

**ORGANIZATIONAL ROLE STRESS AND EMPLOYEE PERFORMANCE: A STUDY OF ROLE OF ACCREDITATION IN SELECT HOSPITALS OF PUNJAB**

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**DOCTOR OF PHILOSOPHY**

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**Management**

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**2025**

## **DECLARATION**

I, hereby declare that the presented work in the thesis entitled “**Organizational Role Stress and Employee Performance: A Study of Role of Accreditation in Select Hospitals of Punjab**” in fulfilment of the degree of **Doctor of Philosophy (Ph. D.)** is an outcome of research work carried out by me under the supervision of **Dr. Shikha Goyal**, working as **Professor**, in the **Mittal School of Business** of Lovely Professional University, Punjab, India. In keeping with the general practice of reporting scientific observations, due acknowledgements have been made whenever the work described here has been based on the findings of other investigators. This work has not been submitted in part or full to any other University or Institute for the award of any degree.

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## CERTIFICATE

This is to certify that the work reported in the Ph. D. thesis entitled “**Organizational Role Stress and Employee Performance: A Study of Role of Accreditation in Select Hospitals of Punjab**” submitted in fulfilment of the requirement for the award of degree of **Doctor of Philosophy (Ph.D.)** in the **Mittal School of Business**, is a research work carried out by **Tejinder Singh Rana, 11617225**, is a bonafide record of his original work carried out under my supervision and that no part of the thesis has been submitted for any other degree, diploma or equivalent course.

**(Signature of Supervisor)**

Name of supervisor: Dr.Shikha Goyal

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## ABSTRACT

Healthcare services are widely recognized as one of the fundamental needs of human beings in modern society. The components of health, such as the prevention and treatment of diseases, are directly linked to the overall development of society, making poor health an unacceptable deprivation of basic needs. Throughout history, health has been considered one of the main benefits of societal development, serving as a key indicator of societal welfare. In this respect, the healthcare system plays a pivotal role in the sustainable delivery of healthcare services, with its primary task being to provide preventive and curative care. The health of any society depends largely on the availability of sufficient and high-quality healthcare services. The healthcare system serves as a living image of the social and economical development of any society, reflecting improved living standards across various dimensions, including better infrastructure, increased income levels, hygienic food, cleanliness, availability of potable water, safe and comfortable living conditions, increased employment and income, and prevention and control of diseases. Thus, the healthcare system is a necessary component of the overall development of any society, with its success reflecting the comprehensive progress of that society in various domains. Hence, the quality of healthcare services becomes the most important factor over a period that needs urgent attention. Accreditation, continuous quality improvement, and safety for patients and workers have become an essential part of healthcare services. Internationally tradition of accreditation of healthcare services has emerged since the 1970s. Viewing its great significance, In many countries, various government and private accrediting organizations have come out and developed gradually to enhance healthcare services and continuous quality improvement programs.

Numerous studies have shown that those working in the healthcare industry have significantly higher levels of emotional and psychological stress than the general population. Healthcare professionals often face high workloads, long working hours, and the need to make critical decisions under time pressure. For example, physicians in hospitals may be responsible for managing multiple patients simultaneously, conducting complex procedures, and handling emergencies, leading to role overload and stress (Ribeiro et al., 2018; Shepherd and Newell, 2020).

Due to the various criteria, expectations, and settings associated with each kind of institution, hospitals that are accredited or not may have different levels of organizational role stress. In accredited hospitals, healthcare professionals may experience stress related to compliance demands, quality improvement initiatives, performance measurement and reporting, and protocol

and procedure updates. The rigorous standards and guidelines imposed by accreditation bodies can create additional administrative burdens and pressures to meet specific criteria (Elkins et al., 2010). On the other hand, in non-accredited hospitals, professionals may face stressors related to resource constraints, establishing a reputation, limited standardization, and funding pressures. These hospitals often have to navigate challenges such as limited resources, the need to build credibility without formal accreditation, and financial uncertainties (Tashayoei et al., 2020). However, literature is lacking on how organizational role stress varies with hospitals or their impact on healthcare professionals' performance.

The present study aims to identify the factors that influence organizational role stress and their impact on employee performance. Additionally, the moderating effect of hospital type on the relationship between organizational role stress and employee performance was examined. The study was conducted in the three regions of Punjab, namely Doaba, Majha, and Malwa, which were considered as the entire population. From these regions, districts with a higher number of private hospitals accredited by the National Accreditation Board for Hospitals and Healthcare Providers were selected. An identical number of non-accredited private hospitals were chosen from the same district for the purpose of data comparison. The study included a total sample size of 480 healthcare professionals, which consisted of two groups: operational-level staff and managerial-level staff. The data was collected through a structured questionnaire, with the statements being recorded on a 5-point Likert scale. The healthcare professionals were given a thorough explanation of the study's purpose and significance and were allowed to carefully read the content before responding. The data collection process was carried out by the researcher, who personally visited each hospital.

The organizational role stress scale, developed by Prof. Pareek and Dr. Surabhi Purohit, and the Employee Performance scale, developed by Linda Koopman et.al. were used to record the healthcare professional responses. ORS scale consists of ten dimensions and every dimension has its own 5 individual statements. All the statements are unidirectional negative statements. EP scale consists of three sub-dimensions TP, CP, and CWB and each dimension has 5, 8, and 5 statements respectively.

In this study, the first objective was to identify the prominent factors that contribute to organizational role stress and it was found that inter-role distance followed by role stagnation and role erosion were the most contributing factors towards organizational role stress. The second objective was to find out the differences in organizational role stress between the accredited and non-accredited hospitals and results show that employee working in accredited hospitals experience more role stress than their counterpart employee working in non-accredited hospitals. The third

objective was to analyze the impact of organizational role stress on managerial-level employee performance and the results confirmed that ORS has a significant effect on managerial-level employee performance for both the cases of accredited and non-accredited hospitals. Further, The negative sign indicates an increase in ORS results in a decrease in employee performance. Based on the standardized coefficient it can be stated that the impact of ORS on EP for managerial professionals is higher for accredited hospitals compared to non-accredited hospitals. The fourth objective was to assess the impact of organizational role stress on operational-level employee performance. Study results reveal that organizational role stress has a significant effect on operational-level employee performance for both the cases of accredited and non-accredited hospitals. Based on the standardized coefficient, it can be concluded that organizational role stress has a significant effect on the performance of operational-level professionals in non-accredited hospitals compared to those in accredited hospitals. The fifth and final objective of our study was to explore the potential moderating influence of hospital type on the relationship between organizational role stress and employee performance. To investigate this effect, we used a multi-group analysis with pairwise comparisons to assess whether the type of hospital moderated the relationship between organizational role stress and employee performance. For evaluating the impact of the moderator, the difference in path coefficients of the two models was used as the invariance test discussed above was found significant. It was concluded that hospital type moderates the relationship between Organizational role stress and Employee performance. By doing so, we hoped to gain a deeper understanding of how different hospitals may impact the relationship between these two variables.

The first chapter of the thesis provides an overview of the independent and dependent variables under the study as well as the accreditation system of the healthcare system operating in India. The second chapter deals with the review of previous studies related to the variables and their relationship. Chapter number three defines the research gap, research objectives, hypotheses, research design, target population, sample size, and various statistical tools and techniques used to achieve the set objectives. Chapter four discusses the analysis and interpretation of the results and Chapter five discusses about the implications, limitations, and future scope for further study.

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## LIST OF ABBREVIATIONS

S.NO	ABBREVIATION	FULL FORM
1	AIIMS	All India Institute of Medical Science
2	ASQua	Asian Society for Quality in Healthcare
3	CAHO	The Commission on Accreditation of Healthcare Organizations
4	CAPA	Corrective Action and Preventive Action
5	CP	Contextual Performance
6	CWB	Counterproductive Work Behaviour
7	DDKM	The Danish Healthcare Quality Programme
8	GNDU	Guru Nanak Dev University
9	IRD	Inter Role Distance
10	ISQua	The International Society for Quality in Healthcare
11	IWP	Individual Work Performance
12	JCI	Joint Commission International
13	KASH	Kerala Accreditation Standards for Hospitals
14	LMIC	Low and Middle- Income Countries
15	MCS	Management Control System
16	MOHME	The Ministry of Health and Medical Education
17	NABH	National Accreditation Board For Hospitals And Healthcare Providers
18	NCQA	National Committee for Quality Assurance
19	ORS	Organizational Role Stress
20	PI	Personal Inadequacy
21	QCI	Quality Council of India
22	RA	Role Ambiguity
23	RE	Role Erosion
24	REC	Role-Expectation Conflict
25	RI	Role Isolation
26	RIn	Resource Inadequacy

27	RO	Role Overload
28	RS	Role Stagnation
29	SHCO	Small Healthcare Organization
30	SRD	Self Role Distance
31	TJC	The Joint Commission
32	TP	Task Performance
33	WHO	World Healthcare Organization



# CHAPTER 1

## 1.1 INTRODUCTION

Healthcare services are widely recognized as one of the fundamental needs of the human beings in society. The components of health are closely related to the development of society, and poor health is considered a deprivation of basic needs. Throughout history, health has been regarded as one of the main benefits of development, signifying societal welfare. In this context, health and healthcare systems are inextricably linked. The primary function of the healthcare system in the sustainable delivery of healthcare services is to provide preventive and curative care. The health condition of any society primarily depends on the provision of a sufficient and high-quality healthcare system. The healthcare system is a true reflection of the social and economic development of any society, encompassing improved living standards, better infrastructure, increased income, hygienic food, cleanliness, availability of potable water, safe and comfortable living conditions, increased employment and income, and prevention and control of diseases. Therefore, the quality of healthcare services becomes the most crucial factor that requires urgent attention over time. Accreditation, continuous quality improvement, and safety for patients and workers have become an essential part of healthcare services. Internationally tradition of accreditation of healthcare services has emerged since the 1970s. Viewing its great significance, In many countries, various government and private accrediting organizations have come out and developed gradually to enhance healthcare services and continuous quality improvement programs.

## 1.2 ACCREDITATION IN HEALTHCARE

A certifying agency or accrediting authority evaluates an organizations performance in comparison to predefined standards as part of the widely accepted accreditation system for organizational improvement. Accreditation programs are designed to enhance organizational performance by providing expert advice, developing new policies and procedures, and upgrading existing ones. This is achieved by defining criteria and performance indicators that are used to evaluate the organization's outcomes and sub-objective elements. Through this process, accreditation aims to improve organizational performance and ensure that organizations are meeting the established standards for their industry. Self-evaluation, on-site assessment, colleague interviews, reviewing documents, equipment checking, and evaluating important clinical and relevant organizational data are all common assessment

methods used during the accreditation process, which is carried out by a multidisciplinary team of healthcare professionals (Braithwaite J, 2010). Healthcare organizations use the accreditation process to accurately evaluate their level of compliance against the established standards and to address any identified non-compliances. This is done through a combination of self-assessment and external peer assessment (by the authorized assessor). Healthcare providers affirm their dedication to patient and staff safety, accountability, enhanced performance, delegated authority, and the safeguarding of patient and staff rights and responsibilities. To achieve accreditation, a group of medical experts evaluates a facility's ability to provide quality care following established criteria. (WHO, 2003, p.58).

The process of examining and certifying healthcare organizations or programmes to guarantee that they fulfil particular quality standards and best practices is referred to as accreditation in the healthcare industry. Accreditation is often handled by third-party organizations that operate independently of the institution being evaluated. These organizations are known as accrediting bodies or agencies.

The evaluation of a healthcare provider's operations from a variety of perspectives, such as patient safety, clinical outcomes, personnel credentials, training, governance, and infrastructure, is done as part of the accreditation process to foster and sustain the provision of high-quality healthcare services. Accreditation provides healthcare organizations with the ability to identify areas in need of improvement and put standardized procedures into place, both of which are intended to improve patient care and safety.

The following is a list of important information to keep in mind about certification in the healthcare industry:

**Accrediting Bodies:** Accreditation is normally carried out by separate organizations that are experts in evaluating healthcare providers and facilities. Accrediting groups such as The Joint Commission (TJC), the Commission on Accreditation of Healthcare Organizations (CAHO), and the National Committee for Quality Assurance (NCQA) are all well-known examples of these types of organizations.

**Standards and Criteria:** In order to obtain accreditation, healthcare organizations are required to comply with a set of specified standards and criteria that are established by accrediting authorities. These standards often encompass a broad range of topics, including patient rights, infection control, drug management, quality improvement, and treatment that is centred on the patient.

**Process of Evaluation:** The process of gaining accreditation for a healthcare organization or programme entails a comprehensive evaluation of that organization or programme. Document reviews, site visits, interviews with staff members and patients, and

performance evaluations are typically all a part of it. Performance evaluations may also be a component. The accrediting authority will evaluate the degree to which the stated requirements are met, and it will pinpoint any areas in which the standards are not met as well as any potential for development.

Accreditation has several positive effects:. It acts as a quality indicator and has the potential to improve an organization's reputation as well as its credibility. Accreditation could also be necessary in order to receive financial assistance from the government or to join specific insurance networks. In addition, the process of certification assists organizations in identifying and addressing areas of weakness, which ultimately results in increased patient safety and quality of treatment.

**Accreditation:** It can be obtained by hospitals, clinics, long-term care facilities, ambulatory surgery centres, and home healthcare agencies among other types of healthcare organizations hospitals, clinics, long-term care facilities, ambulatory surgery centers, and home healthcare agencies are all eligible to pursue accreditation. In addition, there are specialized certification programmes for specific areas of the healthcare industry, such as laboratory services, rehabilitation, behavioural health, and disease-specific programmes. These programmes are designed to accredit healthcare providers in their respective fields.

**Ongoing Compliance:** Accreditation is not a one-time event but rather a process that takes place continuously throughout time. It is customarily required of accredited organizations that they continue to maintain compliance with the standards and go through periodic evaluations or reaccreditation surveys to demonstrate that they continue to fulfil the requirements that have been set forth.

The process of accreditation is critical to ensuring that patients receive care that is of the highest possible quality. Patients, healthcare professionals, and other stakeholders are given the assurance that they need that an organization is meeting the standards of care that have been established.

### **1.3 CURRENT SCENARIO OF ACCREDITATION IN THE INDIAN HEALTHCARE SYSTEM**

Hospitals and other healthcare facilities need to provide a secure environment for all those involved. Governments, non-profits, insurance companies, and groups that advocate for healthcare professionals and patients are all invested in improving hospital and healthcare service quality and patient safety. Accreditation is concerned with demonstrating conformity to specified criteria for both quality and safety. Achieving accreditation motivates

healthcare facilities to strive for improvement over time.

According to ISQua “A self-assessment and external peer review process used by health and social care organizations to accurately assess their level of performance concerning established standards and to implement ways to continuously improve the health or social care system.”

Rapid social, economic, and technological change is the context in which India's current healthcare system must function. The quality and safety of medical care are threatened by these developments. If we want to raise the bar for healthcare facilities everywhere, accreditation is the best bet. Incentives like hospital accreditation help strengthen healthcare systems across the globe, which benefits patients. Healthcare providers, both public and private, are held accountable for their performance through the national accreditation system.

The national accreditation board for Hospitals and Healthcare Providers (NABH, India) was established by the Government of India in 2006 to set a standard for healthcare excellence. The board's “Standards for Hospitals” have been accredited by the international Society for Quality in Healthcare (ISQua), a global organization that recognizes national accreditation bodies as equivalent in the field of healthcare. As of now, 11 countries' hospital standards, including the United States, are available for accreditation by ISQua. The quality management systems of Australia, Canada, Egypt, Hong Kong, Ireland, Japan, Jordan, the Kyrgyz Republic, South Africa, Taiwan, and the United Kingdom have been recognized by ISQua. With the addition of India, the total number of members recognized by ISQua stands at 12. This development showcases India's commitment to quality healthcare and its efforts to align with global standards in the healthcare industry.

The National Accreditation Board for Hospitals (NABH) was established by the Quality Council of India to manage and oversee hospital accreditation standards. The board prioritizes meeting the needs of consumers and takes guidance from the Joint Commission International (JCI) for the advancement of the healthcare industry. Despite receiving support from businesses, consumers, and the government, the board can act autonomously. The National Association of Boards of Healthcare Quality (NAHQ) is an institutional member of the International Society for Quality in Healthcare (ISQua). NABH is affiliated with ISQua, the premier healthcare quality organization worldwide (ISQua). NABH is affiliated with ASQua, the Asian Society for Healthcare Quality (<http://nabh.co/introduction.aspx>). Its standards are on par with

those of the rest of the world, making it the most prominent healthcare accreditation and quality improvement organization in the country. Accreditation and ancillary programs are managed by the organization, with an emphasis on patient safety and healthcare quality in accordance with national/international standards (<http://nabh.co>). The primary mission of the National Accreditation Board for Hospitals & Healthcare Providers is to accredit healthcare facilities, promote quality through initiatives like Safe-I, recognize nursing excellence, certify laboratories, conduct information and education campaigns (IEC) via public lectures, advertisements, workshops/seminars, and educate the public. The NABH's 4th edition of standards contains 10 chapters, 106 standards, and 683 objective elements that must be met for a facility to earn accreditation. NABH is currently working on the fifth edition of its standards.

#### **1.4 CURRENT SCENARIO OF ACCREDITATION IN THE PUNJAB HEALTHCARE SYSTEM**

In order to track advancements and regressions in health, states were graded according to their health condition between 2014-2015 and 2015-2016 in a new document released by the Health Ministry and NITI Aayog called Healthy States Progressive India. As per the report, Punjab stood second among all the states, indicating improved health outcomes and a robust local system that helps to get second rank (The Tribune, Feb.2018). Currently, Punjab has 59 Private hospitals (more than 50 beds), 54 Small healthcare organizations (less than 50 beds), 04 Blood banks, 03 Dental centres, 01 Allopathic centre, and 12 Eye care organizations are accredited by the National Accreditation Board for Hospitals and Healthcare providers (NABH). In Punjab, only Fortis Healthcare in Mohali and SPS Apollo Hospital in Ludhiana have received accreditation from the USA-based organization, Joint Commission International ([www.jointcommissioninternational.org](http://www.jointcommissioninternational.org)).

