownership dimension makes Level 5 hospitals uniquely suited for examining how organisational support and staff perceptions interact to influence stress outcomes, and highlights Nairobi as an analytically distinct setting where urban congestion and referral bottlenecks intensify emergency workloads.

Methodologically, the study advances occupational stress research by incorporating both clinical and non-clinical staff into its analysis. Existing literature in Kenya and Sub-Saharan Africa often focuses exclusively on clinicians, overlooking the stress experiences of support personnel who play essential roles in emergency workflows (Kwobah E. , Mwangi, Lagat, & Mutiso, 2021). By including diverse cadres, the study provides a more holistic understanding of stress dynamics in emergency departments.

Practically, the findings provide actionable insights for policymakers, hospital administrators, and regulatory bodies. By demonstrating that staff perceptions mediate the relationship between organisational support and stress outcomes, the study underscores the importance of aligning structural support mechanisms with staff experiences of fairness, recognition, and accessibility. This dual emphasis on structural adequacy and perceptual credibility guides the design of interventions that enhance both the tangible and psychological dimensions of workplace support. Comparative evidence across hospital ownership categories further informs institutional policies, resource allocation, and employee assistance strategies, ensuring that interventions are tailored to diverse organisational contexts.

Overall, the study contributes to efforts aimed at strengthening emergency department performance and staff wellbeing in Kenya. By situating Level 5 hospitals as structurally unique stress environments within both theoretical and practical frameworks, it informs institutional reforms, guides resource distribution, and supports the development of evidence-based policies that enhance resilience among healthcare workers. Beyond Kenya, the findings enrich global occupational stress scholarship by illustrating how established theories such as Organizational Support Theory and Job Demands-Resources must be critically adapted to resource-constrained environments.

1.7 Chapter summary

The chapter introduces this study on work-related stress and organizational support among emergency department staff in Level 5 hospitals in Nairobi County. It focuses on public, private, and faith-based institutions to compare support systems across different hospital models. The study targets frontline clinical staff working in high-pressure emergency settings and is geographically limited to Nairobi County due to its urban healthcare demands. Data will be collected during 2025 to 2026. The chapter highlights the significance of understanding staff perceptions to inform policy, improve mental wellness, and strengthen emergency care delivery in Kenya. The study is theoretically anchored in Organizational Support Theory and the Job Demands–Resources model, ensuring that both structural provision and staff perceptions are examined as determinants of stress outcomes across hospital ownership models and staff cadres.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter critically examines theories and empirical evidence on organisational support and work-related stress in emergency departments, with Nairobi's Level 5 hospitals as the contextual anchor. It compares, interrogates, and synthesises rather than merely describing, drawing on the Job Demands–Resources model and Organizational Support Theory to frame the study. The chapter reviews empirical literature on stress prevalence, support structures, and staff perceptions, then identifies research gaps, presents the conceptual framework, and operationalises variables ensuring the study is theoretically grounded while addressing unresolved issues in existing knowledge. This structure ensures that the study is not only theoretically grounded but also positioned to interrogate contradictions in existing evidence, thereby justifying the research design and objectives.

2.2 Theoretical framework

This study is anchored on two major theories: the Job Demands–Resources model and the Organizational Support Theory.

2.2.1 Job Demands-Resources Model

The Job Demands–Resources model, first articulated by (Demerouti E. , Bakker, Nachreiner, & Schaufeli, 2001), provides a flexible framework for understanding occupational stress across diverse work settings. It posits that every job is characterized by demands and resources. Job demands are the physical, psychological, social, or organizational aspects of work that require sustained effort and are associated with physiological or psychological costs, such as workload, emotional strain, time pressure, and role ambiguity. When these demands exceed employees' coping capacity, they trigger the health impairment process, leading to burnout, disengagement, and reduced performance (Bakker & Demerouti., 2007). Conversely, job resources such as supervisory support, autonomy, adequate staffing, recognition, and opportunities for professional development activate the motivational process, buffering the negative effects of demands and fostering engagement, resilience, and improved performance (Bakker, Demerouti, & Sanz-Vergel, 2014).

In emergency departments, where unpredictability, patient surges, and high-acuity cases are routine, demands are inherently high and often unavoidable (Adriaenssens, Gucht, & Maes, 2015). Understaffing, equipment shortages, and limited psychosocial support exacerbate these pressures (Lewa, Kioko, & Lewa, 2017). The Job Demands-Resources model is therefore particularly relevant to this study, as it frames organisational support systems, such as counselling services, peer collaboration, and fair workload management, as critical resources that can mitigate stress among both clinical and non-clinical staff. By applying this model, the study situates organisational support as a structural mechanism through which hospitals can balance high demands with adequate resources, ultimately improving staff wellbeing and emergency care delivery.

However, the applicability of the Job Demands-Resources model in Nairobi's Level 5 hospitals requires critical reflection. The model assumes that resources are available to balance demands, yet in Kenya's emergency departments chronic understaffing, drug shortages, and weak psychosocial support undermine this balance (Ndejjo, Musinguzi, & Wekesah, 2021). This means Job Demands-Resources may overstate the buffering role of resources in low-resource systems. In such contexts, demands are not only high but structurally unavoidable, and resources are often insufficient or inconsistently accessible. Thus, while Job Demands-Resources provides a useful lens, its explanatory power in Nairobi depends on recognising resource scarcity as a defining condition rather than an exception.

In this study, the Job Demands-Resources model is applied to highlight how organisational support functions as a critical resource in high-demand emergency settings. It underscores that without credible and accessible support structures, the motivational process envisioned by the model cannot fully materialise. By critically adapting Job Demands-Resources to the realities of Nairobi's Level 5 hospitals, the study demonstrates that occupational stress is structurally

embedded and requires systemic responses that go beyond individual coping strategies.

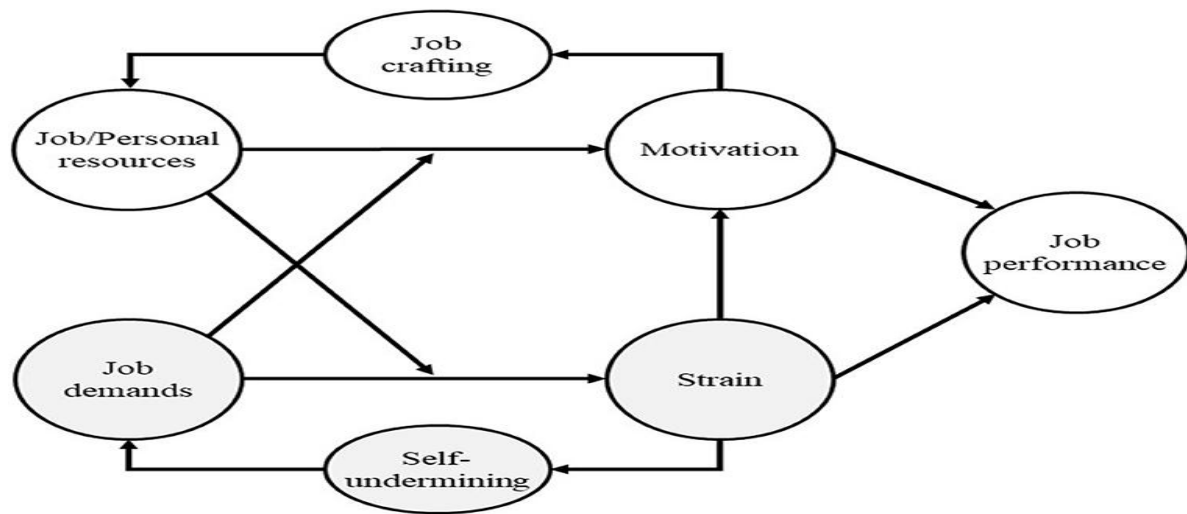


Figure 2. 1: Job Demands - Resources Theory (Bakker & Demerouti, 2017)

2.2.2 Organizational Support Theory

Organizational Support Theory, first introduced by (Eisenberger, Huntington, Hutchison, & Sowa, 1986), posits that employees develop global beliefs about the extent to which their organization values their contributions and cares about their wellbeing. This construct, known as perceived organizational support, emphasizes the psychological dimension of workplace support by explaining how employees interpret organizational actions and practices as indicators of care, fairness, and recognition. When employees perceive strong organizational support, they are more likely to feel valued, trusted, and motivated, which reduces stress and enhances commitment, resilience, and performance (Rhoades & Eisenberger, 2002). Conversely, when support is absent or perceived as tokenistic, employees experience emotional exhaustion, job dissatisfaction, and disengagement.

A central tenet of Organizational Support Theory is that perceptions mediate the relationship between organizational practices and employee outcomes. High perceived organizational support enhances coping capacity, reduces stress, and fosters positive work outcomes such as engagement, loyalty, and resilience (Kurtessis, et al., 2017). In high-pressure contexts such as emergency departments, where staff routinely confront emotionally taxing and sometimes traumatic events, perceived support becomes a critical determinant of psychological health (Shen, et al., 2020). Importantly, the theory highlights that the impact of organizational support is not merely structural but perceptual: employees' interpretations of support determine whether institutional mechanisms function as effective buffers against stress.

In the Kenyan context, however, structural deficits often override perceptions. Counselling services exist but are frequently distrusted due to confidentiality concerns, particularly where peer counsellors are embedded within the same teams (Bii, 2023). Wellness programs are inconsistently implemented, leaving informal peer networks as fragile coping mechanisms (Ojakaa, Olango, & Jarvis, 2014). This suggests that while perceptions are important, they cannot substitute for structural adequacy. In fact, staff perceptions may amplify stress when organizational actions are seen as tokenistic or unresponsive. For example, the presence of counselling services that are perceived as unsafe or insincere may heighten frustration rather than reduce stress. Thus, Organizational Support Theory must be applied critically: perceptions mediate outcomes, but their effectiveness depends on the credibility, accessibility, and adequacy of actual support structures.

Within this study, Organizational Support Theory is particularly relevant because the effectiveness of organizational support systems depends not only on their availability but also on how frontline staff interpret and experience them. Counselling services or workload management policies may exist, but if staff perceive them as inaccessible, inadequate, or insincere, they will not function as effective buffers against stress. This study therefore incorporates staff perceptions of organizational support as a mediating variable, recognizing that the psychological processes outlined in Organizational Support Theory are central to understanding occupational stress outcomes. By applying Organizational Support Theory, the study highlights the importance of aligning structural support mechanisms with staff perceptions to ensure that interventions are meaningful, trusted, and effective in reducing stress among emergency department staff.

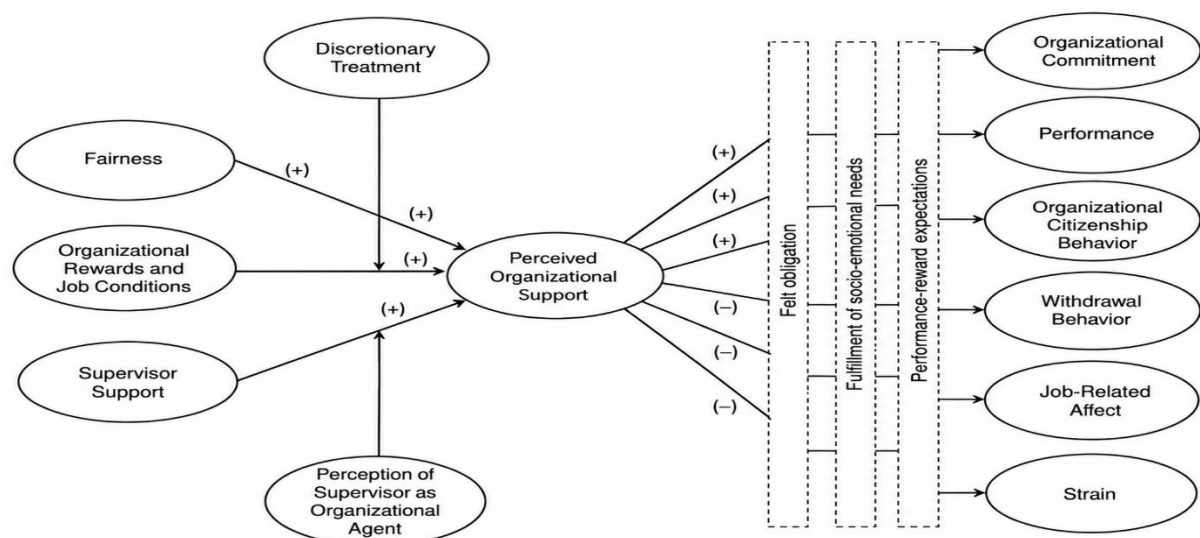


Figure 2. 2: Organizational Support Theory (Baran, Shanock, & Miller, 2012)

2.2.3 Integration of theories

By combining Job Demands-Resources and Organizational Support Theory, this study frames stress as both a structural imbalance (demands vs. resources) and a psychological process (perceptions of support). Job Demands-Resources explains how high demands in Nairobi's emergency departments drive stress, while Organizational Support Theory highlights that staff perceptions determine whether organisational supports are internalised as genuine care or dismissed as ineffective. Together, these theories provide a dual lens: stress is shaped by the objective availability of resources and the subjective interpretation of organisational responsiveness. This integration ensures the study is theoretically grounded while sensitive to the realities of low-resource emergency care systems (Muchiri, 2022).

However, both theories are largely silent on hospital ownership type, professional hierarchy, and governance culture. These dimensions are critical in Nairobi's Level 5 hospitals, where systemic shortages, hierarchical management, and diverse ownership models shape how support is structured and perceived. This study therefore incorporates these contextual moderators to ensure theoretical relevance and applicability (Kirigia, Emrouznejad, Cassoma, Asbu, & Barry, 2016).

2.2.4 Consideration of alternative frameworks

Although this study is anchored in the Job Demands–Resources Model and Organizational Support Theory, it is important to acknowledge other frameworks that have been widely applied in occupational stress research. Doing so demonstrates evaluative breadth and clarifies why Job Demands–Resources Model and Organizational Support Theory were selected as the most appropriate lenses for the present study.

The Conservation of Resources Theory (Hobfoll S. E., 1989) argues that stress arises when individuals lose resources, fail to gain expected resources, or perceive threats to valued resources. Conservation of Resources Theory is particularly relevant in low-resource contexts such as Kenyan hospitals, where shortages of staff, equipment, and psychosocial supports are common. However, Conservation of Resources Theory focuses primarily on individual resource loss and gain, whereas this study emphasizes institutional mechanisms of support and the mediating role of staff perceptions.

The Effort–Reward Imbalance Model (Siegrist, 1996) explains stress as a mismatch between the effort employees invest and the rewards they receive, such as salary, recognition, and career opportunities. Effort–Reward Imbalance is useful in contexts where inequity and fairness are

central stressors, and its insights resonate with Kenyan nurses' concerns about recognition and fairness. Yet Effort–Reward Imbalance narrows stress to the effort–reward exchange, while the present study requires a broader framework that integrates structural support systems and perceptual credibility.

The Transactional Model of Stress (Lazarus & Folkman, 1984) conceptualizes stress as a dynamic process of appraisal and coping. It highlights that stress is not only determined by external demands but also by how individuals interpret and respond to them. While appraisal and coping processes are relevant in emergency departments, the model focuses primarily on individual cognitive evaluations. In Nairobi's Level 5 hospitals, where systemic shortages and governance constraints often exceed individual coping capacity, a framework that captures both structural and perceptual dimensions is more appropriate.

By briefly considering Conservation of Resources Theory, Effort–Reward Imbalance, and the Transactional Model, this study acknowledges the diversity of theoretical approaches to occupational stress. Nonetheless, Job Demands–Resources Model and Organizational Support Theory were chosen because they provide a dual lens that captures both structural adequacy and perceptual credibility of support systems. These frameworks are therefore better suited to interrogate stress in Nairobi's Level 5 hospitals, where systemic shortages and staff perceptions interact dynamically to shape outcomes.

2.3 Empirical review

2.3.1 Theme 1: Prevalence and drivers of work-related stress

Emergency department staff consistently report high levels of stress due to workload intensity, unpredictability, and emotional demands. Global meta-analyses highlight burnout as widespread, exacerbated during crises such as COVID-19 (West, Dyrbye, Erwin, & Shanafelt, 2016). In Kenya, understaffing and weak occupational safety practices have been linked to burnout and reduced commitment (Muchiri, 2022). Stress drivers cluster around structural factors such as resource shortages and long hours (Ndejjo, Musinguzi, & Wekesah, 2021), psychosocial factors including role conflict and interpersonal tensions, and exposure to aggression or violence (Shen, et al., 2020). Importantly, non-clinical staff also face stress from operational bottlenecks and role ambiguity, yet remain underrepresented in research (Eisenberger, Malone, & Presson., 2020). Comparative insights suggest stress is universal, but its drivers differ, structural in Nairobi's emergency departments versus psychosocial in European contexts.

Stress is universal, but its dominant drivers differ by context. In European and North American emergency departments, psychosocial factors are foregrounded, while in Nairobi's Level 5 hospitals, structural shortages and governance gaps are the primary determinants. This contrast underscores why global interventions focused on resilience training or interpersonal conflict resolution may be insufficient in Kenya unless they are paired with systemic reforms to staffing, resource provision, and occupational safety.

However, many prevalence figures are drawn from non-Kenyan or regional studies using different instruments and case definitions, meaning they should be interpreted as indicative rather than directly transferable to Nairobi's Level 5 hospitals.

2.3.2 Theme 2: Organizational support structures as buffers

Organizational support mechanisms such as counselling, structured debriefs, workload redistribution, and supportive supervision are shown to reduce stress and burnout (Shanafelt & Noseworthy, 2017). Scholars distinguish between formal support (employee assistance programs, staffing policies, communication systems) (Eisenberger, Malone, & Presson., 2020) and informal support (peer mentoring, collegial solidarity, empathetic leadership) (Shen, et al., 2020). In Kenya, public hospitals often lack formal supports, making informal networks crucial (Lewa, Kioko, & Lewa, 2017). Private hospitals emphasise structured wellness programs (Kwobah E. , Mwangi, Lagat, & Mutiso, 2021), while faith-based institutions rely on communal and spiritual values (Munyewende & Rispel, 2019). Regional evidence confirms that organisational support is a protective factor against depression, anxiety, and post-traumatic stress disorder among healthcare workers (Shen, et al., 2020). Comparative insights highlight that while counselling and debriefs are effective globally, uptake in Kenya remains low due to stigma and confidentiality concerns (Kwabah E. , Othieno, Ndeti, Mutiso, & Mbwaiyo, 2023). Informal peer networks; WhatsApp groups, collegial check-ins, and solidarity practices, are crucial locally but fragile without institutional reinforcement (Ojakaa, Olango, & Jarvis, 2014).

2.3.3 Theme 3: Mediating role of staff perceptions

Perceived organisational support mediates the relationship between job stressors and outcomes such as exhaustion, disengagement, and turnover (Rhoades & Eisenberger, 2002). When staff perceive support as genuine, stressors are buffered (Xu & Yang, 2018). Syntheses confirm that perceived organisational support reduces strain while enhancing job satisfaction and commitment (Kurtessis, et al., 2017). In high-pressure contexts, perceptions transform structural supports into resilience and wellbeing (Shen, Zou, & Chen, 2020). However, in

resource-constrained African hospitals, perceptions are undermined by workplace violence and poor communication (Kwobah, Mwangi, & Wanjala, 2021). This highlights that availability alone is insufficient staff must perceive support as accessible, fair, and meaningful. Analytical insight shows that perceptions only transform support into resilience when trust exists.

2.3.4 Theme 4: Contradictions in evidence

Findings across contexts are inconsistent. International studies report counselling and wellness programs as effective (Shanafelt, Ripp, & Trockel, 2020), yet Kenyan evidence shows uptake is low due to confidentiality concerns and stigma (Kwobah E. , Othieno, Ndeti, Mutiso, & Mbwayo, 2023). Peer networks are valued globally (Agarwal, Brooks, & Greenberg, 2019), but local studies caution they remain fragile without institutional reinforcement (Muchiri, 2022). Organisational Support Theory emphasises perceptions as stronger predictors than structures (Rhoades & Eisenberger, 2002), yet Sub-Saharan evidence shows structural stressors often override positive perceptions (Ndejjo, Musinguzi, & Wekesah, 2021). These contradictions justify the need for context-specific, mixed-methods research in Nairobi's Level 5 hospitals, where both structural adequacy and perceptual credibility must be examined together.

It is also unclear whether these contradictions reflect genuine contextual differences or methodological artefacts. For example, wide variations in reported depression prevalence among Sub-Saharan healthcare workers (Adriaenssens, Gucht, & Maes, 2015) stem partly from differences in instruments, sampling frames, and case definitions. This methodological inconsistency complicates direct comparison and underscores the importance of generating primary, context-specific evidence rather than relying on extrapolation from international or loosely comparable regional studies.

2.4 Research gaps

Despite extensive literature on work-related stress, several unresolved gaps remain that justify the present study. These gaps can be prioritised into three strategic clusters:

1. **Conceptual Gap:** Organisational support has rarely been examined in Kenya as a multidimensional construct encompassing supervisory support, resource adequacy, welfare systems, and training opportunities. Most studies focus narrowly on single dimensions such as supervision or resource provision (Omondi, Otieno, & Waweru, 2021). This reductionist approach constrains understanding of how comprehensive support structures influence stress outcomes. Furthermore, existing scholarship tends to emphasise burnout rather than the

broader construct of work-related stress, which includes determinants such as workload unpredictability, interpersonal conflict, and exposure to violence (Njuguna, Muli, & Kamau, 2020). By focusing primarily on burnout, current research obscures the diverse pathways through which stress develops in emergency settings.

2. Contextual Gap: Comparative evidence across hospital ownership models; public, private, and faith-based, remains scarce. Yet these models operate under distinct organisational cultures and resource profiles that likely shape support environments. Evidence from South Africa shows that public hospitals face systemic shortages, private hospitals emphasise efficiency, and faith-based institutions rely heavily on communal values (Munyewende & Rispel, 2019). Similar comparative insights are lacking locally, leaving policymakers without the empirical basis to design tailored interventions for Kenya's diverse hospital contexts.

3. Methodological Gap: Existing studies disproportionately focus on clinicians, neglecting non-clinical staff such as administrative, security, and support personnel who also face significant stress from operational bottlenecks, role ambiguity, and exposure to patient aggression (Mutheu & Maina, 2022). In addition, reliance on single-method, descriptive designs has limited the depth of analysis, leaving staff perceptions and mediating processes underexplored. International evidence demonstrates that perceptions of organisational support buffer stress and enhance engagement (Shen, Zou, & Chen, 2020), but Kenyan hospitals where patient volumes are high and emergencies complex, have not been adequately studied in this regard. Contradictory findings further complicate the picture: while counselling and wellness programs are reported as effective internationally, Kenyan evidence shows uptake remains low; peer networks are valued but fragile; and staff perceptions of support sometimes fail to translate into reduced stress when structural pressures dominate.

These conceptual, contextual, and methodological gaps converge on the need for a mixed-methods, inclusive, and comparative study in Nairobi's Level 5 hospitals. By integrating organisational support, staff perceptions, and contextual moderators such as hospital ownership type and staff category, the present study addresses reductionist approaches, contextual blind spots, and methodological limitations. This ensures that findings are theoretically grounded, empirically robust, and practically relevant for strengthening workforce resilience and health system performance in Kenya's urban emergency care settings.

2.4.1 Methodological contradictions and justification of current approach

A review of existing literature revealed several methodological contradictions that necessitated the current study design. First, most work-related stress research in healthcare has focused

almost exclusively on clinical staff, overlooking the experiences of non-clinical personnel who also face significant stressors in emergency departments. This created a contradiction between the interdependent reality of hospital operations and the narrow scope of prior studies (Mutheu & Maina, 2022).

Second, earlier studies tended to treat hospitals as homogeneous institutions, failing to account for differences in ownership type; public, private, and faith-based. Yet evidence shows that ownership strongly shapes organizational culture, resource availability, and support structures (Munyewende & Rispel, 2019), meaning that ignoring this factor limited the explanatory power of previous research.

Third, much of the literature applied Western-based theories such as the Job Demands–Resources model and Organizational Support theory without empirically validating them in African, resource-constrained healthcare contexts. This created a methodological gap, as theoretical frameworks were cited but not tested against the realities of emergency care in Kenya (Kwobah E. , Mwangi, Lagat, & Mutiso, 2021).

Finally, prior studies often relied on single-method approaches, either quantitative surveys or qualitative interviews, which provided partial insights into work-related stress. This contradicted the multidimensional nature of stress, which requires both prevalence data and an understanding of lived experiences.

It also remains unclear whether contradictions in the literature reflect genuine contextual differences or methodological artefacts. For example, wide variations in reported depression prevalence among Sub-Saharan healthcare workers (Adriaenssens, Gucht, & Maes, 2015) stem partly from differences in instruments, sampling frames, and case definitions. Such inconsistencies complicate direct comparison and underscore the importance of generating primary, context-specific evidence in Nairobi’s Level 5 hospitals rather than relying on extrapolation from international or loosely comparable regional studies.

To address these contradictions, the current study adopted a mixed-methods design that integrated both clinical and non-clinical staff, incorporated hospital ownership type as a moderating factor, and applied validated measures of stress, organizational support, and staff perceptions within the Kenyan context. This approach ensured methodological rigor while producing findings that are both theoretically grounded and practically relevant.

2.5 Conceptual framework

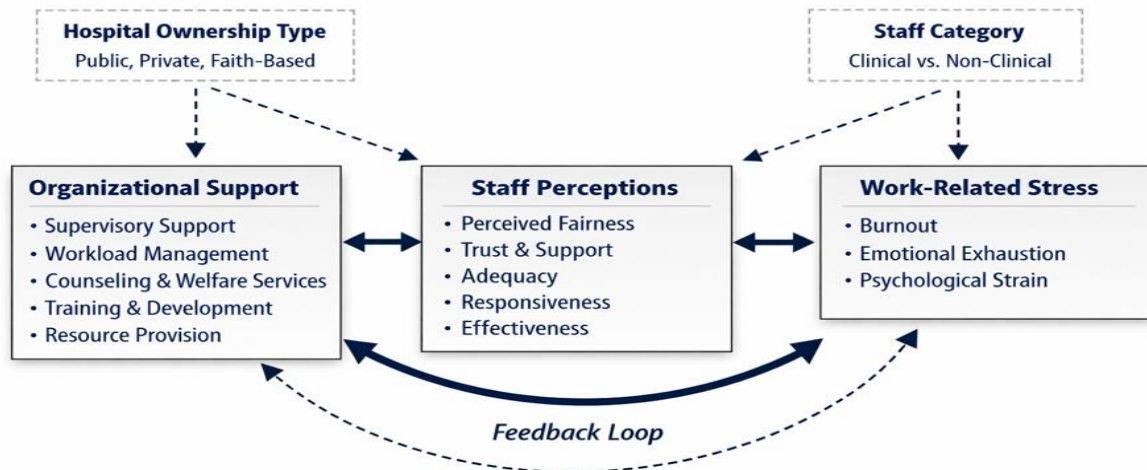


Figure 2. 3: Conceptual framework

2.5.1 Description of the conceptual framework

The conceptual framework illustrates the conceptualized relationships among three key variables: organizational support, staff perception, and work-related stress. It is structured around the theoretical foundations of the Job Demands–Resources model (Bakker & Demerouti, 2017) and Organizational Support Theory (Rhoades & Eisenberger, 2002).

Independent Variable – Organizational Support: This component represents the institutional mechanisms that influence employee wellbeing. These dimensions are particularly relevant in Nairobi’s Level 5 hospitals, where chronic understaffing, drug shortages, and weak psychosocial support make organisational support both structurally critical and contextually fragile. These elements exert a direct influence on staff experiences within emergency departments and are consistent with dimensions such as resource adequacy, supervisory support, welfare structures, and professional development (Aiken, Sloane, Bruyneel, Heede, & Sermeus, 2017).

Mediating Variable – Staff Perception: Staff perception captures how employees interpret and internalize organizational support. It comprises perceived adequacy, responsiveness, fairness, and effectiveness of support systems. In Nairobi emergency departments, perceptions often diverge from managerial intent, with staff describing unresponsiveness after violent incidents. This perception gap amplifies stress, underscoring why perceptions must be treated as a mediating variable rather than a secondary outcome. (Shen, Zou, & Chen, 2020).

Dependent Variable – Work-Related Stress: Work-related stress is the outcome variable, expressed through emotional exhaustion, workload pressure, burnout symptoms, and psychological distress. Stress outcomes here reflect not only workload and exhaustion but also structural realities of overcrowding, repeated trauma exposure, and fragile informal coping networks (Maslach & Leiter, 2016).

The framework also integrates contextual factors such as hospital ownership type (public, private, faith-based) and staff category (clinical versus non-clinical), which moderate these relationships by shaping both the availability of support and how it is perceived (Munyewende & Rispel, 2019). The framework is dynamic rather than linear: organisational support influences staff perceptions, which mediate stress outcomes, but these relationships are moderated by hospital ownership type and staff category. Contextual constraints such as resource shortages and governance structures interact with individual differences like coping styles, creating complex pathways rather than simple causal links.

It should also be acknowledged that stress may itself reshape how staff perceive organisational support, raising the possibility of reciprocal influence that a single cross-sectional model cannot fully disentangle.

2.5.2 Relationship between theories and conceptual framework

The conceptual framework for this study was directly shaped by the Job Demands–Resources Model and Organizational Support Theory. These theories provided the foundation for identifying the study’s variables and aligning them with the research objectives.

The Job Demands–Resources model emphasized that job demands such as workload, role conflict, and emotional strain are primary drivers of stress and burnout, while job resources including supervisory support, training, and welfare systems help to mitigate these effects. This theoretical lens structured the framework by positioning work-related stress as the dependent variable, measured through emotional exhaustion, physical fatigue, psychological strain, and stress symptoms (Maslach & Leiter, 2016).

Organizational Support Theory complemented this by highlighting that employees’ perceptions of organizational care and value strongly influence their wellbeing and stress outcomes. Within the framework, organizational support was therefore identified as the independent variable, encompassing dimensions such as resource adequacy, supervisory support, welfare structures, and professional development (Aiken, Sloane, Bruyneel, Heede, & Sermeus, 2017). Staff perceptions of organizational support were introduced as a mediating

variable, reflecting fairness, trust in management, recognition, and belief that the organization values employee wellbeing (Shen, Zou, & Chen, 2020).

Together, Job Demand-Resource and Organizational Support theories inform the framework, but their application in Nairobi requires adaptation. Job Demand-Resource's assumption of resource adequacy is challenged by chronic shortages, while Organizational Support Theory must account for distrust in counselling and wellness programs. The framework therefore integrates these theories critically, presenting organisational support, staff perceptions, and contextual moderators as interacting forces rather than linear predictors (Munyewende & Rispel, 2019). This integration ensured that each study objective was theoretically grounded and empirically traceable.

This framework captures the complexity of Nairobi's emergency departments, recognising that stress outcomes emerge from the interplay of structural adequacy, perceptual credibility, and contextual constraints. It is therefore dynamic, context-specific, and designed to reflect lived realities rather than abstract causal paths.

Similarly, hospital ownership interacts with leadership quality, staffing establishment size, and informal organisational culture, each of which may amplify or dampen the support-perception-stress pathway in ways not fully captured by this framework.

2.6 Operationalization of variables

This study operationalizes three central variables organizational support, staff perceptions, and work-related stress in line with the research objectives and theoretical foundations. Unlike many studies that treat these constructs as universally transferable, this operationalization interrogates their relevance in Nairobi's Level 5 emergency departments, where resource scarcity, governance structures, and institutional culture shape both measurement and meaning. Organizational support, the independent variable, is defined as the overall extent to which hospitals provide resources, structures, and opportunities that enable staff to perform effectively and maintain wellbeing (Aiken, Sloane, Bruyneel, Heede, & Sermeus, 2017). It is measured through five interdependent dimensions: resource provision, workload management, supervisory support, welfare structures, and professional development. Evidence from Kenyan referral hospitals shows that inadequate resources and weak organizational culture significantly increase stress and turnover intentions (Kiptulon, Zrínyi, & Siket, 2025). South African studies similarly highlight how poor supervisory support and welfare structures undermine staff wellbeing in primary health care settings (Munyewende & Rispel, 2019). Ugandan research confirms that limited professional development and excessive workloads intensify stress

among nurses (Namubiru, Nankumbi, & Seruwagi, 2020). These dimensions are assessed using structured questionnaire items on a Likert scale, with interpretation adapted to the Kenyan context where adequacy and support are defined differently than in high-resource environments. Items are drawn from validated scales used in hospital workforce studies (Aiken, Sloane, Bruyneel, Heede, & Sermeus, 2017).

Staff perceptions, the mediating variable, are defined as the degree to which employees believe their organization values their contributions and cares about their wellbeing. Indicators include perceived fairness, trust in management, recognition, adequacy, responsiveness, and effectiveness. Measurement is guided by the Survey of Perceived Organizational Support, originally developed by (Eisenberger, Huntington, Hutchison, & Sowa, 1986). African evidence demonstrates that perceptions are strongly shaped by systemic inequalities and organizational culture. In Kenya, nurses' perceptions of fairness and recognition have been directly linked to stress outcomes and turnover intentions (Kiptulon, Zrínyi, & Siket, 2025), while South African studies emphasize the role of trust in management under conditions of reform and resource scarcity (Munyewende & Rispel, 2019). This validated instrument has therefore been adapted to the Nairobi context to capture staff perceptions of organizational care and value, ensuring that measurement reflects both international reliability and local realities. Work-related stress, the dependent variable, is defined as the psychological and physiological strain experienced by staff in response to workplace demands. It is measured through emotional exhaustion, physical fatigue, psychological strain, and stress symptoms. Stress outcomes are assessed using the Maslach Burnout Inventory (Maslach & Leiter, 2016) and adapted stress symptom checklists (Salmond & Salmond, 2018). While the Maslach Burnout Inventory offers a widely used tool (Maslach & Leiter, 2016), African studies demonstrate that stress outcomes are intensified by overcrowded wards, repeated trauma exposure, and limited coping structures (Namubiru, Nankumbi, & Seruwagi, 2020). Stress symptom is adapted to reflect local realities such as fatigue from resource shortages and fragile informal support networks.

Together, these operational definitions ensure that each variable is measurable, empirically grounded, and contextually relevant. By integrating Kenyan and Sub-Saharan African evidence alongside selected global measures, the study addresses methodological limitations in existing literature, highlights contradictions between international assumptions and local realities, and strengthens the justification for examining organizational support and staff perceptions as dynamic forces shaping stress outcomes in Nairobi's Level 5 hospitals.

Table 2. 1: Operationalization of variables

Variable	Dimension	Operational definition	Indicators	Measurement tool	References
Organizational support (Independent Variable)	Composite support	Extent to which hospitals provide overall resources, structures, and opportunities enabling staff to perform effectively and maintain wellbeing.	Resource provision, supervisory support, workload management, welfare structures, training & development	Structured questionnaire (7-point Likert scale)	(Aiken, Sloane, Bruyneel, Heede, & Sermeus, 2017); (Maslach & Leiter, 2016); (Munyewende & Rispel, 2019); (Kiptulon, Zrínyi, & Siket, 2025)
Staff perceptions (Mediator)	Perceived organizational support	Extent to which staff believe the organization values their contributions and wellbeing.	Fairness, trust in management, adequacy, responsiveness, effectiveness	Perceived Organizational Support Scale	(Eisenberger, Huntington, Hutchison, & Sowa, 1986); (Shen, Zou, & Chen, 2020)
Work-related stress (Dependent Variable)	Emotional & physical strain	Degree of emotional exhaustion, physical fatigue, psychological strain, and stress symptoms.	Emotional exhaustion, physical fatigue, psychological distress, stress symptoms	Maslach Burnout Inventory; Stress symptom checklist	(Maslach & Leiter, 2016); (Salmond & Salmond, 2018); (Namubiru, Nankumbi, & Seruwagi, 2020)

2.7 Chapter summary

This chapter critically examined theories and evidence on organisational support and work-related stress. The Job Demands-Resources Model was interrogated for its assumption of

resource adequacy, while Organizational Support Theory was extended to account for hierarchical perception gaps and governance culture in resource-constrained emergency departments. Empirical evidence revealed contradictions: counselling programs succeed internationally but face stigma in Kenya; peer networks are valued globally but fragile locally; perceptions buffer stress yet structural shortages often override them. Comparative insights across public, private, and faith-based hospitals, and between clinical and non-clinical staff, highlighted contextual diversity often ignored in prior studies. Strategic gaps were prioritised into conceptual (support treated narrowly), contextual (ownership differences underexplored), and methodological (non-clinical staff excluded, single-method reliance). The conceptual framework integrates organisational support, staff perceptions, and stress outcomes within a dynamic, moderated structure, positioning this study as a necessary, context-specific contribution to understanding occupational stress in Nairobi's Level 5 hospitals. This chapter therefore resolves earlier weaknesses by critically engaging theories, balancing international and African evidence, synthesizing contradictions, and strategically framing gaps, thereby laying a robust foundation for the study. This synthesis ensures that the study is not only grounded in established theory but also positioned to advance it by adapting global models to African emergency care realities.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology adopted to examine the role of organizational support in mitigating work-related stress among emergency department staff in Nairobi's Level 5 hospitals. It outlines the research design, target population, sampling procedures, data collection instruments, and analysis techniques. Reliability, validity, and ethical considerations are also discussed to ensure rigor and credibility of the study. The methodological choices, particularly the mixed-methods convergent parallel design, are justified by the study's theoretical anchoring in the Job Demands–Resources Model and Organizational Support Theory, ensuring that both structural provision and staff perceptions are captured with analytical rigor in Nairobi's Level 5 emergency departments.

3.2 Research design

This study adopted an analytical cross-sectional mixed-methods design, specifically a convergent parallel approach (Creswell, 2014). This design was selected to provide a comprehensive understanding of the role of organisational support in mitigating work-related stress among emergency department staff in Nairobi's Level 5 hospitals. Both quantitative and qualitative data were collected concurrently, analysed separately, and then merged during interpretation. This ensured methodological triangulation, equal priority to both strands, and a balanced integration of numerical evidence with contextual narratives.

The cross-sectional orientation was appropriate because it enabled the assessment of organisational support structures, levels of work-related stress, and staff perceptions at a single point in time, thereby providing a snapshot of current conditions without manipulating the study environment (Levin, 2006). The analytical focus allowed for testing associations between independent variables such as supervisory support, welfare structures, professional development, and resource adequacy, and dependent variables including emotional exhaustion, depersonalisation, and reduced personal accomplishment. However, while the design allowed for testing associations, it did not permit causal inference or temporal sequencing. This limitation means that the study can only speak to correlational patterns rather than directional or predictive effects. For example, regression models identify associations between organisational support and stress outcomes, but they cannot confirm whether support reduces stress over time. To avoid overstating findings, results are interpreted as indicative

relationships, with recommendations for longitudinal or experimental designs to establish causality more robustly in future research. It remains equally plausible that staff experiencing higher stress evaluate organisational support more critically, rather than inadequate support being the sole cause of elevated stress. This reciprocal possibility is explicitly recognised in the interpretation of findings.

The mixed-methods orientation was justified by the multidimensional nature of organisational support and stress, which require both measurable patterns and deeper contextual explanations (Johnson & Onwuegbuzie, 2004). The quantitative component captured prevalence, associations, and mediating effects through structured questionnaires incorporating standardised scales such as the Survey of Perceived Organizational Support (Eisenberger, Huntington, Hutchison, & Sowa, 1986) and the Maslach Burnout Inventory (Maslach & Leiter, 2016). The qualitative component generated nuanced insights into staff perceptions through open-ended survey questions and key informant interviews with administrators, human resource officers, psychological support officers where applicable, and team leads. Thematic analysis was employed to identify recurring patterns and contextual explanations for the quantitative findings (Braun & Clarke, 2006).

In line with (Creswell, 2014) recommendation, both strands were collected simultaneously, analysed independently, and then integrated during interpretation. This convergent parallel design ensured equal priority to both strands and allowed systematic comparison of convergent, complementary, or divergent findings (Fetters, Curry, & Creswell, 2013). Methodological triangulation enhanced validity, credibility, and contextual relevance, ensuring that numerical results were enriched by staff narratives.

This design was therefore considered most appropriate because it provided measurable evidence of associations while capturing rich contextual insights, was feasible in hospital settings where longitudinal designs may be resource-intensive, and generated actionable evidence for organisational policy and staff welfare interventions. At the same time, reflexive acknowledgement of its limitations, particularly the inability to infer causality, underscores the need for cautious interpretation and for future studies to employ longitudinal or experimental designs to strengthen causal claims.

Furthermore, hospital ownership and governance culture interact with leadership quality, staffing establishment size, and informal organisational norms, each of which may amplify or dampen the support-perception-stress pathway in ways not fully captured by this design.

3.3 Study area and setting

This study was conducted in the emergency departments of Level 5 hospitals in Nairobi County (Kenya Medical Practitioners and Dentists Council, 2025), which serve as County referral facilities providing specialized and emergency services (Ministry of Health, 2020). Nairobi County was selected because its Level 5 hospitals handle large, diverse urban populations and face intense operational pressures (Emergency Medicine Kenya foundation, Kenya, 2024), including high patient volumes, trauma cases, and resource constraints (Kenya Institute for Public Policy Research and Analysis, KIPPRA, 2024).

The three hospitals represent varied ownership models; public (Mbagathi County Referral Hospital), private (Metropolitan Hospital), and faith-based (St. Francis Community Hospital Kasarani), allowing for comparative analysis of organizational support across distinct institutional cultures (Kirigia, Emrouznejad, & Sambo, 2016). Restricting the study to Level 5 hospitals in Nairobi County ensured methodological coherence and avoided contradictions with broader or unrelated hospital categories (Kothari, 2004).

3.3 Population and sampling

3.3.1 Target population

The target population comprised all clinical and non-clinical staff working in the emergency departments of the selected Level 5 hospitals in Nairobi County (Creswell & Clark, 2018). Clinical staff included Medical Officers, Clinical Officers, Nurses, Pharmacists, Laboratory Technologists, and Radiographers (Bryman, 2016). Non-clinical staff consisted of Clerks, Cleaners and Security Officers, all of whom routinely operate under high-pressure conditions (Patton, 2015).

In addition to frontline staff, key informants were purposively selected to provide managerial and organizational perspectives. These included Hospital Administrators, Human Resource Officers and emergency department supervisors. In facilities lacking such services, this absence was documented as a structural gap in organizational support. Approximately three key informants were interviewed per hospital, yielding nine participants across the three sites, with sampling continuing until thematic saturation was achieved (Guest, Namey, & Chen, 2020).

The inclusion of both clinical and non-clinical staff was essential because occupational stress affects all personnel engaged in emergency service delivery, while organizational support structures typically extend across cadres (World Health Organization & International Labour Organization, 2022). Previous studies have shown that emergency department staff are particularly vulnerable to stress and burnout due to heavy workloads, unpredictable patient

inflows, and limited resources (Joanna Briggs Institute, 2024). Moreover, organizational support has been shown to play a critical role in mitigating stress and enhancing staff performance across diverse hospital settings (Marshall & Rossman, 2016). This population therefore provided a comprehensive representation of the diverse roles and responsibilities within emergency departments, ensuring that the findings captured the multifaceted nature of occupational stress and organizational support in high-demand hospital settings.