Hospitals with up to 50 beds that have their own appropriate and relevant supportive and utility facilities were eligible to apply for accreditation through the Small Healthcare Organizations (SHCO) accreditation program in 2010. This program is open to hospitals with up to 50 beds. That could also include super speciality hospitals and daycare centres with up to fifty beds. In the United States, the number of small hospitals and nursing homes is considerably higher than that of large hospitals. As a result, the SHCO standards have undergone a reduction in the number of standards and objective elements. One of the primary advantages of adhering to these standards is the attainment of accreditation, which can only be achieved through demonstrating

technical competence in healthcare provision. Accreditation emphasizes education, growth, enhanced efficiency, and reduced risk, thereby motivating healthcare providers to strive for excellence in their practices.

### **1.5 NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS (NABH)**

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) was established by the Quality Council of India (QCI) to establish and oversee healthcare certification initiatives. The national association for the betterment of health was established to improve healthcare quality and ensure that patients are safe at all times. Despite being trusted by industry, consumers, and the government, the board operates independently of any external influence. Moreover, the NABH is recognized by the international Society for Quality in Healthcare (ISQua), and hospitals accredited by the NABH are respected worldwide. India has seen a significant increase in medical tourism due to the country's advanced medical facilities and highly trained medical professionals. To ensure the quality of healthcare services, the National Accreditation Board for Hospitals and Healthcare Providers (NABH) has become an institutional member of the International Society for Quality in Healthcare (ISQua) and serves on its accreditation council. Additionally, NABH is a founding member of the Asian Society for Quality in Healthcare (ASQua). To meet the growing demand for healthcare services in the SAARC/Asian region, NABH has established NABH International, with the Philippines being the organization's first international destination.

Healthcare organizations are impartially accredited by NABH, regardless of their ownership, legal status, size, or level of independence. Healthcare quality and patient safety are two areas that the NABH standards aim to enhance. The following accreditation, certification, and empanelment programs are currently offered by NABH:

#### **Accreditation Programs:**

- ✓ “Hospitals”
- ✓ “Small Healthcare Organizations”
- ✓ “Blood Banks”
- ✓ “Medical Imaging Services”
- ✓ “Dental facilities/Dental clinics”
- ✓ “Allopathic Clinics”

- ✓ “AYUSH Hospitals”
- ✓ “Primary Health Centre”
- ✓ “Clinical Trial”
- ✓ “Panchakarma Clinics”
- ✓ “Eye Care Organization”

**Certification Programs :**

- ✓ “Entry Level Hospital”
- ✓ “Entry-level Small Healthcare Organizations”
- ✓ “Entry Level AYUSH Centre”
- ✓ “Entry Level AYUSH Hospital”
- ✓ “Nursing Excellence”
- ✓ “Medical Laboratory Programme”
- ✓ “Emergency Department”
- ✓ “MVTF Empanelment Certification”

**1.5.1 BENEFITS OF ACCREDITATION**

**Benefits for Patients :**

- The Patients stand to benefit the most out of all the parties involved.
- The results of accreditation include superior patient care and safety.
- Healthcare professionals with the necessary credentials attend to the patient.
- Patient's rights are upheld and safeguarded.

**Benefits for the Organization:**

- Healthcare organizations that are accredited are encouraged to keep improving.
- Assuring the finest clinical outcomes, helps the organization to show that it is committed to providing high-quality treatment and patient safety.
- The community is more confident in the services offered by healthcare organizations when they are rendered by qualified healthcare professionals.
- Healthcare facilities might use it as a chance to compare themselves to the best.
- In the highly competitive healthcare industry, accreditation status also offers a marketing benefit.

**Benefits for Staff:**

- Employee satisfaction is high in recognized healthcare organizations as they offer leadership opportunities, a positive work environment, and continuous growth opportunities.
- Accredited healthcare organizations see improvements in personnel capabilities and efficiency.
- It enhances knowledge, skills, and general professional growth in an organized way with clear accountability and ownership for all personnel, including all healthcare professionals.

**Benefits to paying and Regulatory Bodies:**

Finally, Accreditation offers a neutral method for insurance and other third-party empanelment. Accreditation ensures that people have access to verified, high-quality data about a service's infrastructure, quality of care, and service delivery.

**1.5.2 TYPES OF ASSESSMENT CONDUCTED BY NABH**

To guarantee its operations continue without interruption or degradation of quality, NABH, in coordination with healthcare organizations, may opt to use one of the following approaches for conducting the assessments, based on local environmental conditions that are prevalent. The four main categories of evaluation are outlined in the attached document;

- A. Onsite Assessment
- B. Desktop Assessment
- C. Remote Assessment
- D. Hybrid Assessment

**Onsite Assessment:** Assessors designated by the NABH Secretariat travel to the healthcare organization in person to verify documents, tour the facilities, and conduct interviews over the course of a man's day. This man's day is determined by the bed strength of the healthcare organization. The hospital is responsible for paying the travel and lodging expenses of the evaluator.

**Desktop Assessment:** The healthcare organization will submit information and documents to the NABH assessor according to a checklist based on relevant standards for hospitals. The assessor's suggestions will be taken into account when deciding whether to renew accreditation.



**Remote Assessment:** Rather than visiting the healthcare organization in person, the assessor (or assessors) in this scenario conducts the entire assessment online. The hospital must provide this online portal, and small fees will be assessed to cover administrative costs.

**Hybrid Assessment:** In this evaluation, only one assessor needs to be physically present at the healthcare organization, while the other(s) can work remotely using a virtual platform.

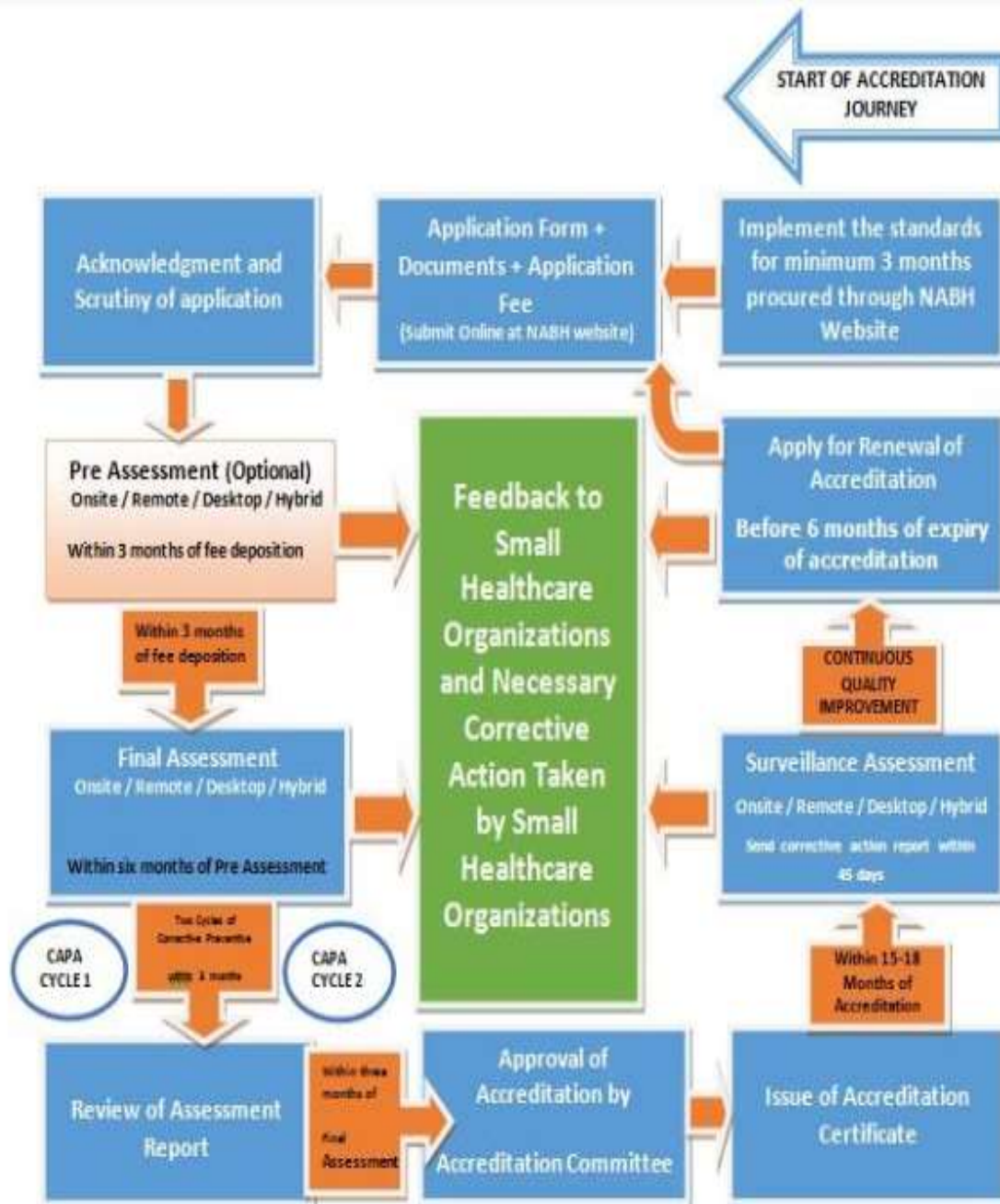
### **1.5.3 PROCEDURE OF ACCREDITATION AND ASSESSMENT**

Accreditation is a self-assessment and external peer review procedure used by healthcare organizations to determine how well they are doing in comparison to defined criteria and to apply strategies for continuous improvement. A health assessment is a strategy for care that details how a person's unique medical requirements will be met by a hospital, clinic, or skilled nursing facility. An individual's health state can be determined by an in-depth physical examination and medical history review. Accreditation by the National Accreditation Board for Hospitals (NABH) in India ensures that patient care meets international standards. The National Association of Boards of Health (NABH) participates in a worldwide healthcare certification agency known as the International Society for Quality in Health Care (ISQUA). By joining ISQUA, NABH has become one of only a select few nations whose healthcare services are matched and authenticated against international benchmarks. As a result, medical tourism in India benefits when hospitals earn NABH Accreditation by providing care on par with international standards.

The step-by-step procedure of NABH accreditation for hospitals in India is as follows.

- Step 1: Preparing for Accreditation
- Step 2: Documentation and Implementation
- Step 3: Application and Pre-assessment
- Step 4: Formal Assessment
- Step 5: Final Decision and Feedback
- Step 6: Corrective actions and Re-assessment
- Step 7: Accreditation Decision
- Step 8: Surveillance Assessments

## PROCEDURE OF ASSESSMENT IN FLOWCHART DIAGRAM



**Figure 1.1 Assessment and Accreditation flow chart**

#### **1.5.3.1 Developing Manuals and Policies:**

To comply with the requirements of the National Board for Hospitals and Healthcare Providers, The healthcare organization is responsible for drafting the required Quality Manuals, various policies and procedures, and other manuals.

#### **1.5.3.2 Application for accreditation:**

In order to apply to NABH, healthcare providers need to follow the steps outlined in the application's online documentation. Careful consideration should be given to the information provided on the application by healthcare organizations, as it will be used to establish the range of services to be provided.

#### **1.5.3.3 Scrutiny of Application:**

After the SHCO pays the application fees through the online application form's 'Make Payment' option, a reference ID is generated for the application. The application will be checked for completeness by a NABH official. To communicate with NABH, healthcare organizations can use the "Remarks" section of their respective portals.

#### **1.5.3.4 Notification of Principal Assessor and Assessment Team:**

Healthcare providers will be evaluated by a team of assessors, one of whom will be designated as the Principal Assessor by NABH. All required documentation, such as the quality manual, policies and procedures, and departmental manuals, will be assessed for compliance with the standards.

#### **1.5.3.5 Pre-Assessment (Optional):**

Pre-assessment is no longer required by NABH. If a healthcare organization does not wish to be pre-assessed, it must indicate this in the comments section of the application form. Pre-assessment, however, will be handled by NABH for all healthcare facilities that want it. Pre-assessment work is delegated to the Principal Assessor and any additional assessors who may be needed. The primary evaluator must upload the preliminary report to an electronic system. The SHCO is responsible for addressing the issues that were flagged by the assessment team. The prerequisite fee must be paid by the small healthcare organization well in advance before the final assessment.

#### **1.5.3.6 Final Assessment:**

Once the hospital has rectified the non-compliances raised at the time of the pre-assessment visit, the National Accreditation Board for Hospitals and healthcare providers will form an assessment team consisting of certified and well-trained assessors to review the healthcare facility for the same. But as was already mentioned, healthcare organizations can skip the preliminary evaluation in favour of a full evaluation. The hospital's size and the variety of services offered will determine how many assessors are needed. Both the hospital administration and the evaluators will need to agree on a date for the final evaluation. All of the accredited facilities must undergo the evaluation. The assessment team examines the hospital's statutory requirements, documentation and policies to ensure it meets NABH requirements. The efficiency and usefulness of the documented quality manuals, various policies and procedures, etc., will be evaluated.

The Principal Assessor compiles the assessors' findings into an assessment report, which is then submitted through the portal. Once the Principal Assessor uploads the report, the hospital staff can view the specifics of any non-conformity that were noted during the assessment.

#### **1.5.3.7 Review of assessment report:**

The healthcare provider is responsible for fixing the problem(s) that caused the non-conformity and providing proof of that fix in the form of an uploaded document. The hospital's corrective action will be examined by the Principal Assessor once it has been submitted. There are a maximum of two rounds of corrective action for nonconformities that healthcare organizations can use.

The accrediting committee reviews the evaluation report, additional information from the hospital, and subsequent verifications when the facility has taken appropriate corrective action. Recommendations on the healthcare organization's accreditation status will be made by the accrediting committee.

#### **1.5.3.8 Issue of Accreditation Certificate:**

The SHCO will receive a three-year accreditation certificate from NABH. The certificate includes both a serial number and an expiration date. Accreditation stipulations are in-

cluded with the certificate. All fees owed to NABH by the applicant healthcare organization must be paid in full before the certificate can be issued.

## **1.6 ORGANIZATIONAL ROLE STRESS (ORS)**

Organizational stress refers to the factors within an organization that cause stress to an individual and have negative effects on the organization as a whole. Organizational role stress occurs when an individual encounters negative consequences in their work-related position inside the organization (Pathak, 2012). Absenteeism, poor performance, burnout, behavioural changes, low morale, negativity, and decreased satisfaction may be the cause of employee stress. There may be several organizational factors that can be the reason for individual stress such as organizational structure, the demand for different tasks and roles, working culture, quality of work, change in the working process, etc. A person's risk of having a stress disorder due to their profession increases the more unfavourable experiences they have there. Organizational role stress refers to pressures brought on by one's assigned function at work. Long-term exposure to stress in the workplace can have a variety of negative health effects, including physical and mental illness, burnout, decreased productivity, low morale, lack of motivation, etc.

### **1.6.1 Role**

An individual's role within an organization is shaped by the expectations of key stakeholders, including the employees themselves. It's a load of responsibilities imposed on you by people you deem "important." It refers to the duties that workers carry out to meet both the needs of their "important" others and their own professional goals.

A person's role is the way they are expected to act in a given situation. A role is an exchange between the sender and the receiver of the role. An individual in a certain position inside an organization receives messages of expectation from role senders. The three types of roles are i) the role that is expected, which refers to the responsibilities and duties that an individual is anticipated to carry out based on their position within the organization (ii) the role that is perceived, which is concerned with how an individual perceives and interprets their role within the organization and (iii) the role that plays out, which is the actual role that an individual ends up fulfilling within the organization, which may differ from the expected or perceived role. Employees are expected to fulfil the function set forth by upper management. Employees' expectations about their behaviour to carry

out their expected role constitute their perceived role. What matters most is how workers actually operate within the company.

In his work, U. Pareek has defined a role as a collection of tasks that an individual completes in order to meet other's expectations for that role. For a role occupant, two role systems make up a given position: role space and role set. However, according to the dictionary's definition, the person filling a role is doomed to experience stress because of the difficulties inherent in the job. This is due to the inherent tension and stress in the very idea of roles, compounded by the associated concepts of "role space" and "role set".

### **1.6.2 Role stress**

Role stress is a source of potential distress, as advocated by (Kahn, Wolfe, Quinn, Snoek, and Rosenthal, 1964). Expectations-generated stress, expectations-resource discrepancies, and role personality mismatch are the three types of role stress identified by Kahn and Quinn (1970). Role confusion and role rivalry are both included in the first group. Inadequate technical information, a conflict between roles, and the responsibility-authority trap all fall under the second heading. Disparities between characters and actors make up the third group.

The very idea of a position within an organization is a system in and of itself. Srivastav argues that the success of HR systems and processes is predicated on the existence of well-defined organizational roles. Membership in an organization and the idea of an organizational role, as argued by Pareek (2004), have the inherent potential for stress. Organizational role stress refers to the pressures of working in a specific position within an organization (ORS).

Pareek explains the meaning of several terms related to roles by noting that every member of society fills multiple roles. One's role space includes all of these responsibilities. The role space revolves around the individual. One assumes many identities within one's own self. The role space is defined by the connections between the various roles, which are at different distances from the self and from one another. A specialized set of tools for each function, or role, is known as a role set. A person's role set is the group of other people in the same or similar roles who have certain expectations of the person in the role. A person's specific role is at the center of this, with all other roles revolving around it.

Multiple factors, including the self, other roles (role senders), other roles' expectations, the self's expectations, the self's expectations of other roles, and other roles undertaken and performed, influence an individual's role behaviours. It's like playing a part with inherent opportunities for tension and struggle. Therefore, anxiety is a normal part of acting. One's path becomes unclear while juggling multiple roles or while operating within a single one. Frustration, anger, conflict, and stress are the results of this.