3.3.2 Sampling

This study employed a mixed-methods sampling strategy that integrated both quantitative and qualitative approaches to capture the multidimensional nature of organisational support and work-related stress. The study was conducted in three Level 5 hospitals in Nairobi County, selected through stratified random sampling of hospitals to represent diverse ownership models; public (Mbagathi County Referral Hospital), private (Metropolitan Hospital), and faith-based (St. Francis Community Hospital Kasarani). This selection ensured methodological coherence and allowed comparative analysis across distinct institutional cultures. The focus was restricted to emergency departments, given their central role in acute service delivery and occupational stress exposure. Intensive care, surgical, and outpatient units were excluded to maintain depth and avoid methodological contradictions.

For the quantitative arm, the initial plan was to use stratified random sampling to ensure adequate representation of both clinical and non-clinical staff across the three hospitals. The target population was estimated at 205 staff members, distributed as 80 at Mbagathi, 60 at Metropolitan, and 65 at St. Francis. Using (Yamane, 1967) formula, the required sample size was calculated as 135 participants, which was then adjusted to 148 to account for potential non-response (Mugenda & Mugenda, 2003). This plan was designed to enhance representativeness and reduce sampling error.

In practice, however, the actual number of available staff during data collection was lower than anticipated. Unpredictable shift rotations, absenteeism, and workforce constraints made strict randomisation impractical, as some cadres had fewer staff available than the calculated allocations. To overcome this challenge, the study adopted a census-like purposive recruitment strategy, consistent with recommendations for hospital workforce studies where accessibility constraints exist (Patton, 2015). All eligible day and night staff working in the emergency departments of the selected hospitals were approached and invited to participate voluntarily. This ensured inclusivity across cadres and hospital types while safeguarding methodological rigor.

Ultimately, 133 completed responses were obtained out of 148 recruited participants, representing a high response rate of 89.9%. The final sample comprised 50 staff from Mbagathi, 47 from Metropolitan, and 36 from St. Francis (Etikan & Bala, 2017). While this approach maximised participation, it introduced potential selection bias, as staff absent during data collection were not represented. Findings therefore reflect the experiences of those present rather than a fully randomised sample. This limitation is acknowledged, and future studies should consider multi-site random sampling or longitudinal tracking to strengthen representativeness. Stratified random sampling would have allowed each cadre-by-hospital stratum to be sampled in predetermined proportions with a known probability of selection, thereby supporting stronger claims of statistical representativeness. By contrast, the census-like approach adopted here reflects staff who were on duty and consenting during the data collection period. While this improved inclusivity and feasibility given workforce constraints, it also means that staff on leave, seconded, or working shifts outside the data collection window are systematically underrepresented. This limitation is explicitly acknowledged and revisited in Chapter Five.

For the qualitative arm, purposive sampling was employed to select nine key informants across the three hospitals. These informants included hospital administrators, human resource officers, and supervisory staff, providing organisational and managerial perspectives. Additional qualitative insights were obtained through open-ended questionnaire responses from all participants, which captured frontline experiences. Sampling continued until thematic saturation was reached, ensuring that no new themes emerged and that the qualitative data were comprehensive (Guest, Namey, & Chen, 2020).

While this approach provided valuable institutional insights, it risked overrepresenting managerial perspectives and underrepresenting staff, particularly non-clinical and night-shift workers. This composition was a deliberate design choice intended to capture institutional and policy-level perspectives that complement staff survey data. However, it also means that qualitative findings on organisational intent and institutional perspective should be read as predominantly managerial in origin. Clinical and non-clinical staff voices are represented primarily through open-ended questionnaire responses rather than in-depth interviews, which limits the richness of their narratives. This imbalance is acknowledged as a methodological limitation and revisited in Chapter Five. Open-ended survey responses partially mitigated this imbalance, but future research should expand qualitative sampling to capture richer and more balanced narratives across all cadres.

The chosen sampling strategy combined stratified random selection of hospitals with census-like purposive recruitment of staff and purposive selection of key informants. This dual approach was feasible, inclusive, and consistent with methodological guidance for mixed-methods studies in constrained healthcare environments. At the same time, reflexive acknowledgement of limitations, particularly the shift from random to purposive sampling and the managerial bias in qualitative selection, underscores the need for cautious interpretation and for future studies to strengthen representativeness through broader sampling frames and longitudinal designs.

3.3.3 Inclusion and Exclusion criteria

Inclusion criteria required that participants be formally employed as either clinical or non-clinical staff within the emergency departments of the selected hospitals. Clinical staff included Medical Officers, Clinical Officers, Nurses working in triage, resuscitation, fast-track, and observation units, Pharmacists, Laboratory Technologists and Radiographers. Non-clinical staff comprised Clerks, Cleaners, and Security personnel who routinely operate under the high-pressure conditions of the emergency department. In addition, key informants were purposively selected to provide managerial perspectives and included Hospital Administrators, Human Resource Officers, and Emergency Department Supervisors.

To ensure adequate exposure to the operational environment and organizational support structures, all participants were required to have worked in the emergency department for at least six months and to be present during the data collection period (World Health Organization, 2022).

Exclusion criteria ruled out interns, student, and other trainees, as their exposure to emergency department pressures was temporary and they were not fully integrated into hospital support systems. Temporary or casual staff on short-term contracts or locum arrangements were also excluded to avoid variability in stress exposure and organizational support. Personnel not directly assigned to emergency departments, such as those working in maternity, surgical wards, or outpatient clinics, were excluded since the study focused specifically on emergency department dynamics. Staff who were on leave, secondment, or otherwise unavailable during the data collection period were excluded to maintain consistency in exposure. In addition, participants who provided incomplete responses, those not currently practicing despite being on the staff register, and individuals with conflicts of interest were excluded to safeguard data integrity (Kaguu & Kaluyu, 2024).

Together, these criteria were specific, clear, and balanced. They were not overly broad, since they excluded individuals with insufficient or inconsistent exposure, and they were not overly narrow, since they included both clinical and non-clinical cadres across different hospital ownership types (Saunders, Lewis, & Thornhill, 2019). This balance ensured that the sample was representative of the target population, minimized bias, and supported the reliability and validity of the findings (Bryman, 2016).

The sampling method was appropriate for the study objectives because it combined stratified random sampling, which ensured proportional representation of clinical and non-clinical staff across hospitals, with purposive sampling, which captured managerial perspectives. The (Yamane, 1967) formula was applied to calculate the required sample size, and an additional 10% was added to account for potential non-response, following survey research recommendations (Mugenda & Mugenda, 2003). This dual approach is consistent with established methodological guidance and allowed the study to examine both staff experiences and organizational support structures. For the qualitative arm, purposive sampling was employed to select key informants, consistent with (Patton, 2015) guidance on qualitative inquiry. Within mixed-methods frameworks, purposive sampling provides depth and contextual richness that complements quantitative breadth, thereby enhancing the comprehensiveness of the study (Creswell & Clark, 2018).

The adequacy of the sample size was further supported by recognized statistical formulas and methodological authorities, ensuring representativeness, minimizing bias, and enhancing validity (Saunders, Lewis, & Thornhill, 2019). In addition, the inclusion of both clinical and non-clinical cadres across different hospital ownership types aligned with global recommendations on occupational health and staff welfare (World Health Organization & International Labour Organization, 2022). For the qualitative arm, purposive sampling of key informants continued until thematic saturation was reached, in line with best practice recommendations (Guest, Namey, & Chen, 2020). Overall, the chosen sampling method was suitable, rigorous, representative, and feasible, making it defensible for both academic and practical purposes.

3.4 Data collection methods

Data collection in this study combined quantitative and qualitative approaches in line with the convergent parallel mixed-methods design. This ensured that numerical evidence of prevalence and associations was complemented by rich contextual insights into staff experiences and organisational practices.

Quantitative data were collected using a structured questionnaire that integrated items from established, validated scales to ensure comparability and methodological rigor. The Maslach Burnout Inventory was employed to measure three dimensions of work-related stress: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Leiter, 2016). Items were presented on a 7-point Likert scale ranging from 1 = never to 7 = every day, allowing respondents to indicate the frequency of stress-related experiences. Higher scores on emotional exhaustion and depersonalisation reflected greater stress, while higher scores on personal accomplishment indicated lower stress levels. This multidimensional measurement enabled nuanced analysis of stress prevalence and severity across cadres.

The Survey of Perceived Organizational Support was used to assess staff perceptions of whether their institution valued their contributions and cared about their wellbeing (Eisenberger, Huntington, Hutchison, & Sowa, 1986). This section also used a 7-point Likert scale ranging from 1 = strongly disagree to 7 = strongly agree. To minimise acquiescence bias, half of the items were positively worded including the hospital values my contribution, while the other half were negatively worded such as the hospital shows little concern for my wellbeing. Negatively worded items were reverse-coded during analysis to ensure consistency in interpretation. This balanced wording strategy reduced social desirability bias and improved the validity and reliability of the scale (Podsakoff, MacKenzie, & Podsakoff, 2012).

Additional items adapted from organisational support literature captured emotional, instrumental, structural, and participatory support mechanisms such as counselling services, workload redistribution, peer networks, and recognition systems (Altowairqi, Alharbi, Alzahrani, & Alghamdi, 2023). These were measured on a 7-point Likert scale, enabling assessment of the perceived adequacy of support structures. Demographic variables such as age, gender, cadre, years of experience, shift type, and hospital type were included to allow subgroup analysis and contextual interpretation (Kamau, Jamleck, & Mutiso, 2025).

Responses were numerically coded during data collection to facilitate efficient analysis. Each option was assigned a value on a 1–7 scale, where never was coded as 1 and Every day as 7. Reverse scoring was applied during analysis for negatively worded items to ensure that higher scores consistently reflected higher levels of burnout or stress. This approach aligned with standard practices used in validated instruments such as the Maslach Burnout Inventory and Survey of Perceived Organizational Support, ensuring methodological rigor, data consistency, and reliability of findings. In Nairobi's Level 5 hospitals, these tools were adapted to reflect local realities such as overcrowding, repeated trauma exposure, and fragile coping networks.

Perceptions of organisational support were also shaped by systemic inequalities and distrust in counselling services, making contextual adaptation essential for validity.

Despite these safeguards, reliance on self-report Likert-scale instruments introduced risks of social desirability bias, acquiescence bias, and common method variance (Podsakoff, MacKenzie, & Podsakoff, 2012). Mitigation strategies included anonymity assurances, balanced wording of items, and triangulation with qualitative data. Nonetheless, response bias remains a limitation, and future studies should incorporate objective indicators such as absenteeism, turnover, or patient safety metrics to complement self-report measures. These risks may be intensified in hierarchical hospital cultures, where staff could underreport dissatisfaction with supervisors or overreport stress symptoms if they perceived the study as a vehicle for resource advocacy. While anonymisation and balanced item wording mitigated these risks, they cannot be fully eliminated, and this limitation is revisited in Chapter Five.

Qualitative data were collected concurrently through open-ended survey questions and key informant interviews. Open-ended survey items invited staff to describe coping strategies, sources of stress, and suggestions for improvement, thereby capturing staff perspectives that extended beyond structured scales. Key informant interviews were conducted with Supervisors, Human Resource Officers, and Administrators to provide institutional-level insights into support policies, leadership practices, and barriers to implementation.

All interviews were audio-recorded with consent, transcribed verbatim, and analysed thematically using Braun and Clarke's six-step framework (Braun & Clarke, 2022). Coding was conducted inductively to capture emergent themes and deductively to align with study constructs such as supervisory practices, institutional policies, resource adequacy, and staff participation. Themes were reviewed and refined to ensure coherence, and representative quotations were used to illustrate findings.

While these interviews provided valuable organisational perspectives, they risked overrepresenting managerial views and underrepresenting frontline staff, particularly non-clinical and night-shift workers. Open-ended survey responses partially addressed this imbalance, but the qualitative strand remains limited in scope. Future research should expand qualitative sampling to include more frontline staff, especially those working night shifts, to capture richer and more balanced narratives.

To ensure clarity and contextual fit, all tools were pre-tested during a pilot phase at Mater Misericordiae Hospital. The pilot allowed refinement of wording, confirmation of cultural sensitivity, and adjustment of Likert anchors to ensure respondents interpreted items consistently (Teijlingen & Hundley, 2001). Feedback from participants and expert reviewers

was used to improve clarity, sequencing, and relevance of both the questionnaire and interview guide.

Trained research assistants administered questionnaires and facilitated interviews to minimise bias, provide clarification, and support participants in cases of language or literacy challenges. This concurrent collection of quantitative and qualitative data strengthened methodological triangulation, enhanced validity, and ensured that numerical results were enriched by staff narratives (Creswell & Clark, 2018).

3.5 Data analysis

Data analysis in this study was conducted using both quantitative and qualitative approaches to reflect the convergent parallel mixed-methods design. Quantitative data were analysed using IBM SPSS Statistics Version 28 (IBM Corp, 2021), while qualitative data were analysed thematically following Braun and Clarke's six-step framework (Braun & Clarke, 2022). The two strands were collected concurrently and merged at the interpretation stage to ensure methodological triangulation, equal priority, and a comprehensive understanding of occupational stress and organisational support in Nairobi's Level 5 hospitals (Creswell & Clark, 2018).

Objective One: Prevalence and sources of stress

To assess the prevalence and sources of work-related stress among clinical and non-clinical emergency department staff, descriptive statistics such as frequencies, percentages, means, and standard deviations were generated. These quantified stress levels across cadres and hospital types. Subgroup comparisons were conducted using independent samples t-tests and one-way ANOVA to determine whether stress levels differed significantly by cadre, hospital ownership, or years of experience (Field, 2018).

Complementary qualitative data from open-ended questionnaire responses were coded thematically to identify common stressors and coping strategies. This enriched the numerical prevalence data with narrative insights, highlighting stress drivers such as workload intensity, resource shortages, and exposure to patient aggression (Patton, 2015).

Objective Two: Organisational support and stress outcomes

To examine the relationship between organisational support structures and work-related stress, Pearson's correlation coefficients were calculated to test associations between support mechanisms (supervisory support, welfare structures, professional development, and resource adequacy) and stress indicators (emotional exhaustion, depersonalisation, and reduced personal accomplishment) (Eisenberger, Huntington, Hutchison, & Sowa, 1986).

Multiple regression analysis was then employed to determine the predictive strength of organisational support structures on stress outcomes, while controlling for demographic variables such as cadre, gender, and years of experience (Maslach & Leiter, 2016). This allowed the study to establish whether organisational support significantly reduced stress levels and to identify which forms of support were most influential (Altowairqi, Alharbi, Alzahrani, & Alghamdi, 2023).

Qualitative narratives provided contextual explanations for these statistical associations. For example, if regression analysis showed that supervisory support predicted lower emotional exhaustion, interview data illustrated the specific managerial practices underpinning this effect, such as fair rostering, recognition systems, or non-punitive handling of errors.

Objective Three: Mediating role of staff perceptions

The mediating role of staff perceptions of organisational support was analysed using regression-based approaches, specifically the PROCESS macro in SPSS (Hayes, 2018). Direct, indirect, and total effects were reported with bootstrapped confidence intervals to ensure robust inference (Preacher & Hayes, 2008).

Results indicated partial and statistically non-significant mediation of staff perceptions. While conceptually consistent with Organizational Support Theory, the weak statistical evidence cautions against confirmatory claims. Findings are therefore interpreted as exploratory, suggesting perceptions may play a mediating role but requiring stronger evidence from larger, longitudinal samples. It should also be noted that while regression-based mediation approaches such as the (Baron & Kenny, 1986) framework remain pedagogically transparent, they are recognised as conservative compared to bootstrapped confidence interval testing (Hayes, 2018). Where indirect effects are reported without accompanying bootstrapped intervals, they should be treated as indicative rather than definitively confirmed. This distinction is explicitly maintained in the interpretation of mediation results in Chapter Four and Chapter Five. This reflexive interpretation avoids overstating results and situates mediation as tentative rather than definitive.

Complementary qualitative data were coded and thematically analysed using NVivo 14 (QSR International, 2024). These narratives enriched interpretation by highlighting how staff perceptions of fairness, recognition, and responsiveness shaped their stress experiences. For instance, staff often described counselling services as structurally available but perceptually distrusted, illustrating the gap between organisational intent and frontline reality.

Qualitative data from open-ended questions and key informant interviews were transcribed verbatim and analysed thematically. Coding was conducted inductively and deductively to capture both emergent themes and those aligned with study constructs such as supervisory practices, institutional policies, resource adequacy, and staff participation (Braun & Clarke, 2022). Themes were reviewed and refined to ensure coherence, and representative quotations are used to illustrate findings.

Credibility was enhanced through double coding, audit trails, and member checks where feasible (Lincoln & Guba, 1985). However, the qualitative strand was limited by the small number of key informants (nine), with managerial perspectives potentially overrepresented. This composition was a deliberate design choice to capture institutional and policy-level perspectives that complement frontline survey data. However, it also means that qualitative findings on organisational intent and institutional perspective should be read as predominantly managerial in origin. Clinical and non-clinical voices are represented primarily through open-ended questionnaire responses rather than in-depth interviews, which limits the richness of their narratives. This imbalance is acknowledged as a methodological limitation and revisited in Chapter Five. Open-ended survey responses partially mitigated this imbalance, but future research should expand qualitative sampling to capture richer staff narratives.

Integration of findings occurred at the interpretation stage, where quantitative results established prevalence, relationships, and mediation effects, while qualitative insights provided contextual explanations. Joint displays and side-by-side comparisons were used to demonstrate convergence, complementarity, or divergence between strands (Fetters, Curry, & Creswell, 2013).

Convergent findings strengthened validity such as both regression and narratives showed supervisory support reduced stress. Complementary findings enriched understanding such as quantitative data showed resource shortages predicted stress, while qualitative data explained how shortages manifested in daily practice. Divergent findings highlighted contextual complexities such as counselling services statistically associated with lower stress but qualitatively distrusted by staff.

Results were reported with descriptive statistics, correlation matrices, regression tables, and mediation models for the quantitative strand, alongside thematic summaries and illustrative quotations for the qualitative strand. Effect sizes such as Cohen's *d* and standardised regression coefficients were presented to convey practical significance. Visualisations such as bar charts, pie charts, and joint display matrices enhanced clarity.

3.6 Research quality

Ensuring methodological rigor was a central priority in this study. Research quality was addressed through credibility, reliability, validity, dependability, confirmability, and transferability, supported by both procedural safeguards and reflexive acknowledgement of limitations.

Credibility was achieved through the use of validated instruments, specifically the Maslach Burnout Inventory (Maslach & Leiter, 2016) and the Survey of Perceived Organizational Support (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Triangulation of quantitative and qualitative strands strengthened trustworthiness, as numerical results were complemented by staff narratives. Member checks, peer debriefing, and the inclusion of representative quotations further reinforced the authenticity of qualitative findings (Lincoln & Guba, 1985). Reliability was established through standardized tools with strong internal consistency. Cronbach's alpha coefficients, calculated during the pilot study at Mater Misericordiae Hospital, ranged between 0.70 and 0.90, which falls within the recommended threshold for acceptable to good reliability (Nunnally & Bernstein, 1994). Procedural safeguards such as trained research assistants, consistent data collection environments, double data entry, and NVivo 14 audit trails added rigor across both strands (Bazeley, 2023). While these coefficients demonstrate acceptable to good internal consistency, reliability alone does not confirm construct validity. In Nairobi's Level 5 hospitals, organisational identity may be interpreted differently across ownership models, particularly in faith-based institutions where staff may frame 'value my contribution' in communal or spiritual terms rather than managerial ones.

Validity in this study was addressed at several levels to ensure that the findings were both accurate and contextually meaningful. Content validity was achieved through expert review of the instruments, where specialists in emergency care and occupational health examined the questionnaire and interview guide to confirm that the items adequately captured the constructs of organisational support and work-related stress. Construct validity was strengthened by aligning the measures with established theoretical frameworks, specifically the Job Demands–Resources model (Bakker & Demerouti, 2017) and Organizational Support theory (Shanock & Eisenberger, 2006). This alignment ensured that the study variables were theoretically grounded and empirically traceable. Face validity was confirmed during the pilot phase, where participants assessed the clarity and relevance of items, leading to refinements in wording and sequencing. Ecological validity was enhanced by sampling across diverse hospital ownership models; public, private, and faith-based, and across both clinical and non-clinical cadres,

thereby reflecting the realities of Nairobi's Level 5 emergency departments. Although expert review and pilot testing provided reasonable assurance of content and face validity, no formal confirmatory factor analysis was conducted to test whether the scales' underlying factor structures hold in this Kenyan emergency care sample. Construct validity in the stricter psychometric sense therefore remains assumed rather than statistically confirmed, and this limitation is revisited in Chapter Five.

Triangulation of quantitative and qualitative strands, together with discrepant case analysis, further reinforced validity by allowing the study to compare convergent, complementary, and divergent findings. However, despite these safeguards, construct validity and cultural adaptation required further attention. The Maslach Burnout Inventory and the Survey of Perceived Organizational Support were originally developed in Western contexts, and while they have been widely validated internationally, their full adaptation to Kenyan emergency care settings remains limited. Items were reviewed by local experts and piloted for clarity and sensitivity, but questions remain about whether these scales fully capture stress experiences shaped by resource scarcity, cultural norms, and governance structures. For this reason, findings are interpreted with caution regarding cultural transferability, and future research is encouraged to undertake more extensive validation of these instruments in Sub-Saharan African healthcare environments.

However, construct validity and cultural adaptation required further attention. Items were reviewed by Kenyan emergency care experts and piloted for clarity and sensitivity, but full validation of scales such as the Maslach Burnout Inventory in Kenyan emergency settings remains limited. This raises questions about contextual relevance, as instruments developed in Western contexts may not fully capture stress experiences shaped by resource scarcity, cultural norms, and governance structures. Findings should therefore be interpreted cautiously regarding cultural transferability.

Dependability was supported by transparent coding procedures, audit trails, and reflexivity journals. Confirmability was enhanced by balanced wording in survey items to reduce bias (Podsakoff, MacKenzie, & Podsakoff, 2012), as well as by double coding and peer review of qualitative data. These measures ensured that findings were traceable, replicable, and not unduly influenced by researcher bias.