### **1.6.3 Causes of Stress**

There are many potential triggers for stress. One person may not find these things stressful at all while they may be a major stressor for another. Individuals can experience stress from both internal and external sources. Some examples of environmental factors that can have a negative impact on mental health are those listed by Ivancevich et al. (society, economy, finances, culture, family, technology, employees). Individuals are negatively impacted by environmental stressors such as work and family commitments, poverty, discrimination, and forced relocation. Market fluctuations give rise to economic uncertainty. People worry more about losing their jobs as the economy contracts as a result of market shifts. Political uncertainty can add to an individual's emotional distress. The “organizational factors” refer to a broad range of stressors at both the individual and societal levels, including policies and strategies, the structure and design of organizations, their procedures, and the overall work environment. The workplace presents various specific challenges such as performance, role ambiguity, conflict and overload, job insecurity, work-family conflict, environmental uncertainty, and situational constraints. Recent meta-analytical findings have demonstrated the detrimental impact of these challenges on workplace productivity. Furthermore, due to the intense pressure to outperform competitors, strategies like reengineering, restructuring, and downsizing have become prevalent. In particular, layoffs have been and continue to be devastating to employees. Workers may feel immense stress from either the actual loss of employment or the threat of reduction.

Employment-related needs are those that must be met in order to do one's job. Workplace conditions and job structure (including the autonomy of workers, the variety of tasks, and the degree of automation) are examples. People in a meeting line may feel pressured if they observe the line moving too quickly.

A person's "role requirements" refer to the expectations placed on them because of their

position in the company. Role conflicts give rise to unrealistic expectations that can be challenging to meet. When responsibilities exceed available hours, a worker is said to be working at full capacity in the position. Due to the role's fuzziness, the employee is uncertain of his or her responsibilities. High-status problems also reduce the likelihood that people will engage in active behaviours that alleviate stress.

In the workplace, "interpersonal demands" refer to those that come from coworkers. Employees with high social needs are particularly vulnerable to the negative effects of a lack of social support from coworkers and poor interpersonal relationships. Fights, bullying, incivility, racial harassment, and sexual harassment are all examples of negative coworker and supervisor behaviours that have been linked to increased workplace stress. Hawthorne's research has established the significance of group cohesiveness, group norms, and the importance of group objectives in achieving organizational goals, all of which contribute to group stress. Disunity is the root cause of all wars. Workers need to be given every opportunity to better themselves. People join the group in the hopes of receiving the promised social benefits. Managers have the burden of making sure their employees feel appreciated, which can cause mental strain. It is important to keep track of interventions regularly. Managers should participate in the group without regard to hierarchy. Maintaining high morale among staff members is essential for preventing stress among teams. Stressors in one's private life can add up just as quickly as those in one's professional life. Marriage, divorce, and death are just a few examples of life events that can have a profound effect on one's professional life. Stressful situations in one's personal life.

(a) Job Security: The pursuit of a better job or career may become a major source of strain. One of the major drawbacks of working in today's uncertain world is a lack of job security. During economic downturns, people tend to feel more insecure. When an employee is the sole provider for his or her family, the threat of unemployment can be devastating. Promotion or increase in responsibilities at work can also be stressful. Everyone deserves to work at a job that is appropriate for their skill set. Care should be taken to ensure that promotions are tied to demonstrated adaptability and skill. Working as a senior to someone who is just as qualified as you is the most stressful thing that can happen in the workplace.



(b) Relocation: Moving an individual to a new location is known as relocation. When people move, it disrupts their regular lives. Working in an unfamiliar environment with unfamiliar people can be nerve-racking. Anxiety stems from the unknown nature of the new workplace and the prospect of forging new relationships. Family members also have difficulties when a member is transferred. It could be something as simple as getting into a new school or as complex as learning a new language. The pressure to find a new job is magnified if the individual must relocate to do so.

(c) Changes in life structure: Various aspects of an individual's life, such as economic status, cultural heritage, belief system, religious beliefs, racial identity, educational attainment, and societal roles, all contribute to their experiences. Additionally, a person's stress management skills and belief systems significantly influence the importance assigned to each of these factors. When things are routine and unhurried, it's easier to deal with the stresses of life. However, a person with high aspirations and a hectic lifestyle is not equipped to handle pressure.

Prof. Uday Pareek (1993) explored different types of role stressors which directly impacted individual total role stress described below:

#### **1.6.4 Role Set Conflict:**

Different influential people have different standards for the roles that others should fulfil. Role-set conflicts refer to disagreements that develop between partners due to incompatibilities in their expectations of one another. The following are some examples of such conflicts.

#### **Role ambiguity (RA):**

Role ambiguity refers to the struggle an individual experiences when he or she does not fully understand the range of others' expectations for him in a given role. Employees were expected to perform adequately despite a dearth of information (Kahn et al., 1964, p. 73). This could be because the person in the role is operating with insufficient data. It could be related to schedules, roles, priorities, customs, or general expectations. It's something people in transitional, process, or newly created roles in organizations go through.

**Role-expectation conflict (REC):**

Such tension may arise when the person filling a role is subjected to demands and expectations that are at odds with one another. Because of the varied norms, one picks up from associating with people of different ages and backgrounds. Tensions arise when workers' expectations of their roles are at odds with those of their coworkers or superiors (Sinha & Subramanian, 2012, p. 71). The significant others' expectations of the same role may be different, and the person filling that role may feel conflicted about which group to please.

**Role overload (RO):**

Role overload occurs when a person perceives that his role set has too many demands from others. "When a person in one role struggles to meet the requirements of another role, role conflict is the result" (Coverman, 1989, p. 968). Quantitative and qualitative measures of stress have been identified. Both "too much to do" and "too difficult" refer to being overburdened with tasks. Individuals' perceptions of their own ability to complete assigned tasks within a reduced workweek and their concern that their workload may compromise the quality of their work are used to quantify role overload. Overload is a common problem for those in executive positions. Where there is a lack of authority, where there are wide swings in the expected output, and where additional time cannot be acquired through delegation or help, role overload is more likely to occur.

**Role erosion (RE):**

Feeling that one's current role doesn't provide enough challenge or that some of the duties they would like to perform have already been assigned to other people. An employee may feel that he or she has lost control over certain aspects of his or her job because they have been delegated to another employee (Chauhan, 2014, p. 159). This can also occur when the person in the role actually does the work but someone else gets the credit. When an organization redefines its purpose and creates new positions, the old ones often become obsolete. According to research, the strain of role erosion was experienced by many such organizations. In a company, a position was removed, and two new roles were created to address the need for executive and strategic planning. This led to considerable strain and a widespread perception that the new roles were less important than the previous ones.

**Resource inadequacy (RI<sub>n</sub>):**

Lack of information, people, materials, finances, or facilities can prevent the role occupant from effectively carrying out their responsibilities. It happens when people in key positions are unable to do their jobs because they lack the required skills (Chauhan, 2014, p. 160).

**Personal inadequacy (PI):**

This kind of anxiety develops when a person in a position of authority worries that he lacks the expertise and experience to carry out the responsibilities of his position successfully. If the people, places, things, machines, tools, equipment, books, documents, and knowledge (i.e., “human relations, buildings, infrastructure, materials, machines, tools, equipment, books, documents, and information”) needed to carry out one's role are inadequately provided, the individual will feel resource inadequacy (Srivastav, 2006, p. 111). This is seen when companies don't provide their workers with regular training to help them adjust to the constant flux of information and circumstances both inside and outside the company.

**1.6.5 Role Space Conflicts:**

“Role space” describes how a person interacts with himself and the several roles he performs. The three key components are the individual, the current role, and the other roles they assume. When these elements clash, it results in role-space conflict or stress. There are essentially four distinct varieties among these.

**Self-role distance (SRD):**

The pressure builds up when one's role doesn't mesh with who they are as a person (Chauhan, 2014, p. 160). When a person's identity conflicts with the demands of their position, stress of this kind arises. Self-role conflict occurs when an individual's personal beliefs and identity are at odds with the expectations of their job. The fundamental problem here is that the individual is a poor fit for the position he holds.

**Inter-role distance (IRD):**

The potential for friction between a person's various roles, such as manager at work and parent at home (Sinha & Subramanian, 2012, pp. 71-73). Role conflicts in organizations

and outside of organizations. Individuals often play multiple roles, sometimes at odds with one another. Consequently, conflict emerges from the dilemma of balancing work and family obligations, or between one's professional duties and other aspects of life. Inter-role distance refers to the gap or conflict among these different roles.

**Role stagnation (RS):** It occurs when a person feels they are not progressing and that they are destined to always play the same role (Bano et al., 2011, p. 106). The unsatisfying sensation of always playing the same part. A person's status and responsibilities within a company tend to increase as he gets older. The need to assume a new role becomes more pressing as an individual develops because new responsibilities fall under their purview. When under this kind of pressure, you might start to think that advancing in your profession is impossible. When someone has been in a role for a while and then moves into a different role in which they feel less comfortable, they may experience a more pronounced version of this feeling.

**Role isolation (RI):** The lack of coordination and communication between one person's job and other positions in the company has a direct impact on productivity (Bano et al., 2011, p. 107; Srivastav, 2006, p. 111). Disconnect between the respondent's job and other functions within the company. Some roles in a set may feel more familiar to the person playing them, while others may seem very foreign. Interaction frequency and convenience are primary indicators of proximity. A good indicator of the strength of the connections between roles is the frequency and ease of interaction between them.

## 1.7 ACCREDITATION AND ROLE STRESS

Accreditation is a procedure that healthcare organizations, such as hospitals, voluntarily go through to guarantee that they fulfil particular quality and safety criteria established by certifying authorities. Accreditation is a process that has been around for quite some time. Accreditation is meant to encourage excellence in the provision of healthcare; nevertheless, it also has the potential to be a cause of stress for hospitals and the employees working in such facilities. The following is a list of common sources of anxiety linked with accreditation:

1. An increase in the amount of work to be done and the necessity for additional paperwork: Accreditation frequently necessitates the completion of more administrative

chores, documentation, and quality improvement activities. The staff members working in hospitals might have to cope with a rise in the amount of paperwork, data gathering, and reporting responsibilities. The increased workload can contribute to stress, especially if there are already resource restrictions or staffing concerns inside the hospital. This is especially true if the institution is already understaffed.

2. Time constraints and submission deadlines: The processes involved in obtaining accreditation often include deadlines for completing particular activities and submitting relevant paperwork. When trying to achieve these deadlines while concurrently managing their usual obligations, the employees at the hospital may feel as though they are under extra time pressure. The stress that can result from having to find a balance between providing ordinary patient care and tasks associated with maintaining accreditation can potentially have a negative effect on the quality of care that is provided.

3. Standards that can be difficult to understand and are subject to change: Standards for accreditation can be difficult to understand and are prone to change over time. To maintain compliance and stay current with the ever-changing regulations, hospitals need to be informed. When there is a lack of clarity or resources for interpretation and implementation, the ongoing requirement to understand and implement new standards can be burdensome for personnel, especially if there is no clear direction to follow.

4. The fear of non-compliance and the potential repercussions that come with it: Hospitals may experience pressure to acquire and retain accreditation because of the potential consequences that come with non-compliance. Non-compliance can result in reputational harm, financial penalties, or even loss of accreditation, all of which can have a substantial influence on the hospital's operations as well as its status in the community of healthcare providers. Stress and anxiety can be caused among staff members if there is a concern that they will not be able to achieve accreditation standards.

5. A higher level of inspection and review: Accreditation requires an independent examination by surveyors or auditors who examine the facility to determine whether or not it complies with the requirements. This process of examination may be exhaustive and include on-site inspections, interviews, and evaluations of paperwork. Members of employees may experience worry and anxiety regarding their performance as a result of the possibility of being reviewed and scrutinized.

6. Alterations to the hospital's culture and organizational structure Accreditation typically necessitates that hospitals make alterations to their policies, practices, and way of life. These changes have the potential to disrupt established processes and habits, which can lead to resistance and stress among staff employees who may struggle to adapt to the new expectations or needs.

**1.7.1 The following are some of the strategies that hospitals can take to properly handle the stress linked to accreditation:**

- Make available educational resources and training programs: Hospitals should make available educational resources and training programs that are thorough to acquaint employees with accreditation criteria and procedures. This can make comprehension better, it can make anxiety less, and it can make compliance easier.
- Foster a supportive culture: During the process of obtaining accreditation, encourage open communication, collaboration, and support among staff members. In addition, establish a culture of learning, improvement, and shared responsibility to reduce stress and increase participation.
- Ensure that hospitals have sufficient resources, including manpower, technology, and infrastructure, in order to meet the requirements of accreditation. This can be accomplished by appropriately allocating resources. The hardship and anxiety that are connected with activities linked to accreditation can be helped to some extent by appropriately allocating resources.
- Define everyone's part and provide explicit responsibilities: Make sure that all of the staff members at the hospital are aware of their commitments by providing a clear explanation of their roles and responsibilities in relation to the accreditation process at the hospital. This clarity can help lessen the ambiguity and tension that are connected with the tasks involved with accreditation.

Engage staff members in the accreditation process by asking for their feedback, involving them in quality improvement projects, and promoting their active involvement. • Involve staff in the process. Involve staff in the accreditation process by encouraging their active participation. By providing a sense of shared responsibility for satisfying accrediting standards, this involvement has the potential to both build a sense of ownership and relieve stress.

Hospitals can traverse the certification process more efficiently while simultaneously minimizing the negative effects on staff well-being and performance if preemptive measures are taken to alleviate the stressors associated with accreditation and supporting initiatives are put into place.

## **1.7.2 Coping strategies for role stress**

### **1.7.2.1 Organizational level strategies:**

The organization's efforts are crucial to maintaining a stress-free workplace. The organizational structure and policies, and the opportunities for professional and personal growth that a given job may present, both contribute to stress at the organizational level. Considerable thought and analysis must be put into the following before they can be successfully implemented.

(a) Efforts to achieve organizational goals are critical for business success. However, setting unrealistic goals can lead to negative consequences such as undue stress and an unhealthy work environment for employees. Therefore, it is essential to establish achievable objectives that align with the organization's resources and capabilities. This approach can promote a positive work culture and help employees stay motivated to meet the targets. By doing so, organizations can enhance productivity, and performance, and ultimately achieve long-term success.

(b) In order to ensure effective management of human resources and to achieve organizational objectives, it is imperative that organizational policies pertaining to training and development, promotion, leave, wages and salary administration, discipline, incentive, etc., are clearly and comprehensively defined. The formulation of such policies can help to establish a framework that guides the behaviour of employees and management alike, thereby fostering consistency and fairness in the treatment of personnel. Additionally, well-defined policies can provide a basis for measuring and evaluating the performance of employees, facilitating the implementation of effective human resource strategies within the organization. As such, it is recommended that organizations prioritize the development and implementation of robust policies that address the various dimensions of human resource management.

(c) The channels for communication should be established in a way that clearly identifies authority and responsibility. It is important to adhere to the principle of unity of com-

mand.

(d) Effective organizational structure, job redesign, and communication strategies can help to reduce employee stress levels. Studies have shown that a well-designed organizational structure can distribute workload and responsibilities more evenly. Improved communication creates a happy and encouraging work atmosphere, while job redesign gives individuals greater influence over their activities. Prioritizing the implementation of these strategies can promote overall well-being.

(e) The design of corporate policies, along with the layout of the physical workspace, should be thoughtfully developed and organized to foster an environment that significantly enhances employee productivity and engagement. This involves creating policies that support efficient workflow, clear communication, and positive work culture, as well as designing a physical environment that is conducive to focus, collaboration and well-being.

(f) Implementing new systems and processes can enhance operational efficiency and productivity.

(g) Managers must have a comprehensive career plan, implemented effectively, to avoid demoralizing employees with poor developmental interventions. Investing in employee's professional growth and development through training, mentoring, coaching, and networking creates a culture of continuous learning and benefits both individuals and organizations.

(h) Employees must be empowered. They need periodic counselling in the form of sound advice, reassuring words, open lines of communication, the release of pent-up emotions, and the facilitation of clearer thought. To maintain a stress-free workplace and maximize productivity, reorientation is a must.

### **1.7.2.2 Individual-Level Strategies**

Define objective for self: Each individual is responsible for establishing personal goals in relation to their own skill set. It is common knowledge that people aim high, expecting to accomplish much in a relatively brief amount of time. They dampen one's natural aversion to failure. Tensions arise when standards are set too high without first considering available resources. Time is a precious commodity in this uncertain age, and people must



adjust their objectives accordingly.

**Social support:** The importance of having a strong relationship with one's family has been widely recognized in the literature. Such relationships provide a source of emotional support and can be protective against various mental health problems. However, it is also important to consider the role of social support from coworkers in the workplace. Research has shown that having friends at work can increase job satisfaction and reduce stress levels. In a time of trouble, these coworkers can provide a valuable source of support and help to restore one's confidence and sense of self-worth. To increase social support in the workplace, it is recommended that individuals adhere to social functions, norms, and religious activities. Participation in such activities can help to build relationships and foster a sense of community within the workplace. In turn, this can lead to increased social support and a greater sense of belonging. Overall, both family and workplace relationships play a critical role in promoting mental health and well-being.

**Time management:** Time must be managed effectively. Managing one's time is important in many contexts, including but not limited to academics, relationships, and careers. The daily level involves tasks like making a schedule for the day. When more than one task needs to be completed at once, everyone should keep a journal detailing their schedule and progress toward completing the most pressing of these tasks. It's crucial to stick to the timetable and make sure that your subordinates do the same. This reduces stress in the workplace and makes it simpler to separate personal and professional tasks in the office. It makes people more punctual and gives them a stronger sense of loyalty to their employer.

## **1.8 ORGANIZATIONAL STRESS THEORY**

Organizational Stress Theory, also known as the Transactional Model of Stress and Coping, is a psychological framework that explains how workplace conditions and demands can lead to stress among employees. The concept of work environment emphasizes the dynamic interaction between individuals and their work context. It suggests that stress arises when there is a misfit between the demands of the job and the resources available to cope with those demands. This perspective underscores the importance of considering both the external demands of the job and the internal resources of the individual when examining stress in the workplace.

Here are the key components and concepts of Organizational Stress Theory:

1. Stressors: Stressors in the workplace can be anything from heavy workloads and tight deadlines to difficult co-workers or challenging tasks. These factors are perceived as demanding, challenging, or threatening, and can have a significant impact on an individual's well-being and performance. They can be categorized into two types:

a. Organizational stressors: These include factors such as excessive workload, time pressure, role ambiguity, lack of control, interpersonal conflicts, organizational politics, and inadequate resources.

b. Individual stressors: These are characteristics and experiences of individuals that can contribute to stress, such as personal financial problems, family issues, health concerns, and coping abilities.

2. Appraisal: According to the theory, individuals assess and evaluate the significance of stressors in their work environment. Primary appraisal involves the initial assessment of a situation to determine whether it is perceived as a threat or a challenge. This involves evaluating the potential impact of the situation on our well-being and goals. Secondary appraisal comes next, where we assess the resources available to us and evaluate our coping strategies to effectively deal with the stressor. It is about considering what we can do to manage or overcome the situation based on our resources and abilities.

3. Coping: Coping refers to the cognitive and behavioural efforts made by individuals to manage stress. This can include a wide range of strategies such as problem-solving, seeking social support, engaging in physical activity, practising relaxation techniques, and adjusting one's thoughts and emotions. Effective coping skills can help individuals navigate difficult situations and maintain their overall well-being. There are two types of coping strategies:

a. Problem-focused coping: This involves taking actions to address the source of stress directly, such as time management, seeking assistance, or problem-solving.

b. Emotion-focused coping: This involves managing the emotional and psychological response to stress, such as seeking social support, relaxation techniques, or engaging in leisure activities.

4. Outcomes: The theory suggests that the interaction between stressors, appraisal, and coping strategies leads to various outcomes:

- a. Psychological outcomes: These include increased anxiety, depression, job dissatisfaction, and burnout.
  - b. Physiological outcomes: Prolonged stress can lead to physical health problems like cardiovascular issues, weakened immune system, and fatigue.
  - c. Behavioral outcomes: Stress can affect job performance, absenteeism, turnover rates, and interpersonal relationships at work.
5. Individual differences: Organizational Stress Theory acknowledges that individuals may respond differently to stressors based on their personality traits, coping styles, social support networks, and prior experiences.

Promoting employee well-being, work satisfaction, and overall organizational success requires an understanding of and ability to manage organizational stress. By identifying and addressing stressors, providing resources and support, and promoting effective coping strategies, organizations can create healthier work environments that minimize the negative impact of stress on their employees.

Organizational stress can arise from various sources within the work environment. Here are some common types of organizational stress:

1. Workload stress: This type of stress occurs when employees feel overwhelmed or have excessive demands placed upon them in terms of workload, deadlines, or responsibilities. It can result from unrealistic expectations, long working hours, tight schedules, or inadequate resources to complete tasks.
2. Role stress: Role stress is experienced when employees face difficulties in meeting the expectations and demands of their job roles. It can stem from role ambiguity (unclear job expectations or responsibilities), role conflict (conflicting demands from different sources), or role overload (having too many tasks or responsibilities).
3. Interpersonal stress: Interpersonal stress can result from conflicts, poor communication, lack of support, disrespectful behaviour, bullying, or harassment in the workplace with colleagues, supervisors, or subordinates.
4. Organizational change stress: Changes within the organization, such as restructuring, mergers, or downsizing, can cause stress among employees. Uncertainty about job security, altered work processes, or shifts in roles and responsibilities can contribute to this type

of stress.

5. Lack of control stress: When employees sense a lack of control over their work environment or decision-making processes, they may get stressed. Limited autonomy, micromanagement, restrictive protocols, or an absence of participation in making choices can all lead to feelings of powerlessness and stress.

6. Career development stress: Employees may experience stress related to their career progression, such as the lack of opportunities for advancement, limited training or skill development, or unclear career paths within the organization.

7. Work-life balance stress: This type of stress arises when employees struggle to balance their work responsibilities with their personal lives. Long working hours, inflexible schedules, lack of support for family needs, or insufficient time for leisure activities can contribute to work-life balance stress.

8. Ethical dilemmas stress: Ethical dilemmas and conflicts between personal values and organizational expectations can cause stress. Employees may feel pressured to compromise their ethical standards or face moral distress when they witness unethical behaviour in the workplace.

It's important to note that these types of organizational stress can often interact and compound one another, leading to a more significant impact on employees' well-being. Organizations can address these stressors through measures such as promoting work-life balance, providing training and support, improving communication, fostering a positive work culture, and involving employees in decision-making processes.

## **1.9 ORGANIZATIONAL ROLE STRESS AND EMPLOYEE PERFORMANCE**

Stress manifests itself in a variety of forms and is always evolving. Due to its multidimensional nature, stress defies a single, overarching description. The complexity of stress prevents it from being neatly boxed. The concept of stress was conceptualized by psychologists. As time has passed, however, the practice has become widespread in many other types of businesses. Workplace stress can be caused by a variety of circumstances, including rapid technological advancement, spiralling procedures, increasing deadline pressure, and so on. Stress's repercussions have received less attention in management and organizational research. In recent years, companies have spent more time and re-

sources exploring stress and its impact on the workplace.

The body's normal response to pressure from the outside world is stress. It's a mental collapse brought on by the pressures of work. This occurs when expectations placed on workers are unrealistic. A stressor is anything—external or internal—that threatens an organism's equilibrium. It's something that leads to or results in the incongruity between a person and his or her immediate environment. That's how it operates because of the effects of human interaction with the environment. The individual, their internal organs, or their psyche could be subjected to significant effort, pressure, or strain. Each of these descriptions places major emphasis on the dynamic relationship between the stressed individual and his or her environment. The word "stress" is frequently used interchangeably when discussing problems at work.

Some stress can be beneficial. Employees are less productive when they are under undue stress. Stress management is essential for workers who wish to maximize their efficiency on the job. If this organizational objective is to be achieved, then all stressors must be properly identified and measured. In addition, there is no single ideal level of stress for any given workforce. The success of the business depends on the employees' ability to deal with stress. By learning about stress, its causes, its consequences, and how to avoid it, an employee's stress level can be reduced or at least mitigated. It's important to catch signs of stress early on to avoid burnout.

### **1.9.1 Role of employees in the organization**

All potential sources of stress for workers in their roles are referred to as role stressors. A common source of role-related stress in the workplace is an erroneous understanding of management's objectives. Role pressures are associated with social roles, which are defined as social positions within a community that have overlapping but distinct sets of expectations. They consist of three parts: role conflict, role ambiguity, and role overload.

In recent years, role theory has been increasingly useful for describing and explaining workplace stresses. Understanding the importance of the term "role" in understanding the function of employees is critical. The first step in building a bridge between employees and the organization is for employees to understand their role within the greater system of interconnected routines and processes that constitute the company. The role theory is frequently used to investigate and assess how role demands impact occupa-

tional stress. Kahn and his colleagues have done extensive research on the topics of role ambiguity and role conflict, two of the most prominent aspects of organizational roles.

Several studies have shown that role pressure occurs when employees' desires and their employers' expectations don't align. Both role over- and under-load have been recognized as major sources of stress. Definitions of roles in the workplace and among employees are relative rather than absolute. There are less contentious and tense workplaces, and there are also some that have managed to cultivate a more pleasant atmosphere. Human behaviour in the workplace is influenced or guided by several physical, social, and psychological factors. The extent to which workers feel like they belong at their company depends on the specific responsibilities they have been assigned. Using this mechanism, workers are brought into the system and allowed to start interacting with it.

It's useful to view the business as a pyramid of interconnected roles. In contrast, a role is a self-contained structure. Now you know that any sort of organization is just a system of roles or a group of roles interacting with one another. Role dimensions are not identical to positional obligations, or the many tasks associated with any given office. The distinction between work and office is more one of duty than of status or influence. Yet, one's "role," rather than their "office," describes the set of responsibilities that come with holding a certain position of authority. In the course of a normal day, a human being may be called upon to perform any number of roles. Many other types of roles exist, including those based on relationships, gender, age, etc. It's a fact of life that most people have many commitments at once, all of which must be met within a relatively short window of time. With so many responsibilities, employees may worry that they aren't in charge, that they are encroaching on others' turf, that they don't fully understand the nature of the task at hand, and so on. The aforementioned issues all contribute to a phenomenon known as "role stress.

People in roles often experience stress due to job ambiguity and role conflict. Role overload and role under-load have both been highlighted as significant aspects of job stressors. Stress in the workplace has been properly assessed, taking into account the role-set factors that contribute to it. Role ambiguity, role conflict, and role overload were the only other potential elements of job roles employed until U. Pareek's popularization of a theoretical conjecture of organizational role stress.

Many of the causes of stress and job dissatisfaction are external to the individual. The role episode model is a tried-and-true approach to figuring out what makes people anxious at work and what can be done about it.

Workplace stress is commonly brought on by role conflict and ambiguity, according to research by Kahn and colleagues. The third form of role stress is called role overload and occurs when an individual is asked to accomplish more than is feasible in a particular time frame and with the resources at hand. Role stress is made up of three separate organizational factors: role conflict, role ambiguity, and role overload. Some studies have found that role ambiguity and role conflict are major causes of stress and burnout on the job. In addition to these two classic types of stress, research has found that work overload, in both its quantitative and qualitative forms, is associated with a wide range of stress-related physiological, psychological, and behavioural symptoms.

Role stressors have been linked to attrition, burnout, disengagement, and poor performance, among other undesirable results, according to some research. Managers need to keep an eye out for stressors such as workplace conflicts, unclear job descriptions, and too much to do. People encounter role conflict when they try to handle too many obligations at once. Role conflict has been defined in a variety of ways, including "incompatible expectations tied to a position" and "work tasks that conflict with one another.

According to the work of Kahn and coworkers, role conflict occurs when "the presence of two or more roles such that to manage with one makes it impossible to manage with other." They decided on a core set of five functions. Intra-sender conflict, which occurs when the focus individual is expected to perform tasks that are at odds with one another, is the first sort of conflict. For example, a role sender can urge a role incumbent to do something that would be illegal for the sender to do in his or her capacity. Yet, the role sender attempts stringency. The second kind of role conflict, known as "inter-sender conflict," occurs when the expected behaviour of one member of a role set is at odds with the expected behaviour of another member of the role set. Third, there is "inter-role conflict," which occurs when the protagonist is simultaneously cast in roles that are incompatible with one another. Intra-role conflict, also known as person-role conflict, is the fourth type of role conflict that occurs when an individual's values and ethics are at odds with those of their job. Fifth, when the center person is asked to take on too many responsibilities from other members of the role set, a situation known as role overload occurs.

Role uncertainty occurs when individuals lack clarity regarding their respective roles. There is a lack of clarity among employees regarding their functions, duties, and levels of power. There are primarily two types of role confusion that employees may experience. The first concerns the nature of the task and the steps involved, while the second centres on the evaluation of those steps. Lack of regular input from one's line manager is a major contributor to employee stress. Frequent and helpful feedback compels employees to evaluate their performance on the job and make any necessary modifications. Receiving both positive reinforcement and constructive criticism can help employees perform at their best while also lowering their stress levels. Workers who don't get regular feedback are more likely to have serious self-doubts about their performance on the job. Consistent feedback can help managers see things more clearly.

Duplicate tasks are a subtle form of conflict between roles. That's what occurs when employees are assigned more tasks than they can handle. When a person's capacity to fulfil a role is exceeded by the demands placed upon them, this is known as role overload. Both quantitative and qualitative approaches are welcome. The inability to complete a qualitative activity derives from a lack of skill, while the inability to complete a quantitative task results from an overload of work or insufficient time. If an employee, especially a new one, is having problems coordinating their various duties, they may be experiencing role overload. This is a highly significant stress marker.

Organizational role stress pertains to the tension that employees feel due to their job responsibilities and the expectations tied to those roles. This type of stress can greatly affect how well employees perform their duties. Below are some important insights about how organizational role stress influences employee performance:

1. **Reduced job satisfaction:** High levels of role stress can lead to reduced job satisfaction. When employees feel overwhelmed, experience role conflicts or ambiguity, or lack control over their work, they are likely to feel dissatisfied with their jobs. This dissatisfaction can affect their motivation, engagement, and commitment to their work, ultimately impacting their performance.

2. **Decreased productivity:** Organizational role stress can negatively affect employee productivity. When employees face excessive demands, conflicting responsibilities, or unclear expectations, it can impede their ability to effectively manage their workload and perform tasks efficiently. Stress can also lead to difficulties in concentration and deci-



sion-making, further impacting productivity.

3. Increased errors and accidents: Role stress can contribute to increased errors and accidents in the workplace. When employees are under stress, they may experience cognitive impairments, reduced attention, and decreased focus on their tasks. This can lead to mistakes, poor judgment, and accidents that can have serious consequences for both the employee and the organization.

4. Higher absenteeism and turnover: The phenomenon of role stress and its influence on employee absenteeism and turnover has been a topic of research in the field of organizational psychology. It has been observed that when employees experience high levels of stress related to their job roles, their attendance at work may be affected. This is evident in the form of frequent sick leave and absenteeism. High levels of stress can lead to job dissatisfaction and reduced job performance, which in turn can increase the likelihood of employees leaving their jobs. Additionally, if the stress becomes chronic and unaddressed, employees may choose to leave the organization in search of a less stressful work environment. Absenteeism and turnover can disrupt workflow, increase costs, and reduce overall productivity.

5. Negative impact on health and well-being: Persistent role stress can have detrimental effects on employees' physical and mental health. It can contribute to symptoms of burnout, increased anxiety, depression, and other stress-related health issues. These health problems can further hamper employee performance, leading to decreased productivity and increased absenteeism.

### **1.9.2 Effect of stress on performance**

One's position or level in an organization, as well as the functions one performs in response to the expectations of the major members of that system, define that person's role within that system. Before the role's senders communicate their expectations, not even the individual performing the role knows what they are. A human resources manager may be appointed by the company, but the manager's actual duties will depend on the employees' stated and unstated needs. Each system's role is thus defined by its senders, which may include the role occupant. The concept of roles and the two role systems are fraught with stress and tension (role Space and role set).

In conclusion, the role episode model is an effective method for managing pressures arising from one's work. The Role Theory's episode model is regarded as the preeminent approach for elucidating variables associated with role conflict and ambiguity. The measurement of role conflict and ambiguity has captured a global perception of role stress, rendering it a ubiquitous tool for studying role stress variables among employees. Moreover, it serves as a valuable instrument in identifying predictors that contribute to role stress variables.

The European Agency for Safety and Health at Work published a study on workplace stress across the European Union in 2009. Workers in every EU member state take part in the European Agency's survey every fifth year. The purpose of the research is to improve workplace safety policies and practices and to anticipate future risks. According to a survey conducted in 2009, the average workday in the newest EU member states is more than eight hours long, while in the original member states it is less than six. The findings suggest that when time is short, people work harder and feel more pressure to get everything done. Employees in the middle age range reported the highest levels of work-related stress, followed by those in their late twenties and early thirties. It was also discovered that men and women react to stress in various ways, with men being categorized as being under more stress than women. However, stress and anxiety are more prevalent in some fields than others.

According to studies conducted by the European Agency, job-related stress accounts for as much as two-thirds of all work absences. The research shows that dealing with the problem of organizational role stress is vital for preventing wasteful society expenditures due to the significant effects it has on both employees and employers (Kelloway, 2000), avoiding personal interests (Barling et al., 2001; Mantell & Albrecht, 1994), being unhappy in one's current position (Budd et al., 1996; Discroll et al., 1995), and looking for a new position or workplace (LeBlanc & Kelloway, 2002) are all indicators of stress. In conclusion, here are some ways in which stress can disrupt an organization. Critical organizational symptoms include employee discontent, dissatisfaction, and low morale; decreased performance/productivity; lower-quality products or services; strained relationships with customers, suppliers, partners, and regulators; customer loss; negative press; tarnished corporate image and reputation; missed opportunities; interrupted production; increased accident and mistake rates; higher-than-average employee turnover; and a lack

of leadership. As a result, businesses incur additional expenses in the form of stress-related costs, such as those associated with decreased performance/productivity, high replacement costs associated with employee turnover, higher sick pay, health care expenses, disability payments, grievances, litigation, compensation payments, and equipment damage.

The societal expenses must be considered alongside the individual and corporate ones. Studies have shown that traumas, together with long periods of absenteeism from work or early retirement, can have a significant economic impact (Barling, 1996; Chappell and DiMartino, 2000). When examining trauma effects, it is crucial to recognize that both victims and bystanders of violence need treatment for their reactions (Rogers and Kelloway, 1997; Leather et al., 1998). Secondary victimization can occur in the context of social interactions when the victim's loved ones respond poorly to the first trauma by, for example, displaying their own distress, providing insufficient assistance, isolating the victim, etc. (Montada, 1988).

### **1.9.3 Organizations can take several measures to mitigate the negative impact of organizational role stress on employee performance:**

- Provide clear job descriptions and expectations to reduce role ambiguity.
- Foster a supportive and inclusive work environment that encourages open communication and collaboration.
- Offer training and development opportunities to enhance employees' skills and confidence in performing their roles.
- Implement strategies to promote work-life balance and flexibility, allowing employees to manage their personal and professional responsibilities effectively.
- Encourage employee involvement in decision-making processes to enhance autonomy and control over their work.
- Provide resources and support systems, such as employee assistance programs or stress management workshops, to help employees cope with and manage role stress effectively.

By addressing organizational role stress and supporting employee well-being, organizations can create a healthier work environment that promotes employee performance, job satisfaction, and overall organizational success.

## **CHAPTER 2**

### **REVIEW OF LITERATURE**

The literature review serves as a crucial tool for scholars to investigate and analyze the available information in their respective research domains. It facilitates a comprehensive understanding of the prior research conducted in the area under investigation, highlights gaps and inconsistencies in the existing studies, and identifies unresolved questions and future research possibilities. Furthermore, a thorough review of the literature provides guidance to researchers to contribute more significantly to the existing corpus of knowledge and expand the scope of research in their respective fields.