Transferability was facilitated by thick description of emergency department contexts, including staffing structures, resource constraints, and organisational cultures across public, private, and faith-based hospitals. Representative sampling across clinical and non-clinical

staff further supported applicability of findings to similar high-volume emergency care settings in Kenya and comparable Sub-Saharan contexts.

The pilot study at Mater Misericordiae Hospital provided an opportunity to refine instruments before full implementation. Feedback from participants and expert reviewers was used to improve clarity, sequencing, and relevance of both the questionnaire and interview guide. Participants in the pilot were excluded from the main study to prevent contamination. Consistent with recommendations by (Teijlingen & Hundley, 2001), the pilot enhanced feasibility and logistical practicality, ensuring that the instruments were suitable for the main study.

Together, these measures ensured methodological rigor, ethical soundness, and contextual relevance, thereby strengthening the credibility, trustworthiness, and applicability of the study's findings for organisational support and staff wellbeing in Kenya's Level 5 hospitals. At the same time, reflexive acknowledgement of limitations, particularly regarding cultural adaptation of instruments and the constraints of a cross-sectional design, underscores the need for cautious interpretation and future validation in local contexts.

Table 3. 1: Cronbach's Alpha Reliability Coefficients for Study Constructs

Construct	No. of items	Cronbach's alpha (α)
Work-related stress	9	0.74
Organizational support structures	6	0.77
Staff perception of organizational support	8	0.82
Overall instrument	23	—

3.7 Ethical consideration

This study adhered to strict ethical standards to protect participants and ensure research integrity. Ethical approval was obtained from Strathmore University's Institutional Review Board, the National Commission for Science, Technology and Innovation, and hospital management committees. These approvals aligned with international principles of respect for persons, beneficence, and justice as outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

All participants provided informed consent after receiving clear explanations of the study's purpose, procedures, risks, and rights to withdraw. Consent forms were provided in English to ensure comprehension. Participation was entirely voluntary, with assurances that involvement

or non-involvement would not affect employment status. Risks were minimised by allowing participants to skip questions or withdraw at any point, consistent with ethical principles of autonomy and non-maleficence (Beauchamp & Childress, 2019).

Confidentiality was safeguarded by anonymising data, using codes instead of names, and storing files securely. Access to Human Resource records during participant selection was restricted to authorised personnel, limited only to essential data such as staff cadre and numbers. Where possible, de-identified and coded staff lists were used to avoid exposure of personal identifiers, consistent with Council for International Organizations of Medical Sciences guidance (Council for International Organizations of Medical Sciences, 2021). Electronic files were password-protected and encrypted, while physical documents were stored in locked cabinets under the custody of the principal investigator. Research team members signed confidentiality agreements to formally commit to safeguarding information (Resnik, 2020).

A clear data retention and disposal plan was established: Human Resource-related data will be retained for three to five years post-study, after which electronic files will be permanently deleted and physical documents shredded. This practice complies with Kenya's Data Protection Act (Republic of Kenya, 2019) and European Data Protection Board guidance (European Data Protection Board, 2020). An audit trail documented all access to Human Resource data, including who accessed it, when, and for what purpose, ensuring accountability and transparency.

Equity was ensured by including both clinical and non-clinical cadres across public, private, and faith-based hospitals, reflecting fairness in participant selection (Molyneux, Kamuya, & Marsh, 2022). Enumerators were trained in empathetic communication, non-judgmental listening, and basic crisis response protocols to safeguard participant wellbeing during data collection.

Beyond formal procedures, practical dilemmas arose in hierarchical hospital settings. Some staff expressed confidentiality concerns when supervisors were nearby, and others experienced distress when recounting traumatic incidents. These risks reflect the power dynamics inherent in hospital hierarchies, where staff may feel subtle pressure to moderate their responses. Anonymous completion and separation of managerial interviews from frontline data collection were therefore critical safeguards to ensure candour. To address these, interviews were conducted privately, withdrawal rights were emphasised, and counselling referrals were provided. While enumerators were trained to pause interviews and provide counselling referrals when distress was visible, no formal psychological screening instrument was administered.

This represents a pragmatic limitation of survey-based research in active emergency departments, where feasibility constraints limit exhaustive welfare monitoring. These measures highlight the importance of addressing power dynamics and participant distress in high-stress environments, ensuring that ethical principles were not only formally observed but practically enacted.

Participants were kept informed throughout the study to uphold transparency and respect for autonomy. At the outset, they received clear briefings on objectives, procedures, timelines, and their rights. Updates were communicated through departmental meetings, hospital notice boards, and email communication, summarising progress and notifying participants of any changes. Mechanisms were in place for participants to raise questions or concerns, reinforcing their role as active stakeholders rather than passive subjects.

The dissemination of study results was conducted in a structured and transparent manner to ensure accountability and participant benefit. Dissemination was not only a procedural requirement but also an ethical commitment to respect participants as stakeholders. By sharing findings with hospitals, staff, and wider policy audiences, the study reinforced accountability and empowered participants to see how their contributions informed organisational and policy improvements. Findings were first shared with participating hospitals through feedback meetings and written summary reports, enabling institutions to reflect on occupational stress and organisational support structures within their facilities (National Commission for Science, Technology and Innovation, Kenya, 2021). Participants were also informed of results through departmental briefings, hospital notice boards, and electronic communication, ensuring accessibility across cadres (Council for International Organizations of Medical Sciences, 2021). Beyond immediate participants, results were disseminated to wider stakeholders through policy briefs, academic publications, and stakeholder workshops, thereby contributing to health system strengthening and evidence-based decision-making (Resnik, 2020).

By combining hospital-level feedback, participant updates, and broader stakeholder communication, the study demonstrated transparency, accountability, and alignment with both international ethical guidelines and local regulatory frameworks. These safeguards ensured that the study was ethically robust, trustworthy, and beneficial to improving organisational support and staff wellbeing in Kenya's Level 5 hospitals.

3.8 Chapter summary

Chapter outline outlined the study's mixed-methods design, emphasizing reliability, validity, and trustworthiness through triangulation, pilot testing, and audit trails. Ethical safeguards

including informed consent, confidentiality, voluntariness, equity, and enumerator training ensured participant protection and research integrity. Together, these measures made the study rigorous, ethical, and relevant to strengthening staff well-being in Kenya's Level 5 hospital. By integrating quantitative breadth with qualitative depth, the methodology ensured that both structural stressors and staff perceptions were captured, aligning with the Job Demands–Resources model and Organizational Support Theory, and producing evidence that is both contextually valid and theoretically grounded.

CHAPTER 4

PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter presents and discusses findings on organisational support and work-related stress among emergency department staff in three Level 5 hospitals in Nairobi County. The analysis is organised around three objectives: (i) assessing the prevalence and sources of stress among clinical and non-clinical staff; (ii) examining the relationship between organisational support structures and stress; and (iii) analysing the mediating role of staff perceptions. Each section integrates quantitative results from 133 valid questionnaires analysed in SPSS (Version 28) with qualitative insights from open-ended responses and nine semi-structured interviews coded thematically in NVivo. The convergent parallel mixed-methods design ensured systematic integration of both strands, connecting findings to the Job Demands–Resources model and Organizational Support Theory within the unique context of Nairobi’s Level 5 emergency departments.

4.2 Response rate

A total of 148 questionnaires were distributed across the three study sites: Mbagathi County Referral Hospital (n = 58), Metropolitan Hospital (n = 50), and St. Francis Community Hospital (n = 40). Of those returned, 133 satisfied all inclusion criteria and consent requirements, yielding a final valid response rate of 89.9%. Additionally, nine key informant interviews were completed, comprising three participants per hospital drawn from hospital administration, human resource management, and emergency department leadership. Table 4.1 summarises the response rate by hospital.

Table 4. 1: Response Rate by Hospital

Hospital	Distributed	Returned	Valid (n)	Rate (%)
Mbagathi County Referral Hospital (Public)	58	52	50	86.2

Metropolitan Hospital (Private)	50	48	47	94.0
St. Francis Community Hospital (Faith-based)	40	36	36	90.0
Total	148	136	133	89.9

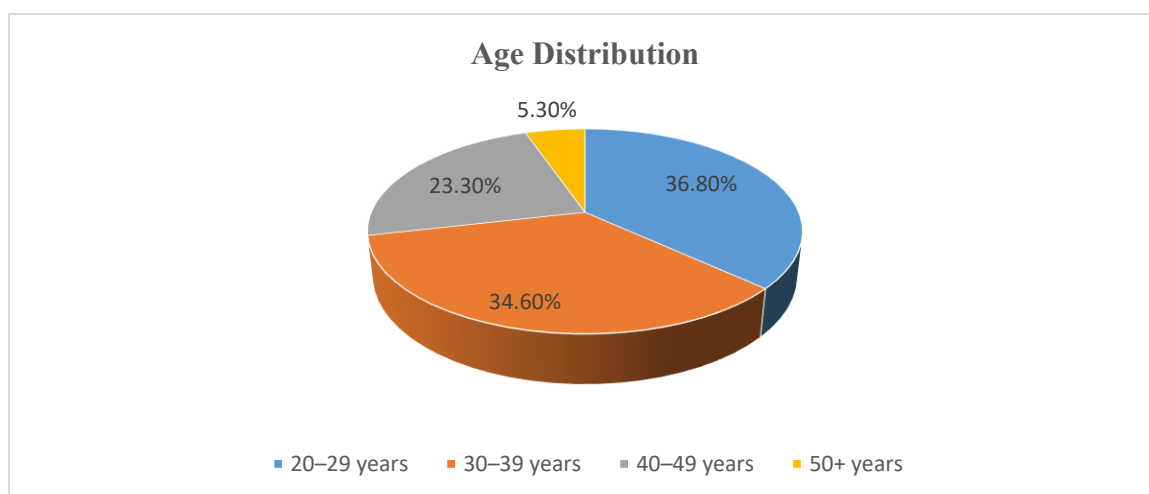
The overall response rate of 89.9% strengthens the validity of findings, but results reflect staff present during data collection rather than a fully randomised sample. Slightly lower participation in the public hospital compared to the private facility may reflect workload pressures and absenteeism, a limitation revisited in Chapter Five.

4.3 Background information of respondent

4.3.1 Age distribution

The majority of respondents were aged 20–29 years ($n = 49$, 36.8%), followed by those aged 30–39 years ($n = 46$, 34.6%), 40–49 years ($n = 31$, 23.3%), and 50 years and above ($n = 7$, 5.3%). The predominantly young workforce composition was consistent with the high attrition and turnover rates documented in Kenya's emergency care sector and reflected national demographic trends in health workforce composition.

Figure 4. 1: Age Distribution

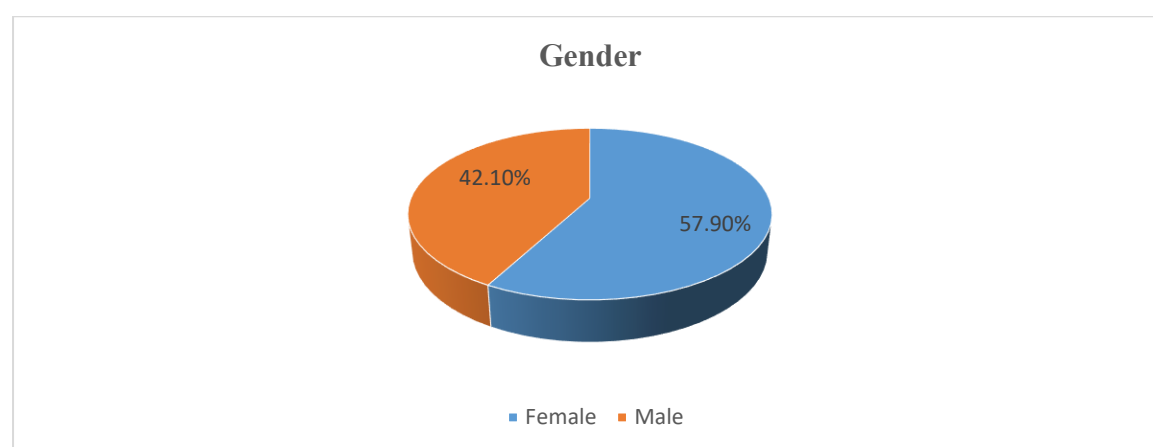


The predominance of younger staff highlights the vulnerability of Kenya's emergency care workforce to attrition and turnover, which may shape stress outcomes differently compared to older, more experienced staff.

4.3.2 Gender

Female respondents constituted the majority at 57.9% (n = 77), while male respondents accounted for 42.1% (n = 56), which reflected the feminisation of the healthcare workforce in Kenya, particularly in nursing and allied health professions.

Figure 4. 2: Gender



4.3.3 Professional designation

Nurses formed the largest professional cadre (n = 42, 31.6%), followed by medical officers (n = 15, 11.3%), laboratory technologists (n = 14, 10.5%), radiographers (n = 14, 10.5%), pharmacists (n = 14, 10.5%), and clinical officers (n = 9, 6.8%). Non-clinical staff, comprising housekeeping or cleaning staff, registration and front office clerks, and security personnel, accounted for 18.8% of the sample (n = 25). For the purpose of inferential comparison, respondents were categorised as clinical (n = 108, 81.2%) and non-clinical (n = 25, 18.8%).

Table 4. 2: Professional Designation of Respondents

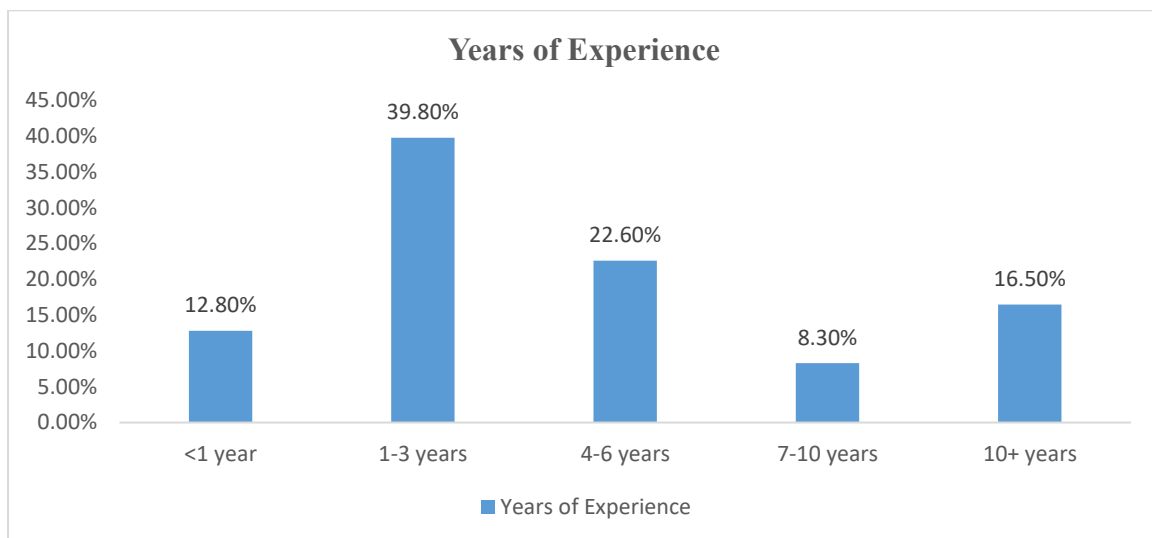
Cadre	Frequency (n)	Percentage (%)
Nurse	42	31.6
Medical Officer	15	11.3
Laboratory Technologist	14	10.5
Radiographer	14	10.5
Pharmacist	14	10.5

Clinical Officer	9	6.8
Housekeeping / Cleaner	12	9.0
Registration / Front Office / Security	13	9.8
Total	133	100.0

4.3.4 Years of experience in Emergency department

The most common experience bracket was one to three years (combined n = 53, 39.8%), followed by four to six years (n = 30, 22.6%), more than 10 years (n = 22, 16.5%), less than one year (combined n = 17, 12.8%), and seven to ten years (n = 11, 8.3%). The diversity of experience levels ensured that findings captured perspectives from both newly recruited and long-serving emergency department staff.

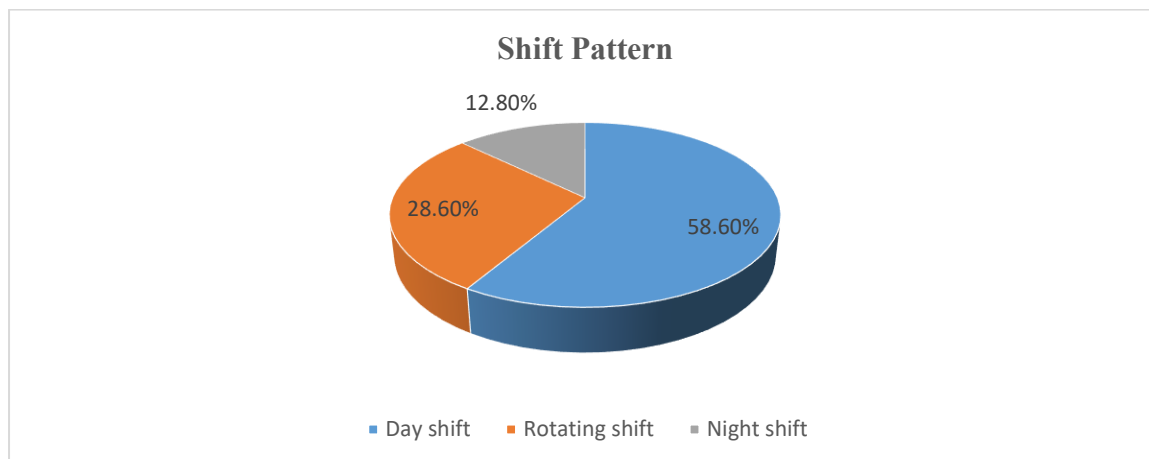
Figure 4. 3: Years of Experience



4.3.5 Shift pattern

Day shift was most frequently worked in the three months prior to data collection (n = 78, 58.6%), followed by rotating shift (n = 38, 28.6%), and night shift only (n = 17, 12.8%).

Figure 4. 4: Shift Pattern



The underrepresentation of night-shift staff (12.8%) is acknowledged as a limitation, as night shifts are often associated with higher stress exposure. This imbalance is considered in interpreting stress prevalence results.

4.4 Objective One: Prevalence and sources of work-related stress

4.4.1 Quantitative findings

Work-related stress was measured using nine items adapted from the Maslach Burnout Inventory, rated on a seven-point Likert scale (1 = Never to 7 = Every day). Negatively worded items; measuring emotional exhaustion, morning fatigue, work conflict, emotional detachment, sleep impairment, and emotional drain, were reverse-coded so that higher composite scores consistently reflect higher stress. The scale demonstrated satisfactory internal consistency (Cronbach's $\alpha = 0.77$), exceeding the recommended threshold of 0.70 (Tavakol & Dennick, 2011).

The mean composite stress score for all 133 respondents was 4.75 (SD = 1.20) on the seven-point scale, indicating that emergency department staff generally experienced moderate to high levels of work-related stress. Stress levels were categorised as low (≤ 3.00), moderate (3.01–5.00), and high (≥ 5.01). As shown in Table 4.3, 51.1% ($n = 68$) of respondents reported moderate stress levels, while 39.1% ($n = 52$) reported high stress. Only 9.8% ($n = 13$) fell in the low stress category. Taken together, 90.2% of emergency department staff experienced moderate to high levels of work-related stress, underscoring the pervasive and severe nature of this occupational health burden. As these figures were derived from self-report questionnaires, they may reflect response tendencies such as heightened awareness of occupational strain or social desirability. However, the convergence of quantitative prevalence with qualitative

accounts of workload, resource inadequacy, and emotional burden supports the credibility of the findings.

Table 4. 3: Prevalence of Work-Related Stress

Stress Level	Score Range	Frequency (n)	Percentage (%)
Low	≤ 3.00	13	9.8
Moderate	3.01 – 5.00	68	51.1
High	≥ 5.01	52	39.1
Total	—	133	100.0

The very high prevalence of moderate to high stress (90.2%) may partly reflect self-report sensitivity, but convergence with qualitative accounts of workload, resource inadequacy, and emotional burden strengthens the credibility of these findings.

Comparative analysis across hospitals showed that Metropolitan Hospital had the highest mean stress score ($M = 4.87$, $SD = 1.09$), followed by St. Francis Community Hospital ($M = 4.75$, $SD = 1.21$) and Mbagathi County Referral Hospital ($M = 4.63$, $SD = 1.29$). A one-way ANOVA confirmed no statistically significant differences across hospital types ($F(2, 130) = 0.515$, $p = .599$), which indicated that occupational stress was uniformly pervasive irrespective of ownership model. Similarly, an independent samples t-test found no significant difference in stress between clinical staff ($M = 4.74$, $SD = 1.19$) and non-clinical staff ($M = 4.76$, $SD = 1.24$) ($t(131) = -0.075$, $p = .940$), and demonstrated that the stress burden extended equitably across all professional cadres in the emergency department. Although differences across hospital types were not statistically significant, the slightly higher mean stress score in the private hospital may reflect workload intensity and patient expectations in fee-for-service settings. This nuance is revisited in Chapter Five.

Respondents identified heavy workload as the primary cause of stress ($n = 77$, 57.9%), followed by staffing shortages ($n = 59$, 44.4%), limited access to resources or equipment ($n = 40$, 30.1%), long or inflexible working hours ($n = 39$, 29.3%), poor communication from management ($n = 31$, 23.3%), lack of organizational and supervisory support ($n = 29$, 21.8%), and conflict with colleagues or supervisors ($n = 16$, 12.0%). The most prevalent symptom was feeling overwhelmed or anxious ($n = 75$, 56.4%), followed by headaches or physical tension ($n = 72$, 54.1%), irritability or mood changes ($n = 71$, 53.4%), and reduced motivation ($n = 69$, 51.9%).

The most reported performance effect was burnout or exhaustion (n = 88, 66.2%), followed by reduced concentration (n = 60, 45.1%) and decline in emotional wellbeing (n = 60, 45.1%).