#### **2.1 STUDIES RELATED TO HEALTHCARE ACCREDITATION**

Shaw (2006) Accreditation, is “a public recognition by a national healthcare accreditation body of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization’s level of performance concerning the standards”.

Hongfan Zhang S.-T. H.-C. (2024) study sought to determine if employees of re-accredited hospitals perceived a greater advantage and were more inclined to suggest the Joint Commission International accreditation program to other hospitals compared to employees from hospitals that had previously held accreditation but no longer do. This particular study undertakes five private hospitals in China and was a prospective cross-sectional comparative study. An electronic-based survey questionnaires were sent to the respondents. Results exhibit that perceptions of hospital employees regarding the JCI accreditation were positive. Re-accredited employees were in favour of recommending JCI to other hospitals as compared to their counterparts. Additionally, re-accredited employees perceived that the successful application of JCI standards requires the active engagement of employees. Healthcare leaders who are contemplating obtaining or reapplying for JCI certification can gain useful insights by understanding the perceived advantages and obstacles of their workforce.

Ahmed (2024) The research assesses how healthcare professionals at Johns Hopkins Aramco Healthcare (JHAH) view the accreditation process and its effect on the quality of

healthcare and patient safety. The researcher used a cross-sectional quantitative survey technique to collect data from the respondents. A total of 2047 respondents fill the online questionnaire which contributes 51% of the total available staff of JHAH. Study results demonstrated that hospital employees show positive experience towards healthcare accreditation which leads to enhanced quality of care and promotes safety culture within the organization. The research also backs the idea of making accreditation a basic necessity for enhancing the processes of the healthcare system. However, it is crucial to maintain the quality of service consistently throughout accreditation periods.

HongFan Zhang (2023) study aimed to explore the perspectives of healthcare leaders regarding the Joint Commission International accreditation program in China. By examining their views, the research seeks to gain a deeper understanding of how these leaders perceive the impact and effectiveness of the accreditation process within the healthcare system. In this particular study, researchers used qualitative survey techniques and gathered the data by interviewing the healthcare professionals working in top positions in various departments like operation, quality and medical in five hospitals in China which were accredited by Joint Commission International. A total of fifteen healthcare professionals were interviewed to gather the qualitative data. From the data analysis, mainly three themes were identified as motivations, challenges and benefits associated with the implementation and carrying forward the JCI accreditation program. Results revealed that leaders were driven by the goal of enhancing care quality and patient safety. They faced obstacles such as grasping accreditation program standards and altering staff behaviours. However, the perks included better leadership, a stronger safety culture, and an enhanced hospital reputation.

Hongfan Zhang (2023) researchers conducted a study to investigate how the Joint Commission International accreditation program impacts the performance of private hospitals in China. Using a multiple-group interrupted time series analysis (ITSA), they compared eight different performance measures between two hospitals over a period of eight years. The metrics included clinical quality indicators such as the hysterotomy rate, episiotomy rate, incidence of LGA, and premature birth rate. For operational performance, they looked at the number of outpatient visits and deliveries, while total revenue and EBITDA were used to assess financial performance. The findings indicated that accreditation had a significant effect on the hysterotomy, number of deliveries, outpatient

visits, episiotomy rate, incidence of LGA, and premature birth rate. However, there was no significant link between accreditation and EBITDA.

Ali Al Mansour (2022) study aimed to explore the perceptions of managerial and front-line staff in Saudi Arabian Joint Commission International accredited hospitals regarding the accreditation process and its impact on patient care quality. Researchers used semi-structured interview methods to collect the data from managerial and front-line staff working in the three public JCI-accredited hospitals. Further, researchers used thematic analysis to identify key themes associated with the accreditation process. A total of twenty managers participated in the interviews and it was found that the managers and front-line staff expressed optimism regarding the reasons for change and the preparation for accreditation. However, they encountered significant challenges when it came to carrying out and sustaining the changes following JCI accreditation. Additionally, they found it tough to bring about cultural change and uphold performance levels. Sustaining these enhancements necessitates continuous dedication, allocation of resources, and a shift in organizational culture, even though accreditation can enhance patient safety and the quality of care.

Salhah Taresh Ahmed Ali AI Seraidi (2021) research focused on understanding the perceptions of nurses employed in primary healthcare centres located in Ras Al Khaimah, UAE, regarding the influence of healthcare accreditation on the overall quality of care provided. To achieve this, the researchers adopted a cross-sectional quantitative methodology, distributing a self-administered questionnaire to collect data from a sample of 130 nurses across eight accredited primary healthcare facilities in the UAE. The results highlighted a noteworthy correlation between the nurse's views on the implementation of accreditation and their educational qualifications as well as their professional designations. This suggests that a nurse's background may significantly shape their perspective on the effects of accreditation in enhancing care quality. Nurses with lower educational levels revealed a higher perception level. Additionally, nurses believe that while accreditation enhances the level of quality of patient care, consistent efforts and awareness are essential to uphold these quality standards.

Abdullah Algunmeeyn (2020) The purpose of this research was to learn about the positive effects that an accrediting program would have on Jordanian hospitals from the viewpoint of medical professionals. This project took a qualitative approach. Hence, 10

nurses across all levels and 10 doctors across all specialities at two Jordanian hospitals were interviewed face-to-face (one private and one public). The hospitals in the study found that accreditation had four main benefits: higher quality care, happier patients, safer patients, lower costs, and a better reputation. The results indicate that while professionals seem to view certification favourably, their views are based on a substantial body of data and are reinforced by studies or monitoring programs that use evidence to determine and quantify the specific benefits of accreditation in terms of quality.

Bevan et al., (2019) posited that due to the financial constraints faced by governments in addressing healthcare needs, external certification has become a crucial tool for improving the performance of healthcare systems. In complex systems such as hospitals, accreditation systems have been shown to drive innovation and improvement. The study highlights the significance of external certification as a means of enhancing the quality and quantity of available healthcare resources.

Greenfield et al., (2019) concluded that accreditation systems have become commonplace in the healthcare industry, demonstrating the need for independent verification of quality. Self-evaluation, evaluation, communication, and change recommendations are all a part of the hospital accreditation process, which is a management control instrument centred on efficiency and effectiveness. The creation of reports that are the focus of inspections, the application of standards, and the determination of the appropriate course of action based on compliance and exception reports are just a few of the elements that are reconstructed in the context of healthcare accreditation.

Amir Ali Ghazanfari (2019) found that the employee satisfaction level was found to be moderate in the context of the accreditation program. However, it is imperative to note that altering the attitude and culture of the organization, coupled with the selection of a suitable accreditation model, is a prerequisite for the successful implementation of any program. Furthermore, it is essential to underscore the significance of program requirements to enhance the quality of healthcare services.

J.A. Carrasco-Peralta (2019) analyzed the role of accreditation in healthcare organizations and analyzed it from the perspective of healthcare professionals. The study revealed that the accreditation role has a positive impact on fostering organizational change, which indicates that it may lead to improvements in the overall functioning of healthcare organizations. However, the study also found that the evidence for clinical outcomes resulting



from accreditation is weak, which suggests that more research is needed in this area to determine the true impact of accreditation on clinical outcomes.

A.Nicolaisen (2018) investigated that DDKM mainly focused on unnecessary documentation and lengthy registration processes rather than focusing on the quality of care. Further, a significant difference between the management level and middle-level managers has a negative perception of DDKM regarding the time spent on registration and documentation.

Alia Ghareeb (2018) the research examined the changes that occurred following the implementation of accreditation Canada internationals accreditation program in a primary healthcare organization in Qatar. It focused on how this accreditation promoted organizational changes by encouraging both learning and quality improvement initiatives. Using a quantitative approach, the study collected data from 500 employees through a structured questionnaire and analysed it with the help of the Spearman correlation coefficient. The results indicated that employees recognized a positive influence from the accreditation process. There was a notable positive relationship between staff perceptions of accreditation and the quality of care delivered. The primary healthcare corporation exhibited two main organizational cultures as group and hierarchical. Additionally, there was a positive correlation between staff views on accreditation and their culture type when identified as a group. This study provides important insights into the changes organizations may undergo in the context of quality enhancement and organizational learning.

Lars Holger Ehlers (2017) studied the attitude of hospital employees in Denmark toward healthcare accreditation. The study found that while physicians were generally sceptical about the accreditation process and its benefits, other healthcare professionals were more positive and supportive. This highlights the need for further exploration and understanding of the differing attitudes toward accreditation within the healthcare industry.

Hussein Algahtani (2017) employed a cross-sectional survey approach to gauge medical staff opinions on how accreditation from Joint Commission International has influenced their ability to provide high-quality care to patients. The study found that accreditation had a beneficial effect on the pace and success of organizational transformation among hospital staff. Accreditation also aids in expanding health care offerings to patients.

Marie-Pascale Pomey (2010) used embedded multiple case study designs to investigate how accreditation facilitates the implementation of changes to improve the quality and safety of care in five Canadian healthcare organizations; found accreditation to be an extremely useful tool for fostering teamwork among recently merged HCOs; facilitating the implementation of continuous quality improvement programs within both accredited and unaccredited organizations; and introducing fresh management to drive quality advancements.

Jeffrey Braithwaite (2010) Employing a blinded independent assessment design, looked at the relationship between accreditation performance, organizational culture, and leadership, as well as self-reported clinical performance and independent ratings of four characteristics of organizational performance. Another analysis revealed no statistically significant correlation between business culture and customer participation in accreditation decision-making. The research findings indicate that accreditation performance is an accurate representation of contextual organizational characteristics that are crucial for either supporting or impeding continual clinical improvement and quality of care. This is particularly valid for organizations with a strong positive culture and track record of leadership.

Jaafaripooyan (2014) research study to find out the potential advantages and disadvantages of the external healthcare performance evaluation program and identified some of the advantages as increased attractiveness of consumers towards healthcare organizations due to high accreditation ranking and increased morale and confidence of employees. Disadvantages include an increase in workload, excessive cost, dependence upon the judgment of an external assessor, and routinization.

Joao Lucas Campos de Oliveira (2017) concluded that healthcare managers and workers perceived accreditation as a catalyst for comprehensive and favourable management reforms in healthcare organizations. The study results revealed that the accreditation process instigated successful modifications in multiple aspects of management practices in the studied hospitals, including but not limited to, standardization and streamlining of the care process, augmentation of physical infrastructure, enhancement of hospital cost management, strategic market positioning, and employee empowerment in decision making. These findings suggest that accreditation serves as a valuable tool for healthcare organizations to achieve better management practices and improve overall quality of care.

David Greenfield (2011) assessed that the motivation that drives staff to participate in their organizational accreditation activities and the benefits that they gain from this participation can be attributed to positive self-reinforcement. In this study, researchers identified three different categories related to accreditation activities i.e. accreditation response, survey issue, and documentation issue. Engaging in the accreditation process fosters a culture of quality and safety within the organization. Employees are motivated to collaborate with their colleagues, seeking opportunities to learn and validate their efforts. Gloria KB Ng (2013) performed a thorough analysis of the literature to determine the variables influencing the implementation of accrediting programs and how this procedure affects hospital quality improvement. Through a SWOT analysis design, 26 studies were selected after critically appraising 348 citations. The researchers noted that although there is not much empirical data to support the efficacy of accreditation programs, they can nevertheless have a positive impact on organizational culture, foster leadership development, improve staff engagement and communication, and raise awareness of continuous quality improvement (CQI). Weaknesses such as organizational resistance to change, increased workload on staff, inadequate staff training, lack of knowledge of CQI, and lack of performance outcome measures were also identified. Opportunities arising from accreditation programs included identifying areas that require improvement, enhancing patient safety, and gaining public recognition. Lastly, the researchers noted potential dangers such as a lack of financing, opportunistic behaviour, and a lack of incentives for involvement.

## **2.2 STUDIES RELATED TO ACCREDITATION AND STRESS**

Geraldine Robbins (2021) This study examines the relationship between the visibility of internal conflicts and management perceptions of the hospital accreditation system, which is an externally imposed management control system (MCS). To get the required data, a sizable public hospital in Spain was utilized as a case study. Twenty-seven upper- and lower-level managers from a variety of departments were interviewed extensively. Tensions are unpacked and analyzed with the use of the literature's organizational dualities classification. Using an explanation of the organizational dualities of learning, performance, organization, and membership, this article shows how hospital accreditation raises the visibility of these conflicts. The management's conflicted feelings about the hospital's accrediting method were glaring.

Feng et al., (2016) explored the relationship between accreditation and organizational reputation. The authors argued that accreditation is a significant factor in determining how the public perceives an organization's commitment to sound management practices. The study also examined the denied or revoked accreditation on an organization's reputation and bottom line. By analyzing data from various sources, including interviews with industry experts and case studies of organizations that have undergone the accreditation process, the authors were able to provide valuable insights into the importance of accreditation for organizations. Overall, this study offers valuable information for managers and executives who are interested in maintaining their organization's reputation and credibility.

Ibrahim Al-Faouri (2018) concluded that accreditation survey visits in healthcare settings lead to a significant increase in the stress level of healthcare professionals, both before and after the survey visit. The study further demonstrated that public hospitals experience significantly more stress in comparison to private hospitals. These results are essential for grasping how accreditation survey visits affect healthcare professionals and highlight the need to create strategies to reduce the adverse impacts of the survey process.

Omid Rezaei (2018) studied 200 nurses (male & female) in Razi Psychiatric hospital to examine the conditions and factors that cause job burnout among nurses and found that nurses felt more emotional exhaustion than those who did not have a formal job. Researchers also found that there was no significant relationship between job burnout and demographic variables like age, working experiences, nursing skills, weekly working hours, and management experience. Further, sex was significantly associated with low personnel accomplishment.

Kim (2015) identified a positive association between turnover intention and job stress after surveying 230 nurses at a single general hospital about their experiences with healthcare accreditation and stress on the job. Healthcare certification was found to have a detrimental effect on turnover intent. Nurses' perceptions of healthcare accreditation were also found to be a significant predictor of their propensity to leave their current position.

Yang (2014) This study, conducted with 220 nurses as a sample from one hospital, sought to evaluate how nurses perceive their roles, their performance, as well as the levels of job stress and burnout, in connection with the hospital receiving the Joint Commis-

sion Internationals gold seal of approval. A negative relationship was identified between burnout and perception of nursing performance, while a positive relationship was found between burnout and job stress.

Gary Elkins (2010) examined the effects of perceived stress on nurses and administration staff related to healthcare accreditation by the Joint Commission in large healthcare organizations before and after a survey. Data were collected from 100 employees of one hospital. Researchers found that the amount of stress was significant four weeks prior to the accreditation visit. Furthermore, results indicate a decrease in stress after the visit as well as a decrease in job satisfaction. The study also suggests the elevated level of stress may be significantly related to symptoms of depression and anxiety, increased psychosomatic health problems, interpersonal relationships, and decreased job satisfaction.

Shu-Fen Su (2008) conducted research to investigate the nurse's stress experiences of working under the current healthcare system in Taiwan by using a qualitative approach. The data was collected from 28 critical care staff nurses from seven hospitals. Study results corroborate that changes in healthcare policies and cultural issues are the key elements that create environmental pressure on nurses' working environment which will lead to high occupational stress. Further, the implementation of the National Health Scheme and Healthcare Accreditation adversely affects the healthcare working environment increasing occupational stress, intention to stay at work, and psychological distress. Researchers also found that nurses confronted high expectations from their society, seniors, patients, and doctors which consequences in significant role overload and conflicts resulting in a high level of role stress.

Esther Chang (2003) explored the association linking role stress and work satisfaction after two and a half months and eleven and a half months of employment among new graduate nurses who had experienced role stress and role ambiguity. After a duration of 10 months, role overload was identified as the predominant factor explaining the variances in role stress scores. In contrast, role ambiguity was recognised as the most significant contributor to role stress in the early months of the study. In the first survey, a negative association was identified between job satisfaction, role ambiguity, and role stress; in the second survey, this negative correlation remained for role ambiguity but was absent for role overload.

Alain Verstraete (1998) the preference of medical technologists towards working in an accredited laboratory was investigated. It was found that while some technologists believed that accreditation improved the traceability of work and could help them identify the cause of errors, most participants perceived it as an increase in workload. However, a small minority from lab 1 and lab 2 believed that accreditation had improved the quality of results. Technologists perceived accreditation as increasing paperwork, decreasing adaptability, and focusing primarily on processes rather than quality. These findings suggest that while accreditation may have some benefits, it is important to consider the potential challenges it poses to the day-to-day work of medical technologists.

Priscilla Higashi (2013) study on the evaluation of perceived stress working in hospitals with or without accreditation involved 262 staff nurses. The study found that nurses working in accredited hospitals perceived greater stress levels compared to those working in non-accredited hospitals. Moreover, nurses working in accredited hospitals reported higher levels of stress in situations related to interpersonal relationships. This research highlights the need for hospitals to address the impact of accreditation on the well-being of their staff, particularly in the domain of interpersonal relationships.

### **2.3 STUDIES RELATED TO ACCREDITATION AND EMPLOYEE PERFORMANCE**

Mohammed Hussein (2021) Accreditation in the healthcare industry is widely accepted as a trustworthy way to gauge and improve service quality. Its impact on efficiency and productivity, however, is still up for debate. The objective of this investigation was to gather and examine data concerning the results of hospital accreditation. Study findings show that accredited hospitals have a consistently positive impact on several areas of hospital performance. Specifically, studies have found that accreditation leads to improvements in safety culture, process-related performance measures, efficiency, and patient length of stay. Nonetheless, it seems that hospital accreditation does not affect a few key performance metrics, including the 30-day hospital readmission rate, personnel happiness, and patient satisfaction and experience. The conflicting results made it challenging to conclude how accreditation affected the death rate and diseases linked to healthcare. There is solid evidence to support the assumption that adhering to accrediting requirements improves performance in hospitals in several tenable ways. Despite conflicting evidence about causality, hospital accreditation programs promote performance

enhancement and patient safety. To institutionalize the process and ensure that performance improvements are maintained over time, it is advised that accreditation be incentivized and brought up to date.

Joao Lucas Campos de Oliveira (2019) analyzed the effect of accreditation on the professional satisfaction of nurses by using polycentric, cross-sectional, mixed-method research. The data was collected from 226 respondents of three different hospitals from which one is an accredited private hospital, the second one is private but not accredited and the third one was a non-accredited public hospital. Study results revealed that accreditation positively impacted the professional satisfaction of nursing workers as a significant association was found between the three hospitals.

Nadia Raquel Suzini Camillo (2016) examined the interdisciplinary team's opinions about accreditation at a public hospital. A multidisciplinary team made up of nurses, pharmacists, quality managers, psychologists, safety technicians, and one leader from the hygiene and cleaning services provided the qualitative data that was gathered from the 28 respondents. Results indicated that participants perceived accreditation as a congruent system to improve the quality of health services in the public healthcare system as it helps to develop professional skills, organization structure, job satisfaction, cost management, and appreciation among employees. Respondents also compare the services of an accredited public hospital to a private hospital and also feel pride to be a part of a public hospital and feel honoured to grow with it.

Joao Lucas Campos de Oliveira L. M., (2016) attempted to examine the perception of hospital quality managers about the benefits and difficulties that arise from accreditation and found that accreditation helps to improve management, centralization of work, and safety of users which helps to deliver the quality of care but on the negative side of the accreditation, it is very difficult to develop positive organizational culture towards quality and reduction in the turnover ratio of hospital staff.

M.S.Vinsi (2015) evaluate the knowledge & attitude of staff nurses working in Bombay Hospital, Indore, India towards the NABH accreditation program. The findings indicated that all the respondents exhibited good knowledge but held negative attitudes towards the NABH accreditation. Furthermore, the study results unveiled a significant partial negative correlation between knowledge and attitude among staff nurses concerning the NABH accreditation program.

Sivasankar (2013) investigated how staff members at K.G. Hospital in Coimbatore felt about the adoption of NABH quality management systems. The data was collected from three different professionals with different roles and responsibilities which includes doctors, nurses, and paramedical staff. The study's findings indicated that worker's attitudes about the NABH quality management system's implementation are generally good. Furthermore, it has been observed that the majority of respondents were in favour of having a separate quality department in the hospital to effectively carry out all activities of the NABH quality management system.

H Dargahi (2007) employed a cross-sectional, descriptive research study to ascertain the knowledge, attitude, and performance of the staff regarding the implementation of the quality assurance system and its indicators in the clinical laboratories of TUMS Hospital. The study discovered that the level of quality assurance and its indicators significantly increased with the increased level of academic education among the staff.

Ch. Platis (2015) analyzed the relationship between job satisfaction and job performance in healthcare services. The data was collected from the 246 staff nurses to investigate the relationship between selected variables. Study results showed that satisfaction from manager administration and job productivity as important factors for job satisfaction and a moderate correlation between them. For job performance, job quality and job personality are identified as important factors and strong correlation between them.

## **2.4 STUDIES RELATED TO ORGANIZATIONAL ROLE STRESS AND EMPLOYEE PERFORMANCE**

Panpan Zhang (2024) the research investigated how role stress affects work engagement among speciality nurses in China. The study utilized a descriptive, cross-sectional quantitative approach and employed a self-structured questionnaire, which was distributed online to 972 speciality nurses at Henan Provincial Peoples Hospital. The findings revealed a negative correlation between role stress and work engagement scores. Regression analysis showed that factors such as age, professional title, and role stress explained 14.6% of the variance in work engagement. Additionally, it was found that role stress had a significant and negative impact on the nurse's work engagement, highlighting its importance as a predictor. The findings suggest that lower work engagement among employees leads to decreased performance levels.



Ismayanti Adytia (2024) study aimed to investigate the impact of recession issues on role stress and employee performance. The respondents consist of employees working in finance companies, particularly in the used car financing sector. The research revealed that job stress adversely affects job performance, even though the recession positively influenced job stress levels. Key stressors identified were role conflict, role ambiguity, and role overload.

Gunhild Bjaalid et.al (2020) found that hospital workers without managerial duties were more likely to suffer unfavourable effects from institutional stress. In the group of employees without managerial duties, the association between institutional stress and job performance was somewhat moderated by competence growth, motivational resource autonomy, and social support. There was a full mediation between institutional stress and performance on the job and the leadership group's access to motivating materials. Leaders' social support showed a small but non-significant effect on employee productivity across all categories.

Ramli (2018) study findings showed that job stress significantly and negatively affects employee performance and organizational commitment, meaning that stressed-out workers are less likely to be committed to their employers and their organizations. Moreover, a strong sense of organizational commitment among employees tends to be linked to higher levels of performance. When team members feel dedicated to their organization, they are more likely to exhibit greater motivation and productivity in their work.

Monika Mittal (2018) investigated how married working women's job stress, job happiness, and job performance were affected by role overload. The study found that role overload negatively affects job satisfaction but positively affects job performance and job stress. The Study recommends that employers recognize and reduce role overload for married working women to improve their job satisfaction while providing support to help them cope with job stress, ultimately enhancing their job performance.

Revenio Jalagat (2017) found a substantial link between stress in the workplace and job performance. Furthermore, position ambiguity has no significant association with employee performance, while work overload and underutilization of talents have substantial relationships. It can be posited that job stress exhibits a noteworthy impact on job performance. Specifically, an increase in job stress is likely to result in a decrease in the performance of the employees, or conversely, a decrease in job stress may positively influ-

ence job performance (Ankita Chaturvedi, 2017).

Vijayan (2017) revealed a substantial influence on employee performance when characteristics linked to workplace stress, such as workload, job security, and work shift, were examined. Further, workload contributes more to employee performance than other factors. Moreover, selected variables are significantly interrelated with each other and have a great impact on the dependent variable.

Kanayo (2016) study results revealed the significant negative impact of role overload, role ambiguity, and self-esteem on employees' job performance working in technical colleges.

Moaz Nagib Gharib et al. (2016) examined the impact of work overload, role ambiguity, and role conflict on the job performance of academic staff and concluded that role ambiguity does not significantly impact job performance while the workload has a positive and role conflict has a negative impact on job performance.

Warraich Usman Ali (2014) conducted a study examining the effects of job stress on employee performance in the higher education sector. The study results revealed that employees experienced stress as a result of various factors, including role conflict, workload, and inadequate monetary reward. These stressors, in turn, led to a reduction in job performance. Results revealed that addressing job stressors is critical to promoting optimal employee performance and productivity. Therefore, organizations need to identify and mitigate sources of job stress to maximize employee potential and ensure organizational success.

Roohangiz Karimi et.al (2014) study results revealed a significant and positive linear relationship between role overload, role ambiguity, role conflict, and occupational stress. Among all the predictors, role conflict emerged as the strongest predictor of occupational stress. These findings suggest that managing role conflict in the workplace could potentially reduce occupational stress levels among employees. Overall, this study highlights the importance of understanding the factors that contribute to occupational stress and the need for interventions aimed at reducing its impact on employee well-being.

Nasrin Arshadi (2013) examined the relationship between job stress, job performance, turnover intention, and organizational-based self-esteem. The study's findings indicated a positive link between turnover intention and job-related stress, while also revealing that job stress negatively impacts job performance. Additionally, the results suggested that

organizational-based self-esteem influenced the relationship between job performance and job stress. These results have important implications for organizations and managers, highlighting the need for interventions to reduce job stress and turnover intention, and to promote positive self-esteem among employees.

Osman M. Karatepe (2008) study demonstrated that job performance is decreased with role ambiguity whereas role conflict escalates job performance. Further results revealed that job conflict and role ambiguity worsen depersonalization and emotional exhaustion. However, role ambiguity had a significant positive relationship with diminished personal accomplishments while role conflict was not.

Rose C. Nabirye (2011) conducted a study in one public and three private (not-for-profit) hospitals in Uganda to analyze occupational stress, job performance, and job satisfaction among nurses and found a significant difference in all three variables under study. Nurses with more than 20 years of experience have more stress. Nurses with lower qualifications experience higher job satisfaction than counterparts with higher qualifications. Further, Nurses having more experience show less job satisfaction.

Laiba Dar (2011) found a negative correlation between employee job performance and job stress, indicating that employee job performance is severely lowered by job stress. In addition, the study's findings clarified why men respondents experience significantly higher levels of stress than their female counterparts.

Gayathri Band (2016) found that all elements of organizational role stress except role overload, role isolation, and self-role distance significantly influenced the stress level of IT employees. Role stagnation, in which workers don't advance and feel stuck in their day-to-day responsibilities, is another major stressor.

Rajesh Kumar (2015) studied the association between organizational role stress and job satisfaction among the nursing staff at Sri Guru Ram Das Institute of Medical Science and Research Center in Amritsar, Punjab, and found that the vast majority of nurses had mixed feelings about their jobs. The findings of this study showed a statistically significant inverse association between stress resulting from one's organizational function and job satisfaction. A notable connection was identified within the different domains of organizational role stress and job satisfaction, although self-role distance, role overload, and role stagnation did not show any significant relationship with job satisfaction.

Ashfaq Ahmed (2013) found Job stress has having negative correlation with job perfor-

mance which means, that a little increase in job stress significantly decreases job performance.

Rajnish Ratna (2013) investigated the stress experienced by IT workers to identify the most significant contributors to that stress, as well as any disparities by gender, age, or years in the industry, and found that they are all significantly connected with one another. The study also indicated that male workers experience more stress than female workers and that the amount of correlation was highest for the component role stagnation. There is a correlation between age and length of service and stress levels. Researchers also discovered that stress leads to lower output and higher turnover.

Bushara Bano (2012) aimed to look into the variations in work-related stress experienced by workers in the public and private sectors. The study also attempted to investigate the impact of demographic factors on stress levels. The findings showed that employees in the public and private sectors both endure moderate levels of stress and that there was no discernible difference in either sector's employee stress levels. Additionally, the study discovered that the amount of stress that workers in both industries face is influenced by their educational background and job experience. In summary, this study offers significant new information about the elements that influence stress at work among workers in both the public and private sectors.

Vinita Sinha (2012) found that lower-level managers experienced a significant amount of organizational role stress caused by the expectations placed upon them by their superiors and colleagues. This stress was a direct result of the high output expectations that were placed on these managers, leading to a greater level of stress for those in lower-level positions. These findings highlight the need for organizations to provide support and resources to help lower-level managers cope with the challenges they face in their roles.

Pathak (2012) studied the link between ORS and work satisfaction and the effect that perceived organizational support had on that relationship. Job satisfaction and organizational role stress were shown to be significantly correlated negatively in the study. The findings also revealed that organizational support moderates the relationship between job satisfaction and ORS. This suggests that reducing organizational stress, thereby enhancing job satisfaction, is largely contingent upon organizational support. Furthermore, the study identified role ambiguity as having the strongest correlation with job satisfaction. These results underscore the critical role of organizational support and clear role expecta-

tions in sustaining employee satisfaction within the workplace.

Sabir (2014) By exploring the role of mediating between these two variables researchers discovered a significant positive relationship among workplace stress and job satisfaction. Positive correlations between job stress and false calls and job satisfaction were also found. However, low wages, extended hours, and stress on the job all contribute to a decline in employee satisfaction.

Shilpa Sankpal et al. (2010) revealed that public and private bank employees experience differing levels of organizational role stress. Research findings indicate that employees working in private banks tend to experience greater levels of organizational role stress compared to those in public banking institutions. Notably, the study identified that specific stressors-such as feeling isolated in their roles, personal feelings of inadequacy, conflicts arising from differing role expectations, and uncertainties surrounding their job responsibilities did not have a significant effect on either group of bank employees. These findings shed light on the unique stressors faced by employees in the private banking sector and highlight the importance of addressing organizational role stress in this context.

Simona Gilboa et al. (2008) concluded that factors of situational constraints and role ambiguity have an adverse impact on job performance. Furthermore, Moderation analysis shows that role overload tends to have a more pronounced negative effect on the job performance of managers as compared to their non-managerial counterparts.

Tankha (2006) examined the role stress between the government and private hospital nurses and found that nurses working in private hospitals experience a greater level of role stress than in government hospitals against eight dimensions out of ten. Furthermore, Male nurses observe more levels of role stress than female nurses.

## **2.5 STUDIES RELATED TO ACCREDITATION AND PATIENT SATISFACTION**

Sindhu Joseph (2020) Many public hospitals in Kerala, which are required to meet certain standards set by the government, have successfully completed accreditation programs at both the national (NABH) and state (KASH) levels. This study analyzed the quality of public healthcare services delivered by both accredited and non-accredited healthcare facilities. It also examined the effects of national and state-level accreditation programs on the public healthcare landscape in Kerala, highlighting how these programs influence ser-

vice quality and access to care. KASH-accredited hospitals had a higher mean score on six measures of healthcare quality than NABH-accredited hospitals. Patient satisfaction was found to be unaffected by certification type, even though the accrediting process did improve several aspects of healthcare quality.

Ellie Bostwick (2019) studied the standard of care and the level of contentment of hospital patients are both projected to rise as a result of accreditation. However, there is a dearth of inconsistent research that demonstrates its impact on patient outcomes, namely patient experience. Recently, Hong Kong and the Australian Council on Healthcare Standards launched a pilot project to evaluate a certification system for hospitals in the public and private sectors. Despite previous research showing that hospital certification does not improve patient outcomes, this study reveals that the accreditation process itself can improve the patient experience. Accreditation is also linked to quality improvement activities, which may help solve patient concerns in Hong Kong, such as patient engagement and clinicians' emotional support.

Joseph (2018) examined the impact of accreditation on patient satisfaction in public healthcare delivery settings and found no significant impact of accreditation on accredited as well as non-accredited hospitals and both hospitals gave similar scores for the variables of satisfaction. Further, patient satisfaction is significantly correlated with the physical facility in the case of the accredited hospital only.

Mohebbifar R (2017) The MOHME accreditation categorization results were used to evaluate the correlation between patient satisfaction and hospital accreditation in seven hospitals in the province of Hamadan, located in western Iran. Except for the areas of emotional support and patient values, the study found a substantial negative relationship between patient satisfaction and accreditation score. Patients were more satisfied with healthcare facilities that had poor accreditation rankings. Longer hospital stays, poorer human resource conditions, older medical technology and infrastructure, less care coordination and communication, and different hospital types all contributed to lower satisfaction ratings.

Wissam Haj-Ali (2014) A cross-sectional study carried out in six hospitals in Lebanon found that most patients were unhappy with the quality of services being provided. The study used the SERVQUAL tool to evaluate how the national accreditation system affected patient satisfaction. The study's findings confirm that no correlation was found be-

tween accreditation and patients' overall happiness. Financial expense paid by an organization to achieve certification can be justified, at least in part, because of tangible characteristics of physical structure and equipment were connected with patient satisfaction.

Helen (2014) The expansion of accrediting programs in low- and middle-income countries (LMICs) exemplifies novel approaches to leadership, governance, and mission that could be replicated elsewhere. Some LMIC accreditation schemes share certain similarities with their developed-world counterparts, such as a reliance on written criteria and a review by independent surveyors, but they also have significant differences. They are particularly concerned with bolstering the least capable healthcare facilities while also enhancing healthcare across the country. Accreditation efforts in the industrialized world, where standards are high and evaluation criteria are onerous, tend to concentrate on finding the finest institutions.

C.Sack (2011) evaluated the connection between accreditation and patient satisfaction. 37000 patients who were treated at 73 different hospitals provided the data for the collection. The findings of the study indicate that there is no meaningful correlation between patient satisfaction and a hospital's accreditation status. Further, it revealed that patients did not consider accreditation as a key factor in improving the quality of care and hence did not under consideration as a referral hospital.

J.Heuer (2004) investigations on the connection between patient satisfaction and hospital accreditation revealed no discernible correlation between the ratings of patient satisfaction and accreditation scores. Patient satisfaction with the room and patient family education category had a favourable, fairly significant correlation with the accreditation summative score, according to the researcher's findings.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

Research methodology is a systematic process that involves recognizing a problem, gathering facts or information, analyzing these facts or information, and arriving at a definite conclusion in the form of answers to the problem at hand or in the form of generalizations for some formulation of a theory. Furthermore, Research methodology refers to the procedures used to gather and analyze data in accordance with the research design, sampling strategy, measurement and instruments, collection of data, conceptual model, and data analysis. There are numerous facets to research methodology, and the best course of action must be selected from various options available. The selection of the most appropriate technique was made after a thorough evaluation of the objectives and evaluation of several approaches. The purpose of this chapter is to provide an overview of the research methodology and the methods employed to address the research questions and meet its research objective. First, the chapter explains the objectives of the research that are devised to fill the gap.

Research Methodology is a process used to collect information and data to obtain meaningful results. The description of the proposed methodology adopted to achieve the objectives of the study is given below: -

#### **3.2. NEED AND SCOPE OF THE STUDY**

This study aims to shed light on how different types of hospitals in Punjab affect workers' levels of stress and productivity in the context of their respective organizational roles. The research includes all medical facilities in the state of Punjab, including hospitals that have received accreditation from the National Accreditation Board for Hospitals and Healthcare Providers (NABH) as well as those that



have not.