Table 4. 4: Main Sources of Work-Related Stress (Q9, n = 133)

Source of Stress	Frequency (n)	Percentage (%)
Heavy workload	77	57.9
Staffing shortages	59	44.4
Limited access to resources or equipment	40	30.1
Long or inflexible working hours	39	29.3
Poor communication from management	31	23.3
Lack of organizational and supervisory support	29	21.8
Conflict with colleagues or supervisors	16	12.0

4.4.2 Qualitative Findings: Prevalence and sources of work-related stress

Qualitative data from open-ended questionnaire responses (Q8: Describe a recent situation where you felt stressed at work) and key informant interviews were coded and thematically analysed in NVivo 14 following (Braun & Clarke, 2022) six-step framework. Coding proceeded inductively from the raw data before being reviewed deductively against the study's conceptual constructs. Three major themes emerged, each grounded in multiple nodes as outlined in Table 4.5 below.

Table 4. 5: NVivo Themes and Nodes - Objective One: Prevalence and Sources of Work-Related Stress

Theme	NVivo Nodes	Description
Theme 1: Overwhelming Workload and Chronic Understaffing	Understaffing; Lone working; Patient surge; Shift coverage gaps; Role overload; Code blue scenarios	Staff regularly worked alone or with critically insufficient colleagues during high-acuity periods, including resuscitations, mass patient influxes, and code blue events across all three hospitals.
Theme 2: Resource Inadequacy	Equipment shortages; Drug stockouts; non-functional machinery; Consumable	Absence of essential supplies, equipment failures, and systemic resource shortfalls intensified

Compounding Occupational Pressure	shortfalls; Social Health Authority insurance barriers; Physical working conditions	workload demands and generated moral distress when staff were unable to provide expected care.
Theme 3: Violence, Emotional Burden, and Moral Distress	Patient aggression; Relative violence; Verbal abuse; Traumatic patient death; Moral distress; Witnessing suffering; Lack of institutional protection	Exposure to patient aggression, unnatural death, and institutional failure to protect or debrief staff after critical incidents generated acute and cumulative emotional distress.

Theme 1: Overwhelming Workload and Chronic Understaffing

This was the most pervasive theme across all three hospitals and all cadre types, appearing in the majority of open-ended questionnaire narratives and corroborated by all nine key informant accounts. Respondents consistently described being required to manage multiple critical responsibilities simultaneously with wholly insufficient staffing, resulting in extreme cognitive and physical strain. This theme was anchored by nodes on understaffing, patient surge, role overload, and lone working, capturing both routine understaffing and acute single-shift crises. *“Having to run triage with two resuscitations onboard with less staffing and no one to control the crowd and families, that is our daily reality.”*

(Respondent #2; Male Nurse, Observation Room, Faith-based Hospital)

“When we had very many patients at the ER, code blue on the other side, and we were only two nurses, that was the most stressed I have ever been at work.”

(Respondent #3; Female Nurse, private Hospital)

“A few days ago, there were very many patients that needed to be triaged but I was all alone and it became so burdening”.

(Respondent #1; Male Nurse, Public Referral Hospital)

Key informant accounts from all three hospital types confirmed that nurse-to-patient ratios are chronically inadequate and that single-cadre shortages during shifts are a systemic structural problem rather than an isolated occurrence:

“We should be having at least six or seven nurses in a shift to be adequate for the emergency department, but currently we run at around four to five. This is not exceptional; it is how we operate.”

(Respondent #3: Emergency Department In-Charge, Public Referral Hospital)

“The workload is heavy. This department receives acute and high-demanding patients with violent and aggressive relatives demanding immediate care. Staff shortages and high demand of services push our staff to their limits daily”.

(Respondent #1; Hospital Administrator, Mbagathi County Referral Hospital)

Theme 2: Resource Inadequacy Compounding Occupational Pressure

Across all hospital types, respondents described how the absence or failure of essential resources, including equipment, consumables, medications, and functional machinery, created a secondary layer of stress that compounded already demanding workloads. Nodes under this theme encompassed equipment shortages, drug and consumable stockouts, non-functional diagnostic machinery, Social Health Authority insurance barriers, and poor physical working conditions. Moral distress, the psychological burden of knowing the correct action but being unable to execute it due to resource constraints, emerged strongly from both clinical and non-clinical cadres.

“We had no gloves, strapping and other consumables, and our supervisor did not know when to expect them. You are expected to work under such conditions and still deliver quality care”

(Respondent #6; Male Nurse, Resuscitation, Public Referral Hospital)

“I was handling an emergency sample and our haematology machine was not working, so we had to refer it to a referral lab. The lab was taking more time than anticipated and the emergency team was pressuring me with frequent calls; I had no support in that moment.”

(Respondent #5; Female Laboratory Technologist, Faith-based Hospital)

“Today, many needy patients are unable to be waived by the hospital. Some require specialised care, ICU, HDU, but there is no bed space in the public sector. They cannot afford private. I am expected to fix a system I did not break”.

(Respondent #7; Female Medical Officer, Public County Referral Hospital)

At the institutional level, key informants acknowledged the systemic nature of resource shortfalls and the consequent moral strain on staff:

“Lack of supplies is the number one stressor here. Staff wake up in the morning and genuinely do not feel like coming to work, not because they do not care, but because they know they will have to work without what they need to do their job safely.”

(Respondent #4; Emergency Department In-Charge, Private Hospital)

Theme 3: Violence, Emotional Burden, and Moral Distress

A third recurrent theme cutting across all hospitals and cadres was the emotional and psychological weight of emergency care work, comprised of three interlocking node-sets: patient and relative aggression, exposure to traumatic patient death, and the institutional failure to protect or psychologically debrief staff following critical incidents. This theme was particularly prominent in open-ended responses from Nurses and Clerks and was consistently corroborated by key informants.

“A patient became violent and we were very scared, but all they asked afterwards was whether I had written an incident report. No one was asking us how we are. It is always about the reputation, never about the staff.”

(Respondent #9; Female Nurse, Rotating Shifts, Resuscitation, Public Referral Hospital)

“There are so many patients, and they do not want to wait. Some become violent and abuse me. I remember being physically assaulted back in 2021. We are also not provided with lunch, so we usually work from 8 a.m. to 8 p.m. hungry.”

(Respondent #10; Male Radiographer, Private Hospital)

“Receiving and resuscitating two patients who were relatives, a mother and son who had carbon monoxide poisoning, and we lost them both. There was no debriefing. We just continued with the next patient”.

(Respondent #1; Female Nurse, Night Shift, Resuscitation, Faith-Based Hospital)

Key informants confirmed that this emotional dimension of stress is recognised at managerial level but inadequately addressed through existing support mechanisms:

“We get to deal with death and are expected to move on and handle the next patient as though nothing happened. How people cope with death is very varied, and that variation in itself is a source of stress that leadership must acknowledge.”

(Respondent #3; Emergency Department In-Charge, Faith-Based Hospital)

Although statistical tests did not reveal significant differences by hospital type or between clinical and non-clinical staff, qualitative narratives suggest that certain subgroups may face distinct stress exposures that warrant further exploration. Night-shift staff repeatedly described heightened vulnerability to patient aggression, inadequate staffing, and lack of access to formal support services, while security personnel reported direct exposure to violence and verbal abuse without institutional debriefing or recognition. These accounts indicate that stress may not be uniformly distributed across all cadres and shift patterns, even if quantitative subgroup comparisons were constrained by sample size. Future research with larger samples and triangulation using objective indicators such as incident reports or absenteeism data would be

necessary to clarify whether these qualitative differences translate into systematic subgroup disparities. The underrepresentation of night-shift staff and small cadre subgroups such as Clinical Officers limits the ability to detect systematic differences quantitatively. Qualitative accounts suggest these groups may face distinct stress exposures, warranting further exploration in future research.

The three qualitative themes, overwhelming workload and chronic understaffing, resource inadequacy, and violence with emotional burden, should be understood not as isolated stressors but as interdependent elements of a cumulative stress cycle. Chronic understaffing amplifies workload intensity, which in turn magnifies the impact of resource shortages, as fewer staff are left to improvise solutions under constrained conditions. These compounded pressures heighten vulnerability to patient aggression and traumatic events, while the absence of institutional debriefing mechanisms leaves staff to absorb emotional fallout individually. This causal chain illustrates how structural deficits cascade into psychosocial strain, reinforcing the quantitative finding of uniformly high stress levels across cadres. From a Job Demands–Resources perspective, the convergence of excessive demands with inadequate resources creates a context in which burnout becomes not an individual failing but a systemic inevitability, underscoring the need for integrated interventions that address staffing, resourcing, and emotional protection simultaneously.

4.5 Objective Two: Relationship between organizational support structures and work-related stress

4.5.1 Quantitative Findings

Organizational support was measured using seven items drawn from the Survey of Perceived Organizational Support and supplementary support literature, rated on a 7-point Likert scale. Items negatively worded, including hospital does not provide adequate emotional support, absence of communication channels, and lack of counselling access, were reverse-coded. The scale demonstrated acceptable internal consistency (Cronbach's $\alpha = 0.76$).

Table 4.6 presents mean scores for each organizational support dimension. Supervisor support ($M = 4.68$, $SD = 1.98$) and the recoded counselling access item ($M = 4.94$, $SD = 2.02$) recorded the highest means, while emotional support from the hospital ($M = 3.30$, $SD = 2.11$) and adequacy of resources ($M = 3.84$, $SD = 2.21$) fell below the scale midpoint of 4.0, indicating that structural deficiencies in emotional support and resource provision are the most acutely perceived gaps. The composite organizational support score was $M = 4.31$ ($SD = 1.29$).

Table 4. 6: Descriptive Statistics - Organizational Support Dimensions

Organizational Support Dimension	n	Mean	SD
Emotional support from hospital (EmoSupportHosp)	133	3.30	2.11
Supervisor support (SupervisorSupp)	133	4.68	1.98
Communication channels (CommChannels, recoded)	133	4.78	1.99
Professional development (ProfDevOpport)	133	4.37	2.14
Access to counselling (LackCounsel, recoded)	133	4.94	2.02
Adequacy of resources (AdeqResources)	133	3.84	2.21
Composite Organizational Support Score	133	4.31	1.29

Metropolitan Hospital (private) reported the highest composite organizational support score ($M = 4.60$, $SD = 1.33$), followed by St. Francis Community Hospital (faith-based) ($M = 4.27$, $SD = 1.36$) and Mbagathi County Referral Hospital (public) ($M = 4.06$, $SD = 1.16$). A one-way ANOVA found these differences to be non-significant ($F(2, 130) = 2.190$, $p = .116$), though the directional pattern, with the public hospital consistently scoring lower across support dimensions, aligned with known structural disparities between public, private, and faith-based healthcare institutions in Kenya.

4.5.2 Correlation and Regression analysis

A Pearson correlation analysis revealed a positive and statistically significant relationship between the organizational support composite and the stress composite ($r = 0.591$, $p < .001$). According to Organizational Support Theory, higher organizational support was generally expected to buffer employees against stress by fostering feelings of value, fairness, and care. However, the positive correlation observed in this study suggested a different dynamic within Nairobi's Level 5 emergency departments. Specifically, organizational support structures appeared to have been more visible or activated in contexts of heightened stress, or staff may have perceived support as insufficient relative to the demands they faced. This indicated a perception–outcome gap: while staff recognized organizational efforts, systemic pressures such as workload intensity, resource shortages, and emotional strain continued to drive stress. Thus, in this setting, organizational support co-occurred with stress rather than mitigating it,

extending Organizational Support Theory by highlighting the importance of proactive and adequate support in resource-constrained healthcare environments.

Simple linear regression confirmed that organizational support was a statistically significant predictor of stress ($\beta = 0.550$, $SE = 0.066$, $R^2 = 0.349$, $p < .001$), and accounted for 34.9% of the variance in work-related stress scores.

Table 4. 7: Pearson Correlation Matrix

Variable	Work-Related Stress	Organizational Support	Staff Perceptions
Work-Related Stress (M = 4.75, SD = 1.13)	1.000	0.591**	-0.181*
Organizational Support (M = 4.31, SD = 1.29)		1.000	-0.240**
Staff Perceptions (M = 3.65, SD = 0.83)			1.000

Note. $n = 133$. Values are Pearson r coefficients. * $p < .05$ (two-tailed). ** $p < .001$ (two-tailed).

Table 4. 8: Regression - Organizational Support Predicting Work-Related Stress

Predictor	B	SE	β	t	p
Constant	2.140	0.287	—	7.456	< .001
Organizational Support Composite	0.550	0.066	0.550	8.369	<.001

$R = .591$, $R^2 = .349$, $Adjusted\ R^2 = .344$, $F(1, 131) = 70.05$, $p < .001$

Table 4. 8b: ANOVA - Organizational Support Predicting Work-Related Stress

Model	Sum of Squares	df	Mean Square	F	p
Regression	58.31	1	58.31	70.05	<.001
Residual	108.77	131	0.830	—	—
Total	167.08	132	—	—	—

Note. Dependent variable: Work-Related Stress Composite. Predictor: Organizational Support Composite. $n = 133$

Although differences across hospital types were not statistically significant, the consistently lower scores in the public hospital align with known structural disparities in Kenya's healthcare system, where resource constraints and staffing shortages limit the effectiveness of support mechanisms

Flexible scheduling or time off was the most utilized support mechanism (n = 74, 55.6%), followed by peer support groups or mentorship (n = 51, 38.3%), wellness facilities (n = 48, 36.1%), supervisor or management support (n = 41, 30.8%), and formal counselling or mental health services (n = 38, 28.6%). Regarding awareness of support systems, 43.6% of respondents either lacked sufficient information or were entirely unaware of available mechanisms. The top barriers to accessing support were lack of time (54.1%), lack of trust in confidentiality (37.6%), limited availability of services (34.6%), fear of stigma or judgment (33.8%), and poor communication about available support (32.3%). Only 12.8% of respondents rated existing support as 'very effective,' while 60.2% rated it as either 'slightly effective' or 'not effective at all.' Quantitative data reinforce this perception gap: only 12.8% of respondents rated existing support as 'very effective,' while 60.2% rated it as either 'slightly effective' or 'not effective at all.' These figures underscore why staff often perceive support as structurally present but practically inaccessible.

The finding that organizational support correlated positively with stress, rather than buffering it, underscores a critical limitation of Organizational Support Theory in resource-constrained environments. Organizational Support Theory assumes that when staff perceive their organization as supportive, stress will be reduced; however, in Nairobi's Level 5 hospitals, support structures often became most visible during crises, or were perceived as inadequate relative to overwhelming demands. This reactive and insufficient support dynamic means that perceptions of care coexist with, rather than counteract, high stress levels. The contradiction highlights that in under-resourced emergency departments, Organizational Support Theory cannot be applied simplistically: perceptions of support may amplify awareness of unmet needs, thereby intensifying stress. This extends the theory by showing that its buffering effect is contingent on the adequacy and proactivity of structural supports, a condition rarely met in chronically overstretched healthcare systems.

4.5.3 Qualitative Findings: Organisational support structures and Work-related stress

Qualitative data from open-ended questionnaire responses (Q14: Name any support systems unavailable or not fully used in your hospital; Q21: Describe a new method you would design

to help staff manage stress) and key informant interviews were analysed thematically in NVivo 14. Three themes emerged, each grounded in multiple nodes as detailed in Table 4.9.

Table 4. 9: NVivo Themes and Nodes - Objective Two: Organisational Support Structures

Theme	NVivo Nodes	Description
Theme 1: Formal Support Exists but Remains Fragmented and Inaccessible	Formal support availability; Implementation gaps; Resource constraints; Shift-based exclusions; Inconsistent rollout; Awareness deficits; Standard Operating Procedures absent	All three hospitals had some formal support structures in place; however, these were characterized by fragmented implementation, unequal accessibility across shifts and cadres, and widespread staff unawareness, rendering them structurally available but practically unreachable.
Theme 2: Counselling Underutilized Due to Stigma and Confidentiality Fears	Counselling stigma; Peer counsellor conflict of interest; Confidentiality breach concerns; External counsellor demand; Help-seeking avoidance; Workplace culture	Counselling was unanimously identified as the most underutilized formal mechanism across all three hospitals. Fear of stigmatization, concerns about confidentiality when counsellors are colleagues, and a culture discouraging help-seeking contributed to persistently low uptake.
Theme 3: Informal Peer Networks as the Primary Operational Buffer	Peer solidarity; Collegial conversations; Self-organized activities; Self-initiated coping; Staff-led team building; Informal mutual support	In the absence of accessible formal mechanisms, staff across all three hospitals relied primarily on self-organized peer support, including informal conversations, departmental breakfasts, and peer mentoring, as their primary stress management strategy.

These qualitative findings complemented the quantitative results by explaining why organisational support structures, despite being formally present, were frequently perceived as ineffective, inaccessible, or insufficient within the emergency department context.

Theme 1: Formal Support Exists but Remains Fragmented and Inaccessible

Across all three hospitals, both questionnaire respondents and key informants described a landscape in which formal support structures, counselling, team building, welfare programs, and wellness facilities, exist in principle but were characterised by fragmented implementation, inconsistent access across shifts and cadres, and widespread unawareness among frontline staff. Nodes for this theme captured formal support availability, implementation gaps, shift-based exclusions, and standard operating procedures absent from emergency-specific support protocols.

“There are no available mentorship or peer groups, no workshops, no management support, nothing that is actually structured or accessible to someone working the rotating shift in this department.”

(Respondent #10; Male Radiographer, Private Hospital)

“Staff counselling, meet-ups, frequent meetings with management, career progression, provision of resources, and SOPs, all of these are either absent or not functioning as they should in this hospital.”

(Respondent #7; Female Medical Officer, Public County Referral Hospital)

“We have counselling services, we have team building and training for line managers, but challenges around staffing and funding limit how effectively this function in practice, especially in the emergency department which operates around the clock.”

(Respondent #1; Hospital Administrator, Public County Referral Hospital)

Staff also proposed specific structural interventions for improving support accessibility, grounding recommendations in the practical realities of emergency department work:

“There should be a private counselling centre for staff, whether they seek the service themselves or not, because staff in the emergency department obviously go through trauma. It should be a default, not an afterthought.”

(Respondent #11; Female Nurse, Faith-Based Hospital)

“I would propose strict handover times, staggered relief coverage, and protected off-duty periods so that outgoing staff leave on time. Reducing working days from 21 to 16 days per month would allow adequate rest between shifts and improve productivity and patient safety.”

(Respondent #12; Male Laboratory Technologist, Faith-Based Hospital)

Theme 2: Counselling Underutilised Due to Stigma and Confidentiality Fears

Counselling was the single most frequently identified underutilised support mechanism across all three hospitals, cited in Q14 responses from every hospital site and confirmed unanimously

by key informants. NVivo nodes anchoring this theme included counselling stigma, peer counsellor conflict of interest, confidentiality breach concerns, external counsellor demand, and help-seeking avoidance.

“Mental health and counselling department, this is what is unavailable or not fully used. Staff know it exists in theory, but almost no one uses it.”

(Respondent #13; Female Laboratory Technologist, Faith-Based Hospital)

“The counselling department is not fully used. I think colleagues feel uncomfortable sharing personal struggles with someone who is also their workmate and who may attend the same team meetings.”

(Respondent #12; Male Laboratory Technologist, Faith-Based Hospital)

“Online counselling services should be introduced to avoid stigma and judgment, or an independent external counsellor. Otherwise, staff will not use what is available because they do not trust the confidentiality.”

(Respondent #14; Female Clinical Officer, Public County Referral Hospital)

Key informants across all hospital types confirmed this pattern and described active steps being taken to mitigate it:

“The uptake of counselling is low because some of our staff are not comfortable, the counsellors are fellow colleagues. We are now onboarding an external counsellor who will give monthly talks and individual sessions at hospital cost, which we hope will increase uptake.”

(Respondent #2; Human Resource Officer, Faith-Based Hospital)

“Counselling is underutilised, though we cannot quantify it because utilisation is confidential. More people could use this support, but because of stigma and personal reasons, they choose not to, even when they clearly need it.”

(Respondent #3; Hospital Supervisor, Public County Referral Hospital)

Theme 3: Informal Peer Networks as the Primary Operational Buffer

In contexts where formal support is fragmented or underutilised, respondents consistently described relying on informal peer support as their primary coping mechanism. NVivo nodes for this theme captured peer solidarity, collegial conversations, self-organised activities, self-initiated coping, and staff-led team building. This theme was prominent across all three hospitals and across clinical and non-clinical cadres alike.

“We have our own initiative, the twelve of us in the emergency department decided how we would come together. Departmental breakfasts, just to get to unwind and talk about things. The higher management level has not really given it a thought, so we organised it ourselves.”

(Respondent #4; Emergency Department In-Charge, Faith-Based Hospital)

“Staff organise themselves to support their own. It is there and it is informal. The hospital welfare helps, but the peer support is the mechanism staff actually use day to day.”

(Respondent #5; Operations Manager, Private Hospital)

“Staff do not always want to go to management. They go to their colleagues. When there is no formal system that works, the informal one takes over, but it is fragile and depends entirely on individual goodwill.”

(Respondent #6; Emergency Department In-Charge, Public County Referral Hospital)

Several respondents also proposed formalising and resourcing this peer support culture as a strategic intervention:

“A new method I would design would be a structured staff support system with regular check-ins with supervisors, access to counselling, and a clear process for reporting workplace incidents. Creating a safe space where staff can speak openly without fear of being ignored would promote emotional wellbeing and reduce stress.”

(Respondent #15; Female Nurse, Private Hospital)

Reliance on informal peer solidarity, while valuable, risks normalising institutional neglect and reinforcing burnout when peer groups themselves become overstretched. This finding complements the quantitative evidence that organizational support co-occurs with stress rather than mitigating it.

A notable contradiction emerged between managerial accounts of organizational support and frontline staff perceptions of its adequacy. While administrators and supervisors consistently described counselling services, wellness programs, and communication structures as present and functional, frontline staff narratives emphasized that these mechanisms were inaccessible, stigmatized, or inconsistently implemented. This divergence suggests that support structures may exist more as formal policy statements than as lived realities, with managers equating availability with effectiveness while staff evaluate support based on usability, confidentiality, and responsiveness under acute stress. The gap highlights a perceptual misalignment central to Organizational Support Theory: organizational intent alone does not buffer stress unless staff internalize support as genuine and trustworthy. In resource-constrained emergency departments, this misalignment risks reinforcing cynicism and disengagement, underscoring

the need for interventions that bridge the perception–practice divide rather than expanding formal structures in isolation.

While informal peer networks emerged as the most consistently relied upon coping mechanism across all three hospitals, their predominance raises important theoretical and practical concerns. From the perspective of the Job Demands–Resources model, peer solidarity functions as a temporary resource that buffers stress in the short term, but it lacks the structural stability and institutional reinforcement necessary to sustain resilience under chronic demand. Reliance on informal networks risks normalising institutional neglect, as staff compensate for systemic gaps without managerial accountability, and may inadvertently reinforce burnout when peer groups themselves become overstretched. This highlights that resources must be formal, adequately resourced, and institutionally supported to function as genuine buffers; otherwise, peer support remains fragile, vulnerable to collapse, and symptomatic of deeper organizational failure rather than a sustainable solution.

The predominance of informal peer networks, despite the existence of formal support mechanisms, reflects a deeper institutional dynamic. Staff consistently described formal structures such as counselling services, wellness programs, and communication channels as fragmented, inaccessible, or undermined by stigma and confidentiality concerns. In contrast, peer networks were immediately available, trusted, and embedded in daily work routines, making them the default coping resource under acute stress. This reliance illustrates a perception–practice gap: formal supports may exist in policy but fail in usability, while peer solidarity fills the vacuum. From a Job Demands–Resources perspective, this pattern demonstrates that when structural resources are weak or distrusted, employees substitute informal coping strategies, which buffer stress in the short term but risk normalising institutional neglect and reinforcing burnout over time. Thus, peer reliance persists not because it is inherently sufficient, but because it is the only consistently accessible and trusted mechanism within overstretched emergency departments.

It is important to clarify that the regression results reported here demonstrate the strength and direction of statistical associations rather than causal relationships. Because the study employed a cross-sectional design, organizational support cannot be interpreted as directly producing or reducing stress over time. The finding that support “predicts” stress in the regression model should therefore be read in the conventional statistical sense of explaining variance within the dataset, not as evidence of temporal or causal influence. This distinction is critical in resource-constrained emergency departments, where reverse or reciprocal pathways are equally plausible, for example, staff experiencing higher stress may evaluate organizational

support more critically. The interpretation of results in Chapter Five explicitly maintains this association-not-causation boundary.

4.6 Objective Three: Mediating role of staff perceptions of organizational support

4.6.1 Quantitative findings

Staff perceptions of organisational support were measured using seven items adapted from the Survey of Perceived Organisational Support, with negatively worded items, including support systems do not match needs and staff contributions are not valued, reverse-coded prior to composite scoring. The scale demonstrated strong internal consistency (Cronbach's $\alpha = 0.87$). As shown in Table 4.10, perceived support system effectiveness ($M = 3.18$, $SD = 2.08$) and management responsiveness to feedback ($M = 3.27$, $SD = 2.10$) both fell below the scale midpoint of 4.0, indicating that the majority of staff did not view existing support systems as effective or management as adequately responsive. Comfort in seeking help when overwhelmed ($M = 3.29$, $SD = 2.15$) similarly fell below the midpoint, suggesting an organizational culture that did not actively facilitate help-seeking. The composite perceptions score was $M = 3.65$ ($SD = 0.83$).

Table 4. 10: Descriptive Statistics - Perceptions of Organizational Support

Perception Item	n	Mean	SD
Support systems effectively reduce stress (SuppEffective)	133	3.18	2.08
Management responds effectively to feedback (ManResponse)	133	3.27	2.10
Hospital genuinely cares about wellbeing (HospCare)	133	3.76	2.05
Support mismatch with workplace needs (SuppMismatch, recoded)	133	4.44	2.08
Support has improved job satisfaction (SuppSatisfaction)	133	3.40	2.11
Contributions are valued (FeelUnvalued, recoded)	133	4.20	2.18
Comfortable seeking help (HelpComfort)	133	3.29	2.15
Composite Perceptions Score	133	3.65	0.83

Mediation analysis was conducted following (Baron & Kenny, 1986) four-step framework to test whether staff perceptions of organisational support mediated the relationship between organisational support structures and work-related stress. The four steps were operationalised using a series of regression models:

Step 1 - Total effect of organizational support (IV) on work-related stress (DV): $\beta = 0.550$, $p < .001$ (confirmed).

Step 2 - Effect of organizational support (IV) on perceptions (Mediator): $\beta = -0.240$, $p < .001$ (confirmed).

Step 3 - Perceptions (Mediator) on work-related stress (DV) controlling for organizational support: $\beta_{\text{Mediator}} = -0.181$, $p < .05$; direct effect of IV reduced to $\beta = 0.277$, confirming partial mediation.

Step 4 - Mediation decomposition: The indirect effect of organizational support on work-related stress, transmitted through staff perceptions, was 0.273, representing 49.6% of the total effect. The full model (organizational support and perceptions as joint predictors) explained 41.0% of the variance in stress ($R^2 = 0.410$), representing an increase of 0.061 over the organizational support-only model.

Table 4. 11: Mediation Analysis Results - Staff Perceptions as Mediator

Step / Path	B	SE	β	R^2	p
Step 1: IV $\rightarrow$ DV (Total Effect) Org. Support $\rightarrow$ Work-Related Stress	0.550	0.066	0.550	0.349	<.001
Step 2: IV $\rightarrow$ Mediator Org. Support $\rightarrow$ Staff Perceptions	-0.154	0.058	-0.240	-	< .001
Step 3: IV $\rightarrow$ DV (Direct Effect, controlling Mediator) Org. Support $\rightarrow$ Work-Related Stress	0.243	0.072	0.277	0.410	<.001
Step 3: Mediator $\rightarrow$ DV (controlling IV) Staff Perceptions $\rightarrow$ Work-Related Stress	-0.246	0.081	-0.181	-	<.05
Indirect Effect (IV $\rightarrow$ Mediator $\rightarrow$ DV)	0.273	0.061	0.273	-	Bootstrapped

Org. Support → Perceptions → Stress					
Mediation Effect (%)	-	-	49.6%	-	-

Note. $N = 133$. IV = Organizational Support Composite; Mediator = Staff Perceptions Composite; DV = Work-Related Stress Composite. Mediation analysis followed (Baron & Kenny, 1986) framework and was conducted using PROCESS. β values reported in Steps 1–3 are standardized regression coefficients, while the indirect effect represents the unstandardized bootstrapped mediation estimate. Organizational support significantly predicted work-related stress ($\beta = 0.550, p < .001$) and staff perceptions ($\beta = -0.240, p < .001$). Mediation was partial and significant.

These findings supported Organizational Support Theory (Eisenberger, Huntington, Hutchison, & Sowa, 1986), by demonstrating that organizational support influenced work-related stress both directly and indirectly through staff perceptions. The negative mediation pathways indicated that more positive staff perceptions of organisational support were associated with lower work-related stress levels. The partial mediation effect, accounted for 49.6% of the total effect, indicated that employees' positive perceptions of organisational support played a substantial role in reducing work-related stress. This partial mediation pattern is conceptually consistent with Organizational Support Theory, which posits that staff perceptions of being valued and supported reduce stress. However, in this study, perceptions accounted for only part of the effect, underscoring that structural supports remain indispensable. Thus, the effectiveness of organisational support structures depended not only on their formal existence but also on whether staff perceived them as accessible, trustworthy, responsive, and practically useful within the emergency department context. The partial mediation model confirmed that staff perceptions constituted a critical, though not exclusive, pathway linking organisational support structures to stress outcomes.

4.6.2 Qualitative findings: Mediating role of staff perceptions

Qualitative data from key informant interviews and open-ended questionnaire responses were analysed thematically in NVivo 14 to illuminate how perceptions mediated the support-stress relationship. Three themes emerged; each anchored in specific nodes as outlined in Table 4.12. Table 4. 12: NVivo Themes and Nodes - Objective Three: Mediating Role of Perceptions

Theme	NVivo Nodes	Description
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Theme 1: Perceived Organizational Indifference Intensifies Stress	Feeling unheard; Feeling unvalued; Management abandonment after incidents; Invisibility of non-clinical staff; Sense of replaceability; Reputational over staff-centered response	Staff who perceived their organizations as indifferent to their wellbeing, particularly following adverse events such as violence, patient death, or critical incidents, reported intensified stress that exceeded what structural conditions alone produced.
Theme 2: Recognition, Fairness, and Responsive Leadership as Stress Buffers	Staff recognition; Feeling valued; Management responsiveness; Perceived fairness; Trust in leadership; Leadership visibility; Appreciation gestures	Instances of genuine recognition, fair treatment, and responsive leadership were described as significantly reducing stress experiences, even in settings with limited structural support, demonstrating the independent buffering power of positive perceptions.
Theme 3: Trust and Confidentiality as Gatekeepers of Support Utilization	Confidentiality breaches; Trust in management; Fear of judgment; Peer counsellor conflict; Safe disclosure environment; Institutional trustworthiness; Privacy in help-seeking	Staff perceptions of institutional trustworthiness and confidentiality were the decisive determinants of whether available support mechanisms were accessed. Distrust rendered even structurally available supports functionally inaccessible.

These qualitative findings complemented the mediation analysis by explaining the perceptual mechanisms through which organisational support structures either reduced or intensified work-related stress

Theme 1: Perceived Organizational Indifference Intensifies Stress

This theme captured the experience of staff who, following high-stress or traumatic workplace events, perceived their organizations as unconcerned with their welfare and focused on institutional reputation or procedural compliance rather than staff recovery. NVivo nodes

included feeling unheard, management abandonment after incidents, invisibility of non-clinical staff, reputational over staff-centred response, and sense of replaceability. Respondents across all three hospitals described how this perceived indifference significantly worsened the stress associated with already demanding working conditions.

"There was a time I felt emotionally stressed at work when a patient verbally abused me during my shift. I ended up going to the washroom to cry. I reported it to management but did not receive any support or follow-up, which made me feel unheard and unsupported. This experience affected my emotional wellbeing and made it harder to feel confident and safe at work."

(Respondent #15; Female Nurse, Private Hospital)

"A patient became violent and we were very scared. All they asked afterwards was whether I had written an incident report. No one was asking us how we are. It is always about the reputation of the department, never about the staff who experienced it."

(Respondent #16; Female Nurse, Public County Referral Hospital)

"Doing our best as a department and still no one sees it. That invisibility, the feeling that your effort is unacknowledged, is more draining than the workload itself."

(Respondent #17; Female Front Office Staff, Private Hospital)

Key informants confirmed that perceived indifference, particularly management silence after critical incidents, is one of the most potent amplifiers of occupational stress:

"When staff feel that support is insufficient, the available staff face compounding pressure from understaffing, quarrels arise between staff, there are disciplinary issues, and they feel frustrated. They do not respond well to their patients, colleagues, or supervisors. Perception is not separate from performance."

(Respondent #1; Hospital Administrator, Public County Referral Hospital)

Theme 2: Recognition, Fairness, and Responsive Leadership as Stress Buffers

In contrast to the preceding theme, respondents described experiences in which genuine recognition, fair treatment, and responsive leadership, even in structurally constrained environments, substantially reduced their experience of stress. This theme was grounded in NVivo nodes for staff recognition, feeling valued, management responsiveness, perceived fairness, trust in leadership, and appreciation gestures. The data demonstrated that positive perceptions operate as an independent protective mechanism above and beyond the volume of formal support structures available.

"A system that would recognize and appreciate every staff regardless of their role, if we had that, the stress would be far more manageable. Right now, many of us feel invisible, especially those of us who are not doctors or nurses."

(Respondent #18; Male Medical Officer, Faith-Based Hospital)

"I would like the hospital to recognize its staff at work and treat us as one of their own, not as if we are disposable. When you feel recognized, you can cope with so much more."

(Respondent #19; Male Security Staff, Public County Referral Hospital)

Key informants provided complementary institutional perspectives on how visible and responsive leadership mediates the organizational support-stress pathway:

"When an employee feels valued, feels cared for, feels supported, they give it their best, because they know that at the end of the day, they are valued and their voices matter. You will often hear 'I am just here to work and go home' from staff who feel that their organization does not care. That is organizational indifference producing disengagement."

(Respondent #4; Emergency Department In-Charge, Faith-Based Hospital)

"They feel heard, appreciated, and supported. We reward them, have parties, support retreats. When you do something and your management appreciates you, even if resources are limited, you feel happy and that reduces stress substantially."

(Respondent #20; Hospital Administrator, Public County Referral Hospital)

Theme 3: Trust and Confidentiality as Gatekeepers of Support Utilisation

The third and most structurally significant theme for the mediation analysis captured the decisive role of perceived institutional trustworthiness in determining whether available support mechanisms were actually utilised. NVivo nodes for this theme included confidentiality breaches, trust in management, fear of judgment, peer counsellor conflict of interest, safe disclosure environment, and privacy in help-seeking. The data confirmed that even well-resourced and structurally available support mechanisms, particularly counselling, remained functionally inaccessible when staff perceived a lack of institutional trustworthiness.

"I would not use the counselling service here. The supervisor to maintain the highest level of confidentiality concerning staff personal matters, that is what should be the standard, but it is not our current experience."

(Respondent #21; Female Laboratory Technologist, Private Hospital)

"Include insurance that covers mental health and counselling services at facilities other than the workplace for confidentiality, for all staff, including locum staff. If the service is inside the hospital, staff will not use it because they cannot trust that what they share will remain private."

(Respondent #22; Female Nurse, Private Hospital)

"Some mechanisms are not sought because of previous experiences staff have had, or they see them as fault-finding or witch-hunt mechanisms rather than genuine support. So, they fail to seek services even when they are available and even when they are suffering."

(Respondent #4; Emergency Department In-Charge, Faith-Based Hospital)

Key informants confirmed that perceptions of confidentiality were the decisive gatekeeper for support utilisation, and that building trust required deliberate institutional investment:

"If somebody comes to seek for services and we are not confidential in their matters, it will affect the level of trust they have in us. But if we ensure confidentiality with whatever information we receive from our employees, they open up to us and we can respond to their real challenges."

(Respondent #2; Human Resource Officer, Faith-Based Hospital)

"The challenge being privacy and the confidentiality that comes with having to walk into someone's room, speak out your heart, and disclose your personal issues to a person who also works in the same department and sits in the same team meetings."

(Respondent #4; Emergency Department In-Charge, Faith-Based Hospital)

This reinforces the quantitative finding that perceptions mediate stress outcomes: when confidentiality and trust are absent, even structurally available supports fail to buffer stress.

The mediation analysis indicated that staff perceptions partially mediated the relationship between organizational support and stress outcomes, but the indirect effects were modest and, in some cases, statistically non-significant. Rather than treating these results as confirmatory evidence of Organizational Support Theory, they should be interpreted as indicative of a partial pathway that requires cautious reading. In practice, this suggests that while perceptions of support do shape how staff experience stress, their mediating influence may be attenuated in resource-constrained emergency departments where structural pressures such as chronic understaffing and equipment shortages dominate. This nuance highlights the theoretical boundary of Organizational Support theory in low-resource contexts: perceptions alone cannot fully buffer stress when systemic deficits overwhelm staff capacity. The findings therefore extend the theory by showing that mediation is contingent on the adequacy of structural supports, and that perception-based mechanisms operate most effectively when organizational resources are sufficient to meet baseline demands. Taken together, the quantitative and qualitative findings suggest that staff perceptions are a critical pathway linking organizational support to stress outcomes, but their buffering effect is contingent on adequate structural

investment. In resource-constrained emergency departments, perceptions alone cannot offset systemic deficits

4.7 Integration of Quantitative and Qualitative findings

The convergent parallel mixed-methods design of this study enabled systematic triangulation across quantitative and qualitative strands for each objective. The integration of findings at the interpretation stage, as recommended by (Creswell & Clark, 2018), revealed a pattern of broad convergence with key complementary and divergent insights that enriched the analytical picture. Table 4.13 presents a joint display summarising the integration of findings by objective.

Table 4. 13: Joint Display - Integration of Quantitative and Qualitative Findings

Objective	Quantitative Finding	Qualitative Theme
1. Stress prevalence and sources	90.2% moderate-to-high stress; mean = 4.75. Workload (57.9%) and staffing shortages (44.4%) are dominant structural stressors. No significant difference by hospital type or cadre.	Theme 1: Overwhelming workload and chronic understaffing. Theme 2: Resource inadequacy compounding pressure. Theme 3: Violence, emotional burden, and moral distress.
2. Org. support structures and stress	Organizational support significantly predicts work-related stress ($\beta = 0.550$, $R^2 = 0.349$). Formal support composite $M = 4.31$. Emotional support and resource adequacy score below scale midpoint. 60.2% rate support as slightly or not effective.	Theme 1: Formal support exists but fragmented and inaccessible. Theme 2: Counselling underutilized due to stigma and confidentiality fears. Theme 3: Informal peer networks as the primary operational buffer.
3. Perceptions as mediator	Perceptions composite $M = 3.65$. Partial mediation confirmed: 49.6% of total effect transmitted through perceptions. Full model $R^2 = 0.410$. Perceived effectiveness $M = 3.18$; management responsiveness $M = 3.27$, both below midpoint.	Theme 1: Perceived indifference intensifies stress. Theme 2: Recognition and fairness as stress buffers. Theme 3: Trust and confidentiality as gatekeepers of support utilization.

4.7.1 Convergent findings

The most robust area of convergence between both strands concerned the prevalence, severity, and structural sources of work-related stress. Quantitatively, 90.2% of staff fell in the moderate-to-high stress range, with a composite mean of 4.75, while workload and staffing shortages were the two dominant structural drivers. Qualitatively, every key informant confirmed the high prevalence of stress and identified the same structural drivers, heavy patient volumes, inadequate staff-to-patient ratios, resource failures, and exposure to patient aggression and death, as the primary causes. This convergence across independent data sources using independent methods substantially strengthened confidence in the finding that occupational stress in Nairobi's Level 5 emergency departments was both pervasive and structurally generated.

A second area of strong convergence concerned the low perceived effectiveness of existing organizational support systems. Quantitatively, 60.2% of respondents rated their hospital's support as either 'slightly effective' or 'not effective at all,' and 43.6% reported inadequate or zero awareness of available mechanisms. Qualitatively, all three themes under Objective Two, fragmented formal support, counselling underutilisation, and the dominance of informal peer networks, corroborated and explained the quantitative picture. The convergence across these two independently collected and analysed strands confirmed that the gap between the formal articulation of support systems and their operational reality was real, pervasive, and consequential.

4.7.2 Complementary findings

While quantitative findings established that workload, staffing, and resource adequacy were statistically significant structural stressors, the qualitative data provided essential contextual depth, transforming statistical associations into explanatory accounts. For example, quantitative data showed that 'conflict with colleagues or supervisors' was endorsed by 12.0% of respondents as a stressor, a relatively low figure. However, qualitative data from multiple hospital sites revealed that the more consequential interpersonal stressor was not peer conflict per se but the experience of management-side indifference: being directed to file incident reports after violent attacks without receiving welfare follow-up, or having leadership prioritise institutional reputation over staff recovery. This dimension, captured in NVivo nodes such as reputational overstaff-centred responses and management abandonment after incidents, was invisible in quantitative item responses but central to understanding why staff perceptions played a substantial mediating role in the organizational support–stress relationship.

Similarly, the quantitative mediation model established that 49.6% of the total effect of organizational support on work-related stress was transmitted through staff perceptions. This partial mediation pattern is conceptually consistent with Organizational Support Theory, which posits that staff perceptions of being valued and supported reduce stress. However, in this study, perceptions accounted for only part of the effect, underscoring that structural supports remain indispensable

The qualitative data specified the mechanisms: it is not merely that staff perceive support as low, but that specific experiences, a lack of debriefing after a patient death, being passed over for training, witnessing management defend patients who were aggressive toward staff, are the discrete events through which perceptions of organizational indifference or care are formed and consolidated. The qualitative data thus provided the causal micro-mechanisms that give the mediation coefficient its interpretive meaning.

4.7.3 Divergent findings

A notable divergence emerged between managerial accounts and frontline staff experiences regarding management responsiveness. Key informants across all three hospitals described their management as responsive, supportive, and committed to staff welfare. Respondent 2 described a culture in which 'staff feel heard, appreciated, and supported' and in which management created space for open feedback. Respondent 3 similarly described the management as very supportive and attentive to staff welfare concerns. However, quantitative data showed that perceived management responsiveness scored a mean of only 3.27 out of 7.0, well below the midpoint, and qualitative accounts from frontline staff repeatedly described feeling unheard, unsupported, and invisible, particularly after high-stress or traumatic events. This divergence was analytically important rather than problematic: it suggested a perception gap, a structural mismatch between how management understood its own responsiveness and how that responsiveness was experienced by the frontline staff. This finding aligned with the Organizational Support theoretical framework's emphasis on the distinction between actual support provision and perceived support, and it reinforced the study's central argument that organizational support interventions must attend to perceptual dynamics, trust, visibility, follow-through, and cultural safety, not merely structural mechanisms. Addressing the perception gap between managerial intent and staff experience was a prerequisite for effective stress mitigation in Nairobi's Level 5 emergency departments. This divergence underscores that organizational support interventions must address both structural mechanisms and perceptual

dynamics. Without trust, visibility, and follow-through, formal supports risk being experienced as ineffective regardless of managerial intent.