### **3.3. RESEARCH GAP**

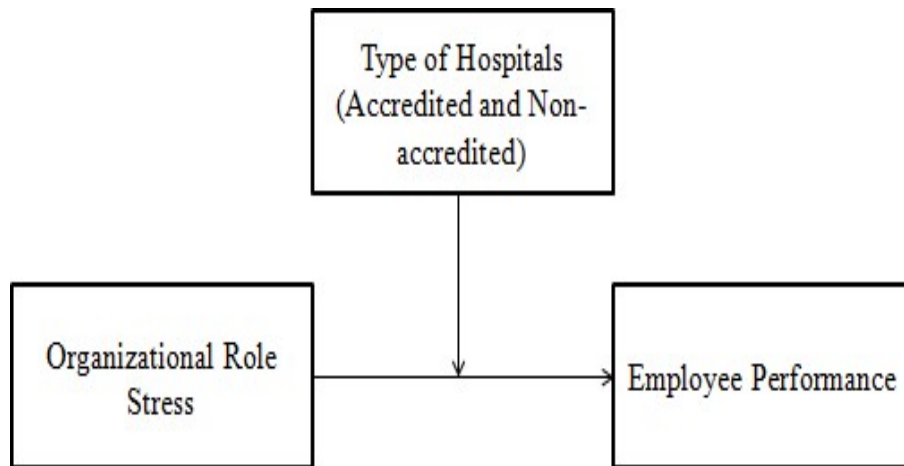
An extensive review of the literature has brought to light several key points:

1. Most of the research studies have been done in an international context and almost negligible studies have been found in the Indian context about the accreditation program and its wide spectrum impact.
2. The primary focus of past researchers was to explore the positive side of the accreditation program only. Very few studies have been done on the adverse impact of accreditation programs in healthcare setup. Moreover, the maximum studies have been done in one hospital setup only.
3. In past studies, nurses were the main respondents in other terms, the focus of the research was mainly on nursing staff only. Hence, more studies are required on different healthcare professionals in the same context to test, validate and enhance information in the existing literature.
4. In past research studies conducted in the international context variables like organization resistance to change, increased workload, and lack of performance outcome measures were identified as a weakness of the accreditation program, so here it is important to test similar variables in addition to other variables in the Indian context to validate the Indian healthcare accreditation program effectiveness.
5. In the context of the healthcare sector, not a single study has been conducted to look into the link between factors like organizational role stress and employee performance.

Based on the extensive literature survey it has been observed that there is an adequate amount of gap present in the existing research studies which need to be filled. Therefore, the present study has been conceptualized keeping in mind the research gap.

### 3.4. OBJECTIVES OF THE STUDY

1. To identify prominent organizational role stressors among healthcare professionals in regard to healthcare accreditation.
2. To examine the difference in organizational role stress level between accredited and non-accredited hospitals.
3. To assess the impact of organizational role stress on managerial-level employee performance among accredited and non-accredited hospitals.
4. To assess the impact of organizational role stress on operational-level employees performance among accredited and non-accredited hospitals.
5. To analyze the moderating effect of hospital type in the relation between organizational role stress and employee performance.



**Figure 3.1 Conceptual Model**

### **3.5. HYPOTHESES OF THE STUDY**

Based on the objectives of the present study, the following hypotheses have been framed:

**H<sub>0</sub>1:** There is no significant difference in organizational role stress level between the accredited and non-accredited hospitals.

**H<sub>a</sub>1:** There is a significant difference in organizational role stress level in accredited and non-accredited hospitals.

**H<sub>0</sub>2:** There is no significant impact of organizational role stress on managerial-level employee performance in accredited and non-accredited hospitals

**H<sub>a</sub>2:** There is a significant impact of organizational role stress on managerial-level employee performance in accredited and non-accredited hospitals.

**H<sub>0</sub>3:** There is no significant impact of organizational role stress on operational-level employee performance in accredited and non-accredited hospitals.

**H<sub>a</sub>3:** There is a significant impact of organizational role stress on operational-level employee performance in accredited and non-accredited hospitals.

**H<sub>0</sub>4:** The type of hospital does not influence the relationship between ORS and EP.

**H<sub>a</sub>4:** The type of hospital influence the relationship between ORS and EP.

### **3.6. RESEARCH DESIGN :**

A research design is the framework that organizes and directs the investigation. An outline of desired data analysis, measurement strategies, and data collection procedures is included in a research design, which is a strategy for conducting a study. Cross-sectional research has been done on this subject using both an exploratory and a descriptive research approach.

The purpose of this study is to look into the association between employee performance –a dependent variable and organizational role stress, an independent variable. Additionally, examining the moderating role of type of hospitals.

### 3.7. POPULATION :

The population for the study has been categorized based on three regions of Punjab state which are Majha, Malwa, and Doaba. There are a total of 23 districts in Punjab named Amritsar, Moga, Bhatinda, Faridkot, Tarntarn, Fatehgarh Sahib, Fazilka, Firozpur, Gurdaspur, Hoshiarpur, Pathankot, Jalandhar, Kapurthala, Ludhiana, Mansa, Barnala, Mohali, Mukatsar, Nawanshahr(SBS Nagar), Patiala, Rupnagar, Sangrur, and Malerkotla. A sample of hospitals for the study has been taken from these regions. District-wise NABH accredited hospitals are listed below.

**Table 3.1 List of NABH-accredited hospitals in Punjab**

<b>REGIONS OF PUNJAB</b>	<b>DISTRICTS</b>	<b>NABH ACCREDITED HOSPITAL'S</b>
<b>DOABA</b>	Jalandhar, Kapurthala, Hoshiarpur, Nawanshahr	<b>Jalandhar-</b> Akal eye hospital, Ashoka Neuro Psychiatric Hospital & De-Addiction Centre, BBC Heart care pruthi hospital, Dr. Sarabjit Singh Neuropsychiatric Hospital, Duggal Eye Hospital, <u>Ghai Hospital</u> , Jammu hospital, Mahajan Eye hospital, Oxford hospital, Sharnjit Hospital, Thind Eye Hospital Limited
		<b>Hoshiarpur-</b> No hospital accredited by NABH so far.
		<b>Nawanshahr-</b> No hospital accredited by NABH so far.
		<b>Kapurthala-</b> Dr.Rajan Eye care hospital
<b>MAJHA</b>	Amritsar, Gurdaspur, Pathankot, Tarn Taran	<b>Amritsar-</b> Apex Hospital, Kansal Neuro & cardiac Superspeciality Centre, Dhingra General Hospital, Dr Om Parkash Eye Institute, Dr Shakeen Eye & dental hospital, Dr. Gurvinder Singh's Hargun Hospital, Dr. Parminder Singh Panu Memorial Janta Hospital, Dr.Punj's Artemis Hospital, Madaan hospital, Nanda Hospital,

		Ohri Hospital, Pulse Hospital, <u>Randhawa Hospital</u> , Sukh Sagar Hospital
		<b>Gurdaspur-</b> No hospital accredited by NABH so far.
		<b>Pathankot-</b> No hospital accredited by NABH so far.
		<b>Tarn Taran-</b> No hospital accredited by NABH so far.
<b>MALWA</b>	Ludhiana,	<b>Ludhiana-</b> Arora Neuro centre, Eva Hospital, Jain Multispeciality hospital, Kalyan Hospital, Kular Hospital Pvt Ltd, N.K. Aggarwal Joints and Spine Centre
	Bathinda,	<b>Bathinda-</b> <u>Vasu Eye Institute &amp; Skin Centre</u>
	Patiala,	<b>Patiala-</b> A.P Healthcare & Trauma Centre, Patiala Heart Institute
	Faridkot,	<b>Faridkot-</b> Madhu Nursing Home, Brar Eye Hospital Pvt. Ltd, Singla Eye hospital
	Ferozpur,	<b>Ferozpur-</b> No hospital accredited by NABH so far
	Fazilka,	<b>Fazilka-</b> No hospital accredited by NABH so far
	Moga,	<b>Moga-</b> Garg Hospital
	Muktsar,	<b>Sri Muktsar Sahib-</b> No hospital accredited by NABH so far
	Barnala,	<b>Barnala-</b> No hospital accredited by NABH so far
	Sangrur,	<b>Sangrur-</b> No hospital accredited by NABH so far
	Mansa,	<b>Mansa-</b> No hospital accredited by NABH so far
	Mohali,	<b>Mohali-</b> Ace heart and Vascular institute, Amar Hospital, JP eye hospital, JP Hospital, Trinity Hospital and Medical research institute
	Rupnagar,	<b>Rupnagar-</b> Parmar Hospital
Fatehgarh Sahib	<b>Fatehgarh Sahib-</b> No hospital accredited by NABH so far	

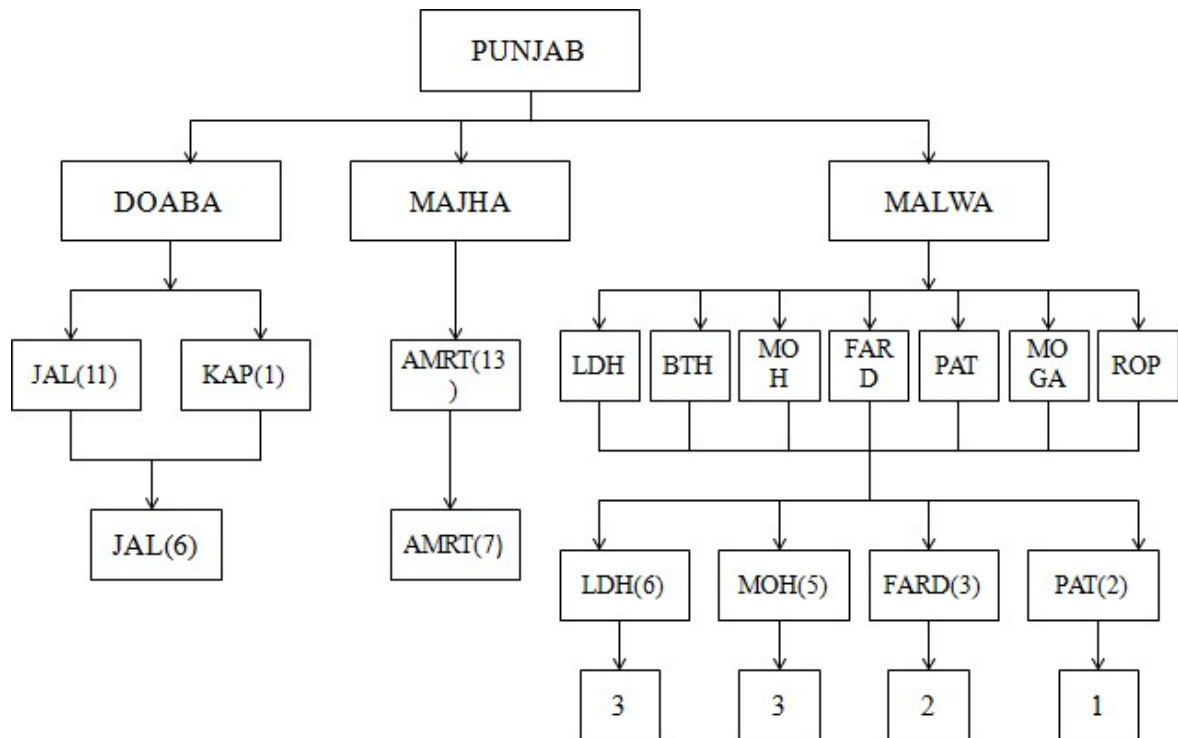
**Source:** <https://nabh.co/frmViewAccreditedSHCO.aspx> (nabh.co, 2020)

### **3.8. SAMPLING UNIT**

The sample group comprises individuals in managerial roles, including administrators, quality managers, and HR managers, as well as employees in operational positions such as doctors, nurses, laboratory technicians, and radiographic technicians. These individuals have been selected as respondents from both accredited and non-accredited hospitals.

### **3.9. SAMPLE SIZE**

The main goal of sampling is to select a representative subset of the population and draw conclusions based on it. There is a total of 44 NABH-accredited hospitals (Small healthcare organizations) in Punjab so far. Secondly, region-wise districts will be selected according to the proportion sampling and here we have applied 25% proportion sampling which means districts as the fourth part of the total districts belong to the region. Thirdly, each district having a greater number of hospitals will be selected. Fourthly, a 50% proportion of the selection criteria will be implied for the selection of the hospitals from the selected districts in the previous stage. As illustrated in fig 3.2, The participant's districts shall be Jalandhar (6), Amritsar (7), Ludhiana (3), Mohali (3), Faridkot (2), and Patiala (1). Accordingly, we have 22 NABH-accredited hospitals for study and the same numbers of non-NABH accredited hospitals will be selected from the same districts with a convenience sampling technique. As per the definition provided by the National Accreditation Board for Hospitals and Healthcare Providers(NABH), small healthcare organizations are the ones that have a maximum of 50 beds capacity. Additionally, these organizations must possess supportive and utility facilities that are relevant and appropriate to the services being offered by them.



1. 25% Proportional sampling technique is used to select districts from the respective regions.
2. Districts having more numbers of hospitals is selected.
3. 50% proportional sampling is used to select hospitals from selected districts

**Figure 3.2 Sampling frame**

During the pilot study, it was observed by the researcher that hospitals with 50 bed capacity have on average 120 -150 working employees including operational and administrative staff. As per the records, there were a total 44 numbers of hospitals that are accredited by the NABH in Punjab. Corresponding to this we considered 44 non-NABH hospitals against the NABH-accredited hospitals to keep the same ratio of hospitals. As per these estimates we have having maximum population size is 13200. By using the online sample size calculator [Sample Size Calculator by Raosoft, Inc.](#) at a confidence level of 95% and a margin of error is 5% the sample size of 374 is more than enough for this population. Moreover, According to Sekaran(2003), page no.294, table no.11.3, provides generalized scientific guidelines for calculating sample size. It is mentioned in the table that even for a 10 lakh population size, 384 sample size is enough for the research study. It has been observed that nurses

are maximum in strength followed by other staff in the hospital. Accordingly, respondents were chosen from two different groups i.e. Administrative and Operational employed in both NABH-accredited and non-accredited hospitals as detailed below:

- Medical (Doctors): 02
- Nurse: 06
- Para-Medical (Technicians): 02
- Admin/Managerial: 02

The total number of respondents is as follows:

The total number of selected hospitals are 44 (22 + 22) and the number of respondents from each hospital shall be 12, Hence  $44 * 12 = 528$ .

The researcher approached to hospital's appropriate authority to get the necessary permission prior to conducting a survey of their organizations. Then with the assistance of the concerned head of the department, questionnaires were distributed to the respondents during their convenient time. A total of 528 questionnaires were distributed, out of which 506 were returned. However, 26 of these were deemed unusable due to incomplete responses, not legible handwriting, overwritten, and missing information. The final sample size therefore comprised 480 respondents from both hospitals, yielding a response rate of 90.9%.

### **3.10. Sampling Technique**

Multistage quota sampling and convenience sampling techniques were employed to gather a sample from the targeted population. Employees who have at least six months of exposure to implementing the accreditation process were selected as respondents from accredited hospitals.

### **3.11. Data Sources and Research Instrument**

To meet its goals, this study makes use of both primary and secondary data. A 5-point Likert scale questionnaire was given to respondents as part of a quantitative survey approach used to gather primary data. To measure organizational role stress, the researcher utilized the scale developed by Prof. Udai Pareek & Dr. Surabhi Purohit (2010), while Employee performance was measured using the scale developed by Linda Koopmans et al (2016).



### 3.11.1 Organizational Role Stress:

Organizational Role Stress will be measured by using a 50-item scale developed by Prof. Udai Pareek and Dr. Surabhi Purohit (2010). ORS scale is a five-point Likert scale ranging from “never feel this way” to “frequently feel this way” to measure the role stress experienced by an individual at his/her workplace on the following ten major role stressors. Each stressor has five statements to record the data.

- a. “Inter-role distance” (5 statements)
- b. “Role stagnation” (5 statements)
- c. “Role expectation conflict” (5 statements)
- d. “Role erosion” (5 statements)
- e. “Role overload” (5 statements)
- f. “Role isolation” (5 statements)
- g. “Personal inadequacy” (5 statements)
- h. “Self-role distance” (5 statements)
- i. “Role ambiguity” (5 statements)
- j. “Resource inadequacy” (5 statements)

**Table 3.2 Organizational Role Stress Scale items**

STRESSORS	STATEMENTS
“Inter-role distance”: Conflicting expectations between different roles	1,11,21,31,41
“Role stagnation”: Feeling stuck without growth opportunities	2,12,22,32,42
“Role-expectation conflict”: Arises from conflicting demands	3,13,23,33,43
“Role erosion”: Occurs when responsibility gradually diminish	4,14,24,34,44
“Role overload”: Excessive workload and time pressure	5,15,25,35,45
“Role isolation”: Entails a lack of connection with colleagues	6,16,26,36,46

“Personal inadequacy”: Feeling incapable	7,17,27,37,47
“Self-role distance”: Disconnect from one’s role	8,18,28,38,48
“Role ambiguity”: Arise from unclear expectations	9,19,29,39,49
“Resource inadequacy”: Lack of essential resources	10,20,30,40,50

### 3.11.2. Employee Performance:

The definition of IWP as “behaviours or actions that are relevant to the goals of the organization” (Campbell, 1990) was adopted. Thus, rather than emphasizing the outcomes of an employee’s actions, job performance focuses on the employee’s behaviours or actions. Individual work performance is further subdivided into three types i.e. Task performance, Contextual performance, and Counterproductive work behavior.

- a. Task performance (TP) is “the proficiency with which individuals perform the core substantive or technical tasks central to his or her job” (Campbell, 1990).
- b. Contextual performance (CP) is “behaviours that support the organizational, social and psychological environment in which the technical core must function” (Borman & Motowidlo, 1993).
- c. Counterproductive work behaviour (CWB) is “ any behaviour that harms the well-being of the organization” (Rotundo & Sackett, 2002). Several behaviours have been used to describe counterproductive work behaviour, including absenteeism, off-task behaviour, theft, and substance abuse (Koopmans et al., 2011).