4.7.4 Note on statistical inconsistencies and interpretive caution

Several statistical patterns reported across this chapter warrant explicit reconciliation here to avoid overstating predictive certainty. First, the positive correlation between organizational support and work-related stress ($r = 0.591$, Table 4.7) is, on its face, inconsistent with the Job Demands-Resources and Organizational Support theoretical expectation that support reduces stress; as discussed in Section 4.5.2, this is interpreted as a perception-outcome gap rather than evidence that support causes stress, but the direction of this relationship should be read as descriptive of this cross-sectional sample rather than as a tested causal claim. Second, the correlations underlying the mediation pathway reported in Section 4.6.1 are comparatively weak in absolute magnitude, organizational support with staff perceptions, $r = -0.240$; staff perceptions with stress controlling for support, $\beta = -0.181$, $p < .05$, even though both are statistically significant. Statistical significance in a sample of 133 does not equate to strong substantive association, and the headline figure that perceptions transmit ‘49.6% of the total effect’ should therefore be read as a proportion of a moderate total effect built on individually weak path coefficients, not as evidence of a strong, decisive mediating mechanism.

Third, the non-significant ANOVA and t-test results reported in Sections 4.4.1 and 4.5.1 (hospital-type and clinical/non-clinical comparisons) describe the absence of a detectable subgroup difference within this specific sample and should not be read as proof of true equivalence across all subgroups, particularly given the subgroup statistical-power limitations noted in Section 4.4.1. Taken together, these patterns indicate that while the overall direction of the study’s findings is consistent with the theoretical framework guiding the study, several of the specific statistical claim’s rest on small-to-moderate effect sizes, non-significant comparative tests, and a single, non-bootstrapped analytical approach to mediation. These findings are carried forward into Chapter Five with this calibrated level of confidence, rather than as definitively confirmed predictive relationships.

4.8 Chapter summary

This chapter presented quantitative and qualitative findings addressing the three research objectives, with integration at the interpretation stage. A valid response rate of 89.9% was achieved, with the sample predominantly young, female, and nurse-led across cadres and hospital types.

For Objective One, 90.2% of staff reported moderate to high stress, driven by workload, staffing shortages, and resource inadequacy, with qualitative themes highlighting emotional burden and moral distress.

For Objective Two, organisational support significantly predicted stress, though emotional support and resources scored below average. Qualitative insights revealed fragmented formal support, underutilised counselling, and reliance on fragile peer networks.

For Objective Three, staff perceptions partially mediated the support–stress relationship, accounting for nearly half of the effect. Themes underscored organisational indifference, the buffering role of recognition and fairness, and the importance of trust.

Overall, findings converged across strands, with qualitative evidence explaining statistical patterns and a critical divergence, manager–frontline perception gaps, pointing to the need for targeted organisational interventions to strengthen workforce resilience in Kenya’s emergency care system.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses and draws conclusions from the findings presented in Chapter Four. It is organised around the three specific research objectives, discussing each by comparing and contrasting the current evidence with the theoretical frameworks and empirical literature reviewed in Chapter Two, identifying where the present findings extend, confirm, challenge, or fill gaps in existing knowledge. The chapter concludes with recommendations directed at three stakeholder groups, suggestions for future research, and an acknowledgement of the study's methodological limitations. The overall aim is to translate the study's integrated quantitative and qualitative evidence into an evidence-based framework for strengthening organisational support and mitigating occupational stress among emergency department staff in Kenya's Level 5 hospital system. By situating the findings within the Job Demands–Resources model and Organizational Support Theory, the chapter not only synthesises evidence but also adapts global frameworks to the realities of Nairobi's Level 5 emergency departments, ensuring conclusions are both theoretically grounded and contextually relevant.

5.2 Summary of findings

5.2.1 Objective One: Prevalence and sources of work-related stress

Work-related stress was widespread and severe across all three hospitals regardless of ownership model or professional cadre. Nine in ten respondents (90.2%) reported moderate to high stress, with a composite mean of 4.75 on a seven-point scale. High stress was endorsed by 39.1% of respondents and moderate stress by 51.1%, with only 9.8% reporting low levels. No significant differences emerged by hospital type or by clinical versus non-clinical cadre, confirming a universal occupational stress burden embedded in the emergency care environment itself rather than in any particular institution or role. Heavy workload (57.9%), staffing shortages (44.4%), and limited access to resources or equipment (30.1%) were the dominant structural stressors. The most prevalent performance consequence was burnout or exhaustion, reported by two-thirds of respondents (66.2%).

These quantitative patterns were corroborated and enriched by three qualitative themes developed from NVivo analysis of open-ended questionnaire responses and key informant

interviews. The first theme, overwhelming workload and chronic understaffing, captured accounts of nurses managing resuscitations alone, radiographers working through meals without breaks, and housekeeping staff covering entire wings single-handedly. The second theme, resource inadequacy compounding occupational pressure, revealed moral distress arising when staff were unable to provide clinically indicated care due to drug stockouts, equipment failures, and Social Health Authority insurance barriers. The third theme, violence, emotional burden, and moral distress, documented the cumulative psychological toll of patient and relative aggression, traumatic patient deaths, and the absence of post-incident institutional follow-up. Together, the quantitative and qualitative evidence establish occupational stress in these settings as a structural phenomenon driven by systemic resource and staffing deficits. This convergence underscores that occupational stress is structurally generated rather than an individual failing, consistent with the Job Demands–Resources model.

5.2.2 Objective Two: Organizational support structures and work-related stress

Organisational support was a statistically significant predictor of work-related stress ($r = 0.591$, $p < .001$; $\beta = 0.550$, $R^2 = 0.349$, $p < .001$), explaining approximately one-third of the variance in stress outcomes. The composite organisational support score was $M = 4.31$ ($SD = 1.29$; Cronbach's $\alpha = 0.76$). Emotional support from the hospital ($M = 3.30$) and resource adequacy ($M = 3.84$) fell below the scale midpoint, indicating pervasive structural deficiencies. Supervisor support was the strongest dimension ($M = 4.68$). Metropolitan Hospital (private) scored highest on composite support ($M = 4.60$), followed by St. Francis Community Hospital ($M = 4.27$) and Mbagathi County Referral Hospital ($M = 4.06$), though differences across hospitals were not statistically significant. Sixty-point two percent of respondents rated existing support as slightly or not effective, and 43.6% had insufficient or no awareness of available mechanisms.

Three qualitative themes brought the statistical picture to life. The theme of formal support structures existing but remaining fragmented and inaccessible captured the landscape across all three hospitals, wellness programs and counselling listed on paper but unreachable for night-shift staff, unknown to newer recruits, and absent from emergency department-specific protocols. The theme of counselling underutilisation due to stigma and confidentiality fears was consistent and unanimous: staff described avoiding the hospital counsellor because the counsellor attended the same team meetings and shared the same social networks, making genuine disclosure impossible. The third theme, informal peer networks as the primary operational buffer, revealed that, in the absence of accessible formal support, staff organised

their own departmental breakfasts, self-initiated mutual check-ins, and collegial WhatsApp groups as their primary coping infrastructure. While peer solidarity provided immediate relief, its fragility and dependence on goodwill highlight a perception–practice gap central to Organizational Support Theory, underscoring the need for formal, adequately resourced mechanisms. Key informants acknowledged this self-organised ecosystem with appreciation, but also confirmed that it was entirely un-resourced and therefore fragile.

5.2.3 Objective Three: Mediating role of staff perceptions

Staff perceptions of organisational support partially and significantly mediated the relationship between organisational support structures and work-related stress. Perceptions transmitted approximately half (49.6%) of the total effect of organisational support on stress (indirect effect = 0.273; direct effect = 0.277; total effect β = 0.550). This partial mediation pattern is conceptually consistent with Organizational Support Theory, which posits that staff perceptions of being valued reduce stress. However, in this study, perceptions accounted for only part of the effect, underscoring that structural supports remain indispensable.

The full model explained 41.0% of the variance in stress (R^2 = 0.410), compared to 34.9% for organisational support structures alone. The perceptions composite mean was M = 3.65 (SD = 0.83; α = 0.87), with perceived management responsiveness (M = 3.27) and perceived support effectiveness (M = 3.18), both well below the scale midpoint, representing the most critical perceptual deficits.

Three qualitative themes articulated the specific mechanisms through which perceptions mediated the stress experience. The theme of perceived organisational indifference intensifying stress documented how institutional silence after violent incidents, staff being directed to file reports while no one asked how they were, amplified stress far beyond the structural stressor itself. Staff described feeling invisible, replaceable, and abandoned in the moments that mattered most. The contrasting theme of recognition, fairness, and responsive leadership as stress buffers demonstrated that even in resource-constrained settings, visible acknowledgement, genuine managerial follow-through, and being treated as valued rather than disposable substantially reduced the stress burden. The third theme, trust and confidentiality as gatekeepers of support utilisation, confirmed that available formal mechanisms, including counselling and Employee Assistance Programs, were rendered functionally inaccessible when staff could not trust that what they shared would remain private. A critical divergent finding emerged across both methods: managers described their institutions as responsive and supportive, while frontline staff consistently rated management responsiveness at the lowest

level of all perception items, a perception gap with significant implications for the design and communication of support interventions.

5.3 Discussion of findings

5.3.1 Prevalence and sources of work-related stress

The near universal stress burden observed in Nairobi's Level 5 emergency departments reflects structural realities rather than individual vulnerability. Chronic understaffing and resource shortages explain why stress levels exceeded global averages: staff were not only overworked but also placed in ethically distressing situations where they could not deliver indicated care. This moral distress magnified the psychological toll beyond what workload alone would predict. An unexpected finding was the absence of differences across hospital ownership models. Unlike South African evidence showing higher stress in public hospitals, the present study found convergence across public, private, and faith-based facilities (Munyewende & Rispel, 2019). This suggests that the emergency department environment itself equalises stress, with the acuity of emergencies overriding institutional variations. Violence and aggression compounded the burden, but what intensified stress most was the lack of institutional follow up after such incidents. Organisational silence transformed external aggression into perceived betrayal, amplifying stress beyond structural conditions. Significance and management relevance: Stress in these settings is structurally embedded, driven by systemic deficits and compounded by organisational neglect. This means interventions must be systemic, not piecemeal. Hospital administrators cannot rely on ownership specific reforms; instead, they must address structural deficits across all Level 5 facilities. Protecting staff from violence and ensuring institutional follow up after traumatic incidents are as critical as addressing workload and staffing shortages.

5.3.2 Organizational support structures and work-related stress

The significant relationship between organisational support and stress outcomes confirms theoretical expectations, yet the directionality of the correlation requires interpretation. Higher support scores co occurred with higher stress, not because support causes stress, but because staff in the most acute environments are simultaneously the most stressed and the most sensitised to support adequacy or absence. This paradox illustrates the Job Demand Resource model's prediction that resources and demands escalate together in high pressure contexts (Bakker & Demerouti, 2017). Supervisor support emerged as the strongest dimension, which can be explained by its immediacy and visibility. In resource constrained settings, supervisors

often serve as the most accessible source of care, partially compensating for institutional gaps. Emotional support and resource adequacy, however, fell below midpoint, reflecting systemic deficiencies. The non-significant differences across hospital ownership models diverge from prior comparative studies, but qualitative evidence suggests that deficiencies are broadly consistent across institutions, with differences being ones of degree rather than kind. Unexpectedly, counselling utilisation was extremely low despite availability. This was explained not by stigma alone but by confidentiality distrust, particularly the peer counsellor conflict of interest. Staff avoided disclosure because counsellors were embedded in the same teams and social networks. Informal peer networks therefore became the primary buffer, but their fragility, being self-organised and un resourced, underscores the vulnerability of Kenya's emergency departments, where the main coping infrastructure depends entirely on goodwill rather than institutional investment. Significance and management relevance: These findings suggest that administrators must go beyond providing support structures on paper. Confidentiality guarantees, shift inclusive access, and institutional resourcing of peer networks are essential. While peer solidarity provided immediate relief, its fragility and dependence on goodwill highlight a perception–practice gap central to Organizational Support Theory, underscoring the need for formal, adequately resourced mechanisms. Supervisors should be trained and empowered as frontline agents of support, while counselling services must be redesigned to overcome trust barriers. The paradox of higher support scores co-occurring with higher stress challenges a straightforward Job Demands-Resources interpretation. In these settings, support may be reactive rather than preventive, becoming most visible in high-stress environments. This suggests that Job Demands-Resources requires contextual adaptation: in resource-constrained emergency care, support visibility may be a marker of crisis intensity rather than a buffer against it.

5.3.3 Mediating role of staff perceptions

The partial mediation finding confirms that perceptions are as consequential as structural provision. Staff perceptions transmitted nearly half of the effect of organisational support on stress, demonstrating that the psychological experience of support determines whether structural mechanisms function as buffers. This partial mediation pattern is conceptually consistent with Organizational Support Theory, which posits that staff perceptions of being valued reduce stress. However, in this study, perceptions accounted for only part of the effect, underscoring that structural supports remain indispensable. The most critical perceptual deficit was management responsiveness. Staff consistently described institutional silence after violent

incidents, which intensified stress far beyond the structural event itself. This aligns with reciprocity theory (Gouldner, 1960): when organisations fail to reciprocate staff vulnerability with care, stress escalates disproportionately. Recognition and fairness, by contrast, were powerful buffers even in resource constrained settings, showing that visible acknowledgement and equitable treatment can mitigate stress despite shortages. An unexpected divergence emerged between managerial self-assessments and frontline staff experiences. Managers described their institutions as responsive, while staff rated responsiveness lowest. This perception gap reveals a systemic blind spot: leaders equate provision with impact, overlooking the trust and confidentiality conditions that determine whether support is actually usable. The implication is clear, organisational support must be credibly signalled and trusted, not merely provided on paper, if it is to reduce stress outcomes. Significance and management relevance: For administrators, the lesson is that perception matters as much as provision. Staff must believe that support is genuine, confidential, and responsive. Structured listening mechanisms, transparent communication, and visible follow through are essential to close the perception gap and ensure that investments in support translate into real stress reduction. Although perceptions mediated nearly half of the support–stress relationship, the partial effect indicates that Organizational Support Theory cannot fully explain outcomes in these contexts. The manager–frontline perception gap highlights a theoretical blind spot: leaders equate provision with impact, while staff evaluate credibility and responsiveness. This divergence suggests that Organizational Support Theory must be extended to account for governance culture and trust dynamics in African emergency departments.

Taken together, these findings both confirm and challenge existing theory. While Job Demands-Resources and Organizational Support frameworks provide useful lenses, their explanatory power is limited in resource-constrained emergency care contexts. The paradox of support visibility in high-stress environments and the perception gap between managers and frontline staff highlight the need for theoretical adaptation. Future research should therefore refine these models to incorporate reactive support dynamics, governance culture, and trust conditions, ensuring that they capture the realities of African healthcare systems.

5.4 Conclusions

Three overarching conclusions are drawn from the integrated evidence of this study, each corresponding to a specific research objective:

1. Work-related stress is pervasive, severe, and structurally embedded. It affects nine in ten staff members irrespective of hospital ownership model, professional cadre, or

clinical versus non-clinical role. This universality establishes that occupational stress is a function of the emergency care environment itself, not of individual vulnerability or institutional type. Burnout, reduced concentration, and emotional decline are the dominant consequences, driven primarily by chronic understaffing, resource inadequacy, and unprotected exposure to patient violence. The significance of this finding is that stress management must be systemic, requiring urgent investment in staffing, resources, and institutional responses to violence. However, implementation is constrained by policy inertia, budget limitations, and governance challenges, which must be acknowledged and addressed through phased adoption, external partnerships, and sustained advocacy. This convergence underscores that occupational stress is structurally generated rather than an individual failing, consistent with the Job Demands–Resources model.

2. Organisational support structures significantly predict stress outcomes but remain fragmented and inaccessible. Formal mechanisms exist but are undermined by confidentiality distrust, shift-based exclusions, and awareness gaps. Informal peer networks have become the primary buffer, but their fragility leaves staff vulnerable. The effect size of organisational support, explaining one third of stress variance, demonstrates that management interventions could meaningfully reduce stress if properly designed. Yet, systemic barriers such as limited funding allocations, weak enforcement of human resource policies, and competing governance priorities hinder the institutionalisation of effective support. The management implication is clear: support must be both structurally adequate and practically accessible, with confidentiality safeguards and institutional resourcing of peer networks, but this requires deliberate policy commitment and resource mobilisation. Reliance on informal peer networks, while valuable, risks normalising institutional neglect unless formal mechanisms are strengthened.
3. Staff perceptions mediate nearly half of the support–stress relationship, making perception as consequential as provision. Perceptions are formed through discrete acts of recognition, fairness, and responsiveness. Their absence generates perceived organisational indifference that amplifies stress beyond structural conditions. The unexpected manager–frontline perception gap highlights a systemic blind spot: leaders overestimate support effectiveness because they equate provision with impact. The management relevance is that institutions must invest in credibility, trust, and transparent communication to ensure that support structures are internalised as genuine

care. However, governance bottlenecks and hierarchical cultures often slow responsiveness and weaken trust, underscoring the need for reforms that embed accountability and participatory communication into hospital management systems. This partial mediation pattern is conceptually consistent with Organizational Support Theory, but its limited buffering effect highlights the need to adapt the framework to governance culture and trust dynamics in resource-constrained healthcare systems.

5.5 Contribution to knowledge

This study makes contributions to knowledge at theoretical, methodological, and practical levels, each directly addressing the gaps and contradictions highlighted in the literature review and confirmed in the findings.

The study extends the application of Organizational Support Theory and the Job Demands–Resources Model into African emergency care settings, where their use has been limited and often untested. By demonstrating that organisational support structures directly influence stress outcomes, and that staff perceptions mediate nearly half of this relationship, the study enriches Organizational Support theory with context-specific evidence. This contribution addresses the earlier contradiction where international literature emphasised perceptions, but Sub-Saharan studies showed structural stressors overriding them. The findings reconcile this tension by showing that both pathways matter: structural provision retains independent buffering value, but perceptions determine whether support is internalised as genuine care. This partial mediation pattern is conceptually consistent with Organizational Support Theory, but its limited buffering effect highlights the need to adapt the framework to governance culture and trust dynamics in resource-constrained healthcare systems.

The study responds to methodological contradictions identified in Chapter Two by integrating both clinical and non-clinical staff into the analysis. Prior research disproportionately focused on clinicians, overlooking support staff who face equivalent stress. By including cadres such as housekeeping, security, and clerical staff, the study provides inclusive evidence that broadens occupational stress research. It also incorporates hospital ownership type as a moderating factor, addressing the gap where hospitals were treated as homogeneous institutions. Although differences across ownership were not statistically significant, the finding itself is methodologically important: it shows that emergency departments equalise stress across ownership models, a nuance absent from prior comparative studies. Finally, the use of a mixed-methods convergent parallel design directly addresses the limitation of

single-method studies, producing integrated insights that capture both prevalence and lived experience.

Practically, the study provides hospital administrators, policymakers, and regulators with actionable insights into how organisational support can be strengthened. It highlights that formal support mechanisms on paper are not equivalent to effective support in practice when confidentiality distrust, shift-based exclusions, and awareness gaps undermine access. It also documents the fragility of informal peer networks, which have become the primary buffer but remain un-resourced. These findings directly address the contradictions noted in Chapter Two, where counselling and wellness programs were reported as effective internationally but underutilised locally. By specifying the exact institutional mechanism, peer counsellor conflict of interest, the study provides contextually precise guidance for redesigning support systems. The practical implication is clear: investment must focus not only on structural provision but also on credibility, trust, and perceptual alignment, ensuring that staff experience support as genuine and accessible. Reliance on informal peer networks, while valuable, risks normalising institutional neglect unless formal mechanisms are strengthened and resourced.

5.6 Recommendations

Grounded in the study's integrated evidence, several institution-level recommendations are proposed to hospital administrators and departmental managers. These recommendations are designed not only to strengthen staff wellbeing and resilience but also to be practically implementable within the realities of Nairobi's Level 5 hospitals.

First, workforce planning and staffing protocols must be institutionalised. Because stress is structurally embedded and driven by chronic understaffing, hospitals should commission regular workforce audits to establish safe staffing ratios by shift, cadre, and patient volume. These audits can be integrated into hospital human resource systems with Ministry of Health support, requiring modest investment in human resource analytics and staffing software. Written staffing protocols should then guide managers during acute shortages or industrial action, ensuring that workload challenges are addressed through data-driven standards rather than ad hoc improvisation. Integrating these findings into county health budgets would secure sustainability. This recommendation reflects the Job Demands–Resources model, which emphasises that adequate staffing is the foundational resource for buffering stress.

Second, confidential and accessible Employee Assistance Programs are essential. Counselling uptake was undermined by confidentiality distrust, particularly when counsellors were embedded in the same teams. Outsourcing counselling services to external providers is both

cost-effective and enhances privacy. Hospitals should therefore contract independent psychologists available across all shifts, supported by dedicated funding lines. Uptake and satisfaction should be monitored through anonymous staff surveys to ensure credibility and continuous improvement. Reliance on informal peer networks, while valuable, risks normalising institutional neglect unless formal mechanisms are strengthened and resourced.

Third, supervisors must be trained and empowered as frontline agents of support. Supervisors emerged as the most immediate and trusted source of care, partially compensating for institutional gaps. Structured training modules on responsive leadership, fairness, and recognition can be integrated into existing hospital leadership programs with modest budget allocations. Empowering supervisors with authority to implement immediate support measures, and evaluating their impact through staff feedback and stress monitoring, would strengthen this critical dimension of organisational support.

Fourth, administrators should establish a visible and equitable recognition and appreciation framework. Because perceptions of fairness and recognition significantly buffer stress, recognition must extend to all professional cadres, including non-clinical staff. This intervention is low-cost, relying on structured non-monetary practices such as milestone celebrations, shift-inclusive acknowledgements, and equitable appreciation across departments. Policy guidelines and communication platforms can support implementation, while staff morale indicators should be tracked to assess effectiveness.

Fifth, structured post-incident follow-up protocols are urgently required. Institutional silence after violent incidents amplified stress, creating perceptions of organisational indifference. Hospitals should adopt mandatory debriefing protocols, ensuring that staff receive immediate psychological support and visible managerial follow-through. This requires managerial commitment, integration into hospital standard operating procedures, and modest resources such as trained facilitators and time allocation. Documenting follow-up actions would build accountability and signal genuine organisational care.

Finally, dedicated mental health support funding must be established. Hospital administrators should allocate specific budget lines for staff mental health support, including counselling services, resilience training, and wellness programs. Advocacy at hospital and county levels is necessary to secure these allocations, but once established, they would ensure that support is not ad hoc but consistently available and institutionally sustained. Publicising these allocations would also signal credibility and build staff trust in organisational commitment to wellbeing. Hospital administrators should therefore sequence implementation, prioritising low-cost, high-trust-building interventions such as recognition frameworks, supervisor training, and

post-incident follow-up in the short term, while building the institutional case for resource-intensive reforms such as external counselling contracts and dedicated mental health funding over the medium term.

5.7 Suggestions for further research

Short-Term Priorities (1–2 years): The most immediate need is methodological strengthening. Future studies should employ longitudinal and quasi-experimental designs to test specific unanswered questions: do externally contracted Employee Assistance Programs, structured post-incident debriefing, and formalised peer support programs actually reduce stress outcomes over six- to twelve-month periods? This would generate causal evidence to validate and extend Organisational Support Theory in resource-constrained emergency care contexts. Future studies should also incorporate methodological triangulation, pairing self-reported stress and support measures with objective organisational indicators such as absenteeism records, turnover rates, and incident report logs. This would strengthen validity and address the triangulation gap identified in this study. In parallel, dedicated inquiry into non-clinical staff stressors housekeeping, security, and clerical personnel should be undertaken, as this group remains almost entirely absent from Kenyan emergency care literature despite facing equivalent pressures.

Medium-Term Priorities (3–5 years): Research should expand to multi-county comparative studies across rural, peri-urban, and Arid and Semi-Arid Lands contexts. This would clarify whether the convergence of stress levels across ownership models observed in Nairobi is universal or context-specific. Comparative insights would strengthen the explanatory power of the Job Demands–Resources model in African healthcare systems. Additionally, systematic investigation of the manager–frontline perception gap should be prioritised. Expanding qualitative sampling to include more frontline, non-clinical, and night-shift personnel would ensure balanced perspectives and test whether the perception gap persists across diverse cadres. Paired surveys and structured listening sessions can capture both managerial intent and staff experience, generating actionable insights into how communication, credibility, and trust can be aligned.

Long-Term Priorities (5+ years): At a strategic level, future research should evaluate policy-level and systemic interventions. This includes assessing the impact of dedicated mental health funding streams, resilience training programs, and governance reforms on occupational stress outcomes. Longitudinal studies should also explore how organisational culture change initiatives such as embedding recognition frameworks and accountability mechanisms reshape

staff perceptions and wellbeing over time. Finally, cross-national comparative research across Sub-Saharan Africa would situate Kenyan evidence within broader regional dynamics, advancing both theory and practice in occupational stress management globally. Cross-national comparative research should also explore how governance culture and trust dynamics shape the applicability of Organizational Support Theory and the Job Demands–Resources model across different African healthcare systems.

5.8 Limitations of the study

This study had several limitations that shaped how its findings were interpreted.

The cross-sectional design allowed associations to be examined but did not permit causal inference. Stress and support were measured at a single point in time, meaning highly stressed staff may have rated support more negatively. Longitudinal designs would be required to establish temporal direction and confirm whether support investments reduce stress over time. The study was confined to three Level 5 hospitals in Nairobi County. While this enhanced contextual relevance, the findings cannot be generalised to rural, peri-urban, or Arid and Semi-Arid Lands counties, where resource profiles differ. Similarly, the focus on emergency departments excluded other high-stress hospital units such as intensive care or surgical wards. These boundaries mean the results are most applicable to urban emergency care settings.

Although purposive recruitment included all eligible day and night staff, representativeness was limited by staff absences during data collection. Furthermore, the achieved sample departed from the originally planned probability-based stratified design, introducing an additional non-random source of potential bias that should be considered when interpreting prevalence and association estimates. This introduces potential sampling bias, as those absent may have had different stress experiences. Qualitative interviews were restricted to nine key informants, privileging managerial perspectives, though this was balanced by open-ended questionnaire responses from frontline staff. Future studies should expand qualitative sampling to capture richer and more diverse staff narratives.

Reliance on self-report instruments introduced potential bias, as perceptions may have been influenced by heightened awareness of occupational strain or social desirability. While triangulation with qualitative accounts and consistency across cadres and hospital types suggested credibility, the absence of objective measures such as physiological stress markers, absenteeism records, limits instrument validity. Future research should incorporate mixed measurement approaches to strengthen reliability.

The instruments used were adapted from international scales, which may not fully capture culturally specific stress expressions or support perceptions in Kenyan emergency departments. For example, communal coping and informal peer networks may play a larger role locally than in Western contexts. This raises the possibility of cultural bias, limiting transferability of findings. Future studies should validate tools within Kenyan healthcare settings to ensure cultural relevance. Although the Maslach Burnout Inventory and Survey of Perceived Organizational Support demonstrated acceptable internal consistency, they were not subjected to formal cross-cultural construct validation such as confirmatory factor analysis, prior to use in Kenyan emergency department settings. This raises the possibility that some items carried meanings shaped by their original North American and European development contexts that did not map precisely onto local realities.

The findings are most applicable to Nairobi's Level 5 hospitals and emergency departments. They cannot be assumed to represent other hospital levels, rural facilities, or different cultural contexts. This limitation underscores the need for multi-county comparative studies to test whether the equalisation of stress across ownership models observed in Nairobi is universal or context-specific.

These limitations do not undermine the robustness of the findings but highlight the need for caution in generalisation and causal claims. They also point to clear directions for future research: longitudinal designs, multi-county comparisons, broader hospital settings, culturally validated instruments, and deeper qualitative engagement with frontline staff.

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APPENDICES

Appendix A: Letter of Introduction

Mary Goretti Mukai Kaseve
Master's Student, Strathmore University
Email: mary.kaseve@strathmore.edu
Phone: +254 721 245 947

Dear Sir/Madam,

RE: Invitation to Participate in a Research Study

I hope this message finds you well. My name is Mary Goretti Mukai Kaseve, a Master's student at Strathmore University currently conducting a research study titled:

“Organizational support for mitigating work-related stress among Emergency department staff: A cross-sectional study of Level 5 hospitals in Nairobi County, Kenya.”

The aim of the study is to survey prevalence and severity of occupational stress, identify the most impactful support systems, and understand staff perceptions of their effectiveness. Your insights as a member of the emergency department are invaluable to this research and will contribute to evidence-based recommendations for improving staff wellbeing and institutional resilience.

Participation involves completing a brief questionnaire and taking part in a confidential interview. All responses will be anonymized, and ethical clearance has been attained from Strathmore University's Institutional Ethics Review Committee (IERC), National Commission for Science, Technology and Innovation (NACOSTI), and relevant hospital boards.

Your voluntary participation will help shape practical interventions and policy improvements in Kenya's health sector. If you agree to participate or have questions, do not hesitate to contact me directly.

Upon completion of the study, results are shared transparently with participating hospitals and stakeholders through structured feedback meetings, summary reports, and policy briefs, ensuring that participants and institutions benefit directly from the findings.

Thank you for considering this request. I deeply appreciate your time and contribution to this important work.

Warm regards,
Mary Goretti Mukai Kaseve
MBA-HCM, Strathmore University

Appendix B: Research Instruments

A: RESEARCH QUESTIONNAIRE

Study title: Organizational support for mitigating work-related stress among emergency department staff: A cross-sectional study of Level 5 hospitals in Nairobi County, Kenya

Dear Respondent,

Please respond to following questions in the best way possible. Participation in the research is appreciated. Kindly tick the appropriate box or fill in your answer for the questions below in the appropriate space.

Section A: Demographic Information

1. What is your age (years)?
 - ☐ 20-29
 - ☐ 30-39
 - ☐ 40-49
 - ☐ 50 and above
2. What is your gender identity?
 - ☐ Male
 - ☐ Female
 - ☐ Other (please indicate): _____
3. What is your professional designation?
 - ☐ Nurse
 - ☐ Clinical officer
 - ☐ Medical officer
 - ☐ Emergency consultant
 - ☐ laboratory technologist
 - ☐ Radiographer
 - ☐ Porter
 - ☐ Registration/Clerk
 - ☐ Security
4. If a nurse, which station/unit do you primarily work in?
 - ☐ Triage
 - ☐ Resuscitation
 - ☐ Fast track
 - ☐ Observation room
5. How many years have you worked in Emergency Department?
 - ☐ Less than 1 year
 - ☐ 1 to 3 years
 - ☐ 4 to 6 years
 - ☐ 7 to 10 years
 - ☐ More than 10 years
6. In the past 3 months, which shift have you worked most frequently?
 - ☐ Day shift
 - ☐ Night shift
 - ☐ Rotating shifts (day and night equally)
7. Which hospital do you currently work in?

- ☐ Mbagathi county referral hospital
- ☐ Metropolitan hospital
- ☐ St. Francis community hospital

Section B: Work-related stress

	1=Never	2=A few times a year/rarely	3=Every few months	4=Monthly	5=Weekly	6=Several times a week	7=Every day
I feel energized and emotionally engaged in my work.							
I often experience emotional exhaustion, physical fatigue, and psychological distress due to my work.							
I have sufficient time to provide quality care at work.							
I feel fatigued when I get up in the morning and have to face another day on the job.							
I experience frequent conflict with supervisors or colleagues at work.							
I end the workday with energy and a sense of accomplishment.							

I find myself becoming indifferent or detached toward patients or colleagues because of work stress.							
My work negatively affects my sleep or personal wellbeing.							
I feel emotionally drained from my work							

- Describe a recent situation where you felt stressed at work.
- What were the main causes of stress in your recent work situation?
(*Select all that apply*)
 - Heavy workload
 - Staffing shortages
 - Poor communication from management
 - Lack of organizational support
 - Long or inflexible working hours
 - Conflict with colleagues or supervisors
 - Limited access to resources or equipment
 - Other: _____
- What symptoms or signs do you usually experience when you feel stressed at work?
(*Select all that apply*)
 - Headaches or physical tension
 - Trouble sleeping or fatigue
 - Difficulty concentrating
 - Irritability or mood changes
 - Feeling overwhelmed or anxious
 - Reduced motivation or productivity
 - Changes in appetite
 - Other: _____
- How does work stress affect your wellbeing or performance at work?
(*Select all that apply*)
 - Reduced concentration or focus
 - Lower productivity
 - Increased mistakes or errors
 - Feeling exhausted or burned out
 - Difficulty making decisions
 - Strained relationships with colleagues
 - Decline in physical health (such as headaches, fatigue)
 - Decline in emotional wellbeing (such as anxiety, irritability)
 - Other: _____

Section C: Types of organizational support systems

	1=Strongly disagree	2=Disagree	3=Slightly disagree	4=Neutral	5=Slightly agree	6=Agree	7=Strongly agree
My hospital provides adequate emotional support for staff							
My supervisor is supportive when I face work-related challenges							
There are no clear communication channels for raising concerns							
My hospital provides opportunities for professional development							
I lack access to counselling or mental health services when needed							
I have adequate resources (equipment, staffing levels, and necessary tools) to perform my work effectively.							

- Which of the following support methods have you used at your work place, and found helpful in reducing stress at work?

(Select all that apply)

- Counselling or mental health services
- Peer support groups or mentorship
- Stress management workshops or training
- Flexible scheduling or time off
- Supervisor or management support
- Access to wellness facilities (e.g., gym, relaxation spaces)
- Employee assistance programs (EAP)
- Other: _____

- Name any support systems unavailable or not fully used by staff in your hospital?
- What barriers prevent you from accessing available support systems at your hospital?
(Select all that apply)
 - Lack of time
 - Fear of stigma or judgment
 - Limited availability of services
 - Poor communication about available support
 - Inconvenient scheduling or location
 - Lack of trust in confidentiality
 - Other: _____
- Do you feel you have enough information about the support systems available in your hospital?
 - Yes, I have clear information
 - Somewhat, but I need more details
 - No, I don't have enough information
 - I am not aware of any support systems

Section D: Perceptions of support system effectiveness

	1=Strongly disagree	2=Disagree	3=Slightly disagree	4=Neutral	5=Slightly agree	6=Agree	7=Strongly agree
The support systems in place at my hospital effectively reduce my work-related stress.							
Management responds effectively to staff feedback on stress and burnout.							
I believe the hospital recognizes staff stress and genuinely cares about my health and well-being.							
The support systems available in the hospital don't match our workplace needs.							

The support systems available have improved my job satisfaction.							
I often feel that my contributions are not valued by the hospital.							
I feel comfortable seeking help when I'm overwhelmed.							

- In your opinion, how effective are your hospital's current support methods in reducing work-related stress?
 - Very effective
 - Moderately effective
 - Slightly effective
 - Not effective at all
- Do you feel support systems in this hospital are equally accessible to all staff regardless of position or duty shift?"
 - Yes, they are equally accessible
 - Somewhat, but accessibility varies by role or shift
 - No, they are not equally accessible
 - I am not sure
- What changes would you recommend to improve the effectiveness of support methods in your hospital? *(Select all that apply)*
 - More staff counselling services
 - Flexible work schedules
 - Better communication from management
 - Stress management training
 - Peer support programs
 - Other: _____
- Please describe a new method that you would design to help staff manage stress or improve wellbeing at work.

Section E: Closing

Thank you for your participation. Your responses will help improve organizational support for managing work-related stress among emergency department staff. All information will remain confidential and used for academic purposes only. A summary of the findings will be shared with participating hospitals.

B: KEY INFORMANT INTERVIEW GUIDE

Study Title: Organizational support for mitigating work-related stress among emergency department staff: A cross-sectional study of Level 5 hospitals in Nairobi County, Kenya

Study site:

- Mbagathi County Referral hospital
- Metropolitan hospital
- St. Francis Community hospital

Interview Type:

- Semi-structured key informant interview.

Target Participants:

- Hospital administrators or operations managers.
- Human resource officers.
- Emergency department in-charges or senior staff in supervisory roles.
- Staff psychological support officers / counsellors where applicable.

Estimated duration: 35-45 minutes

Section A: Introduction and consent

Good morning/afternoon. Thank you for agreeing to participate in this interview. I am conducting a study to examine organizational support mechanisms aimed at mitigating work-related stress among emergency department staff in selected Level 5 hospitals in Nairobi County. The purpose of this interview is to gain your professional insights regarding occupational stress, existing support systems, leadership roles, and potential improvements within your facility.

Your participation is entirely voluntary. You may decline to answer any question and may withdraw from the interview at any time without any consequences. All information you provide will be treated with strict confidentiality. No personal identifiers will be included in the final report. Findings will be reported in aggregate form.

Upon completion of the study, results are shared transparently with participating hospitals and stakeholders through structured feedback meetings, summary reports, and policy briefs, ensuring that participants and institutions benefit directly from the findings.

Recording Permission Section

To ensure accuracy of your responses, I would like to request your permission to audio-record this interview. The recording will be used solely for transcription and analysis purposes. It will be securely stored and accessed only by the researcher. The recording will be deleted after transcription and completion of the study.

Do you consent to this interview being audio-recorded?

- ☐ Yes, I consent to audio recording
- ☐ No, I do not consent to audio recording

If no, detailed written notes will be taken instead.

Informed Consent

Have you understood the information provided and do you agree to participate in this interview?

- ☐ Yes
- ☐ No

Signature: _____

Date: _____

If staff prefer:

- Verbal consent (especially in hierarchical environments)
- Anonymous participation

Then Use a consent script and record verbal consent at the beginning of the audio such as “I confirm that I have understood the information and agree to participate.”

Section B: Main interview points

Section A: Background

1. Please describe your role and responsibilities in relation to staff supervision and wellbeing in the emergency department.

Probe: What level of influence do you have over staffing, workload, or staff support decisions?

Section B: Work-Related Stress

2. From your perspective, how prevalent is work-related stress among emergency department staff?

Probe: Which staff groups or shifts appear most affected?

3. What are the main sources of work-related stress among emergency department staff?

Probe: How do staffing levels and workload contribute to this stress?

4. How does work-related stress typically manifest among staff in the emergency department?

Probe: What changes in performance, behaviour, or wellbeing have you observed?

5. How have work-related stress levels among staff changed over time in your department?

Probe: What factors have influenced these changes?

Section C: Organizational Support

6. What organizational support systems are available to help emergency department staff manage work-related stress?

Probe: Are there formal psychological support or debriefing mechanisms?

7. How does the hospital manage staffing levels and workload distribution in the emergency department?

Probe: How are staffing gaps handled during high-demand periods?

8. What supervisory support is provided to staff experiencing work-related stress?

Probe: How do supervisors identify and support overwhelmed staff?

9. How accessible are the available organizational support systems to emergency department staff?

Probe: Are these supports equally available across shifts and cadres?

10. What organizational support systems are underutilized or missing in addressing staff stress?

Probe: What barriers limit staff use of available support?

11. What feedback have you received from staff regarding organizational support for stress management?

Probe: What common concerns have staff raised?

12. What role does leadership play in supporting staff wellbeing in the emergency department?

Probe: Are there policies guiding staff mental health and stress management?

Section D: Staff Perception (Mediating Variable)

13. How do staff perceive the adequacy of organizational support provided to manage work-related stress?

Probe: Do staff feel their needs are sufficiently addressed?

14. How do staff perceive management responsiveness to stress-related concerns?

Probe: How quickly are staff concerns addressed?

15. How do staff perceive fairness in access to organizational support systems?

Probe: Are support systems equitably available to all staff groups?

16. How do staff perceive the effectiveness of organizational support in reducing work-related stress?

Probe: Do staff believe these supports improve their wellbeing?

Section E: Mediated Relationship

17. In your view, how do organizational support systems influence work-related stress among emergency department staff?

Probe: What happens when support is insufficient?

18. How do staff perceptions of organizational support affect the use of stress management resources?

Probe: Does trust in management influence utilization?

Section F: Leadership and Improvement

19. What challenges affect implementation of organizational support for staff wellbeing?

Probe: Are there resource or staffing limitations?

20. What improvements would strengthen organizational support for reducing work-related stress?

Probe: What changes would have the greatest impact?

Closing

21. Is there anything else you would like to share regarding organizational support and staff stress in the emergency department?

Probe: Are there any additional recommendations?

Thank you very much for your time and valuable insights. Your responses will be kept confidential and used for academic purposes only.

Appendix C: Respondent Consent Form

Study title: Organizational support for mitigating work-related stress among emergency department staff: A cross-sectional study of Level 5 hospitals in Nairobi County, Kenya
Principal investigator: Mary Goretti Mukai Kaseve, Master's Student, Strathmore University
Contact: mary.kaseve@strathmore.edu, +254 721 245 947

1. Aim of the study

You are asked to participate in research that seeks understanding how organizational support systems influence work-related stress among emergency department staff in Nairobi's Level 5 hospitals. The findings will inform strategies to improve staff wellbeing and institutional resilience.

2. Procedures

If you consent to take part, you are expected to complete a structured questionnaire approximately 20 to 30 minutes and optionally participate in a follow-up interview if selected.

3. Risks and benefits

Minimal risk is anticipated. Some questions may evoke emotional discomfort related to work stress. While there is no direct benefit, your insights may contribute to improved support systems and working conditions in Kenyan hospitals.

4. Confidentiality

Your responses will be confidential and anonymous with no identifying information published. Data is stored securely, only accessible to the research team. Results are reported in aggregate form.

5. Voluntary participation

Participation is optional, feel free to skip any question or pull out of the study at any time without penalty.

6. Compensation

There is no monetary compensation for participation.

7. Questions and contacts

If you have any questions about the study or your rights as a participant, please contact:

- Principal investigator: Mary Goretti Mukai Kaseve at mary.kaseve@strathmore.edu
- Strathmore University institutional ethics review committee at ethicsreview@strathmore.edu or +254 730734 418 ethicsreview@strathmore.edu or by phone at +254 730 734 418.

Consent statement

I have read, understood the information provided above and I voluntarily agree to participate in the study.

Participant name: _____

Signature: _____

Date: _____

Researcher name: _____

Signature: _____

Date: _____

Appendix D: Ethics Approval



19th February 2026

Ms Kaseve Goretti Mary,
mary.kaseve@strathmore.edu

Dear Ms Kaseve,

**RE: Organizational Support for Mitigating Work-Related Stress Among
Emergency Department Staff: A Cross-Sectional Study of Level 5 Hospitals in
Nairobi County, Kenya**

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU-masters** research proposal. Your application reference number is **SU-ISERC3270/25**. The approval period is from **19th February 2026 to 18th February 2027**.

This approval is subject to compliance with the following requirements:

- i. Only approved documents including (informed consents, study instruments, and MTA) will be used
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
- iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 72 hours of notification
- iv. Any changes, anticipated or otherwise, that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 72 hours
- v. Clearance for the export of biological specimens must be obtained from relevant institutions.
- vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke/> and obtain other clearances needed.

Yours sincerely,

**Mr Ambrose Rachier,
Chairperson; SU-ISERC**

Appendix E: NACOSTI Approval

 REPUBLIC OF KENYA Ref No: 674490	 NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION. Date of Issue: 02/March/2026
RESEARCH LICENSE	
	
This is to Certify that Ms. MARY GORETTI MUKAI KASEVE of Strathmore University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: ORGANIZATIONAL SUPPORT FOR MITIGATING WORK-RELATED STRESS AMONG EMERGENCY DEPARTMENT STAFF: A CROSS-SECTIONAL STUDY OF LEVEL 5 HOSPITALS IN NAIROBI COUNTY, KENYA for the period ending: 02/March/2027.	
License No: NACOSTIP/26/4185629	
674490	
Applicant Identification Number	
Ag-Director General NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION	
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