Employee performance will be measured by a scale developed by Linda Koopmans et al (2016). Individual work performance scale is of five points Likert scale ranging from seldom to always to measure how an individual carried out his/her work during the past three months. The individual work performance scale has a total of 18 statements. Individual work performance is divided into three broad dimensions as follows:

- a. Task performance (5 statements)
- b. Contextual performance (8 statements)
- c. Counterproductive work behavior (5 statements)

### 3.12. Experts involved in the face validity and reliability of the questionnaire.

The questionnaire's face validity must then be checked to make sure the items are suitable, pertinent, and logical (Connell et al., 2018). Before the final distribution of the research questionnaire, It was sent to the five academic experts who are familiar with the constructs to assess the face and content validity of the research instrument. Thereafter, with minor modifications where necessary, the updated questionnaire has been shared with the seven healthcare professionals who are working in the administrative and operational profiles to ensure that the content is understandable to the actual respondents. Additionally, it also made sure that the scale seems to measure the things it is supposed to. The independent variable in this study was organizational role stress, while the dependent variable was employee performance. Further, the study hypothesized that the relationship between organizational role stress and employee performance may be moderated by the kind of hospital.

**Table 3.3 List of Academicians**

<b>Academician Name</b>	<b>Position</b>	<b>Affiliation</b>
Dr. A.J. van der Beek	Professor	Amsterdam Public Health Research Institute, Netherlands
Dr. Bikramjit Singh Hundal	Professor	GNDU, Amritsar
Dr. Hirek Das Gupta	Assoc. Prof	Symbiosis International University, Pune
Dr. Rajesh Kumar	Assist. Prof.	All India Institute of Medical Science (AIIMS), Rishikesh
Dr. Sanket Dash	Assist. Prof	IIM, Rohtak

**Table 3.4 List of Industry Expert**

<b>Industry Expert</b>	<b>Position</b>	<b>Affiliation</b>
Mr. Rohit Sachdeva	Manager	Neelam Hospital, Patiala
Dr.Amandeep Singh	Consultant	Sohana Hospital, Mohali
Mr.Parvesh Sharma	Manager	Ivy Hospital, Mohali
Ms.Manpreet Kaur	Ward Incharge	Grecian Hospital, Mohali
Dr.Chetna Hans	Medical Officer	Neelam Hospital, Rajpura
Mr.Lakhwinder Singh	Chief Pharmacist	Parmar Hospital, Ropar
Mr.Gagan Kumar	Chief Pharmacist	Neelam Hospital, Patiala

### **3.13 RELIABILITY**

Sekaran (2003) affirmed that it's important to ensure that the scales developed and used measure variables accurately and correctly. Reliability occurs when the same outcomes are obtained after multiple measurements on the same dataset. The data was collected from 10% of the total population to check for Cronbach's alpha values. The Cronbach alpha values for each scale are above the given threshold of 0.7. This means that the questionnaire is suitable for final data collection.

**Table 3.5 Reliability Statistics**

<b>Variable</b>	<b>Factor</b>	<b>Items</b>	<b>Cronbach's Alpha value</b>
<b>Organizational Role Stress</b>	Inter role distance (IRD)	5	0.89
	Role Stagnation (RS)	5	0.88
	Personal inadequacy (PI)	5	0.89
	Role ambiguity (RA)	5	0.89
	Resource inadequacy (RIn)	5	0.88
	Role erosion (RE)	5	0.87
	Role Overload (RO)	5	0.89
	Self-role distance (SRD)	5	0.86
	Role expectation conflict (REC)	5	0.87
	Role isolation (RI)	5	0.89
<b>Employee Performance</b>	Task performance (TP)	5	0.85
	Contextual performance (CP)	8	0.90
	Counterproductive work behaviour (CWB)	5	0.86

### 3.13.1 TEST RE-TEST RELIABILITY

A set of participants fills out a personality characteristic questionnaire; if they repeat it days, weeks, or months later and respond the same way, this suggests excellent test-retest reliability. In this case, To confirm the reliability of the questionnaire, the same respondents were presented with the same questionnaire again to collect responses after an interval of 6 weeks as recommended by the authors of the scale. Following reliability analysis, Cronbach's alpha value for the scale was determined to be within acceptable limits, confirming its suitability for final data collection. Cronbach alpha is given by Lee Cronbach in 1951 and the values are considered as more than or equal to 0.7 is acceptable, > 0.8 is

good, and  $> 0.9$  is excellent. It is clear from the above values that the value of Cronbach alpha is within the acceptable range.

**Table 3.6 Reliability Statistics**

<b>Variable</b>	<b>Factor</b>	<b>Items</b>	<b>Cronbach's Alpha value</b>
<b>Organizational Role Stress</b>	IRD	5	0.87
	RS	5	0.88
	REC	5	0.89
	RE	5	0.79
	RO	5	0.86
	RI	5	0.86
	PI	5	0.84
	SRD	5	0.87
	RA	5	0.91
	RIN	5	0.88
<b>Employee Performance</b>	TP	5	0.79
	CP	8	0.89
	CWB	5	0.89

### **3.14. STATISTICAL TOOLS USED FOR ANALYSIS**

The data collected was meticulously organized and processed to unveil significant patterns and trends, which were then analyzed using advanced statistical tools and techniques. To conduct this analysis, the researcher relied on the powerful statistical package for social science, version 26, and the analysis of moment of structure software, version 26 (AMOS-26), ensuring the most accurate and insightful re-

sults. Descriptive statistics provide a concise overview of a huge body of data, illuminating its key features for the researcher in a short amount of time. Data in the study were described using the following descriptive statistics:

- Frequency
- Percentage
- Mean
- Pie charts and Bar graphs for data presentation

Inferential statistics: By analyzing the sample, inferential statistics were taken into consideration to extrapolate the findings to the entire population. The use of inferential statistics is beneficial for testing research hypotheses, providing answers to the research questions, and drawing conclusions based on statistical findings. Inferential statistical analysis was performed on the data using the following tests.

- T-test
- ANOVA
- Correlation
- Regression
- Factor analysis
- Structural Equation Modelling (SEM)

**T-test:**

This test is used for comparing the means of two groups. The study compares organizational role stress between accredited and non-accredited hospitals.

**Analysis of Variance (ANOVA):**

The study used ANOVA to test the impact of organizational Role Stress on managerial-level employee performance in accredited and non-accredited hospitals.

**Correlation:**

The correlation test is used in statistics to establish a link between two independent variables. If the coefficient of correlation ( $r$ ) is positive, then the relationship between the variables is direct, and if it is negative, then the relationship is inverse. In this research, the Pearson correlation coefficient was uti-

lize to determine the relative strength of the relationships between the variables.

**Regression:**

This is a statistical method employed to gauge the correlation between a dependent variable and one or more independent variables. Specifically, simple regression analysis is applied when there is a single independent variable, whereas multiple regression analysis analysis is utilized when there are multiple independent variables. In this study, simple regression was used to forecast the influence of stress related to organizational roles on employee performance. This technique enabled the researcher to evaluate how much the stress levels experienced by healthcare professionals in their roles affected their comprehensive job performance.

**Factor Analysis:**

The multivariate statistical method reduces the number of variables with identical features to a select group of constructs (factors), hence lowering the complexity of the data. For this study, exploratory factor analysis and confirmatory factors analysis has been done. The Sample's adequacy was checked through Kaiser-Meyer-Olkin (KMO).

**Structural Equation Model (SEM):**

SEM is a robust multivariate method that models intricate causal linkages between variables to evaluate hypotheses. A set of regression equations that graphically describe the causal link between variables makes up the SEM term (Byrne, 2010).

In structural equation modeling (SEM), the measurement model, which delineates the association between observed variables and latent constructs, and the structural model, which outlines the variables and their interrelationships, operate in conjunction to elucidate the interplay among latent variables or constructs. When the measurement model and the structural model are combined, we get the full structural model.

The study runs SEM analysis to test the causal relationship between Organizational Role Stress (exogenous variable) and employee performance (endogenous variables) based on standardized regression weights with p values.



## **CHAPTER 4**

### **RESULTS AND DISCUSSION**

In this chapter, the researcher delves deep into the examination of the gathered data to obtain the outcomes of the research. The various methodologies used to scrutinize the collected data are explained in detail, along with the findings of the study. Before data processing, a completeness check was performed to exclude the incomplete responses from the analysis. The collected data was then coded and tabulated using the SPSS 26.0 version. A variety of statistical tools were used to analyze the data, based on the requirements of the study. The following subsections provide detailed explanations of the data analysis process and research findings.

#### **4.1 Demographic details of the healthcare professionals**

#### **4.2 Data screening: Normality testing**

#### **4.3 Exploratory Factor analysis for Organizational Role Stress (ORS) scale**

#### **4.4 Exploratory Factor analysis for Employee Performance Scale**

#### **4.5 Confirmatory Factor Analysis**

#### **4.6 Objective-Wise Testing of Hypotheses**

4.6.1 Prominent Organizational Role Stressors among Healthcare Professionals.

4.6.2 The difference in Organizational Role Stress level between accredited and non-accredited hospitals.

4.6.3 Structure Equation Model: Impact of Organizational Role Stress on Employee Performance.

4.6.4 The impact of organizational role stress on managerial level employee performance among accredited and non-accredited hospitals.

4.6.5 The impact of organizational role stress on operational-level employee performance among accredited and non-accredited hospitals.

4.6.6 The influence of hospital type on the relationship between ORS and EP.

#### 4.1. DEMOGRAPHICS DETAILS OF HEALTHCARE PROFESSIONALS

The questionnaire served as a means of gathering the respondents' demographic information. This section explains the demographic data for every respondent who participated in the survey. Below are the respondents' gender, marital status, age, qualification, working experience, monthly income, hospital type, and nature of work.

##### 1. Hospital type

**Table 4.1 Demographic factor- Hospital Type**

<b>Hospital Type</b>	<b>Number of respondents</b>	<b>Percentage</b>
Accredited	240	50
Non-Accredited	240	50

It is observed from Table 4.1 that the total number of respondents was 480(100 per cent). There were two types of hospitals under the study i.e. accredited and non-accredited. An equal proportion of respondents were selected from the two different categories of hospitals.

##### 2. Nature of Work

**Table 4.2 Demographic factor- Nature of work**

<b>Nature of Work</b>	<b>Number of respondents</b>	<b>Percentage</b>
Managerial	82	17.1
Operational	398	82.9

It is observed from Table 4.2 that there were mainly two types of employees taken into consideration for this research study i.e. managerial and operational employees. It is clear from the above table that out of a total of 480 employees, the majority of the

employees were operational (82.9 per cent), whereas 17.1 per cent of employees belong to the managerial category.

### 3. Gender

**Table 4.3 Demographic factor- Gender**

<b>Gender</b>	<b>Number of respondents</b>	<b>Percentage</b>
Male	164	34.2
Female	316	65.8

As per table no 4.3, out of a total of 480 respondents, the majority of the respondents 316 were female(65.8 per cent), whereas the total number of male respondents was 164(34.2 per cent).

### 4. Marital Status

**Table 4.4 Demographic factor- Marital status**

<b>Marital Status</b>	<b>Number of respondents</b>	<b>Percentage</b>
Married	255	53.1
Un-married	225	46.9

From the above table no 4.4 above, we can say that out of a total of 480 respondents, the majority of the respondents 255(53.1 per cent) fall into the married category while 225 (46.9 per cent) respondents come under the un-married category.

### 5. Age

**Table 4.5 Demographic factor- Age**

<b>Age</b>	<b>Number of respondents</b>	<b>Percentage</b>
Under 25	141	29.4
From 25-35	278	57.9
From 36-45	54	11.3
Above 45	7	1.5

According to Table 4.5 the majority of respondents, 278 (57.9 per cent) belong to the

age category of 25-35 years, followed by 141(29.4 per cent), whereas 54(11.3 per cent) respondents were from the 36-45 years age category, and least respondents 7(1.5 per cent) from age category of above 45 years.

## 6. Educational Qualification

**Table 4.6 Demographic factor- Educational qualification**

<b>Educational Qualification</b>	<b>Number of respondents</b>	<b>Percentage</b>
Diploma	221	46
Graduation	184	38.3
Post-graduation	73	15.2
Other	2	0.4

Table 4.6 shows the educational qualifications of the respondents under study. It is clear from above table 4.6 that the majority of the respondents 221(46 per cent) were diploma holders, followed by the respondents 184(38.3 per cent) had graduate degrees and 73 respondents(15.2 per cent) with post-graduation degrees whereas only 2(0.4 per cent) respondents were from another category.

## 7. Working experience

**Table 4.7 Demographic factor- Working experience**

<b>Working experience</b>	<b>Number of respondents</b>	<b>Percentage</b>
Less than 6 months	0	0
7-12 months	96	20
13-18 months	39	8.1
19-24 months	56	11.7
More than 24 months	289	60.2

It is observed from the above table that the majority of the respondents 289 (60.2 per cent) belong to the working experience category of more than 24 months, and 96(20 per cent) respondents were from the working experience category of 7-12 months. In addition to this, the count of respondents 56(11.7) comes under the 19-24 months category, whereas under the category 13-18 months only 39(8.1 per cent) respondents were recorded.

## 8. Monthly Income

**Table 4.8 Demographic factor- Monthly Income**

<b>Monthly Income</b>	<b>Number of respondents</b>	<b>Percentage</b>
Less than 10000	187	39
10001-20000	129	26.9
20001-30000	60	12.5
30001-40000	58	12.1
Above 40000	46	9.6

As per Table 4.8, the maximum number of respondents 187(39 per cent) comes under the less than 10000 category, followed by the category 10001-20000 where the total number of respondents was 129(26.9 per cent). In addition to this 60(12.5 per cent) employees under the category of 20001-30000, 58(12.1 per cent) employees belong to category 30001-40000, and only 46 (9.6 per cent) employees fall into the above 40000 income group.

### 4.2. DATA SCREENING

The act of scrutinizing data for imperfections and subsequently rectifying or removing them is commonly known as "data screening." The researchers conducted a thorough screening of the data to ensure its reliability, usability, and validity to test causal theory.

**Normality:** The condition of normality of data is a prerequisite for conducting Structural Equation Modeling (SEM). The present data's normality was assessed through the skewness and kurtosis values. According to the results of Hair et al.,(2010), the standard deviations are greater than 0.5 and the values of skewness and kurtosis are between +2 and -2, respectively. These results provide evidence that the data conforms to a normal distribution. Table 4.9 illustrates that the skewness and kurtosis statistics meet the established criteria (except for CWB 2 & 3, the kurtosis values are higher than 2). Moreover, all the items exhibit a standard deviation (SD) greater than 0.5. Thus, the data conforms to a normal distribution and displays sufficient variability for enhanced analysis.

**Table 4.9 Descriptive statistics of research variables**

		Mean	SD.	Skewness	Kurtosis
“Inter Role Distance”(IRD)	IRD 1	1.62	1.257	.337	-.880
	IRD 2	1.48	1.273	.506	-.793
	IRD 3	1.51	1.365	.464	-1.010
	IRD 4	1.32	1.270	.559	-.816
	IRD 5	1.53	1.279	.423	-.876
“Role Stagnation”(RS)	RS 1	1.23	1.062	.564	-.457
	RS 2	1.42	1.327	.514	-.940
	RS 3	1.41	1.313	.569	-.817
	RS 4	1.36	1.229	.561	-.679
	RS 5	1.31	1.165	.539	-.640
“Role Expectation Conflict”(REC)	REC 1	1.28	1.119	.592	-.432
	REC 2	1.18	1.187	.696	-.557
	REC 3	1.23	1.215	.669	-.623
	REC 4	1.31	1.211	.595	-.650
	REC 5	1.33	1.187	.611	-.532

“Role Erosion”(RE)	RE 1	1.17	1.172	.688	-.582
	RE 2	1.20	1.205	.656	-.606
	RE 3	1.39	1.294	.597	-.772
	RE 4	1.45	1.296	.487	-.885
	RE 5	1.47	1.306	.461	-.958
“Role Overload”(RO)	RO 1	1.60	1.341	.429	-.966
	RO 2	1.39	1.228	.374	-.979
	RO 3	1.42	1.267	.469	-.933
	RO 4	1.28	1.226	.590	-.737
	RO 5	1.42	1.218	.486	-.747
“Role Isolation”(RI)	RI 1	1.23	1.249	.756	-.495
	RI 2	1.25	1.175	.516	-.810
	RI 3	1.35	1.221	.551	-.684
	RI 4	1.34	1.166	.505	-.603
	RI 5	1.34	1.287	.587	-.813
“Personal Inadequacy”(PI)	PI 1	1.03	1.256	1.017	-.144
	PI 2	1.38	1.304	.632	-.725
	PI 3	1.09	1.203	.853	-.352
	PI 4	1.31	1.282	.685	-.654
	PI 5	1.30	1.207	.675	-.498
“Self-role Distance”(SRD)	SRD 1	1.21	1.230	.705	-.596
	SRD 2	1.21	1.289	.761	-.641

	SRD 3	1.11	1.262	.904	-.307
	SRD 4	1.64	1.342	.333	-1.051
	SRD 5	1.26	1.226	.581	-.801
“Role Ambiguity”(RA)	RA 1	1.09	1.269	.866	-.435
	RA 2	1.28	1.301	.649	-.794
	RA 3	1.24	1.270	.750	-.537
	RA 4	1.22	1.179	.733	-.373
	RA 5	1.16	1.258	.812	-.469
“Resource Inadequacy”(RIn)	RIn 1	1.16	1.201	.792	-.376
	RIn 2	1.37	1.332	.584	-.890
	RIn 3	1.47	1.355	.513	-.961
	RIn 4	1.22	1.184	.640	-.595
	RIn 5	1.49	1.363	.466	-1.055
“Task Performance”(TP)	TP 1	2.59	1.105	-.161	-.960
	TP 2	2.62	1.092	-.254	-.874
	TP 3	2.51	1.042	-.033	-.955
	TP 4	2.52	1.128	-.228	-.802
	TP 5	2.40	1.142	-.152	-.818
“Contextual Performance”(CP)	CP 1	2.27	1.194	-.025	-.979
	CP 2	2.31	1.109	-.037	-.874
	CP 3	2.57	1.046	.037	-1.038
	CP 4	2.56	1.093	-.121	-.894



	CP 5	1.93	1.282	.230	-1.042
	CP 6	2.01	1.239	.140	-.994
	CP 7	1.97	1.299	.154	-1.127
	CP 8	1.85	1.345	.309	-1.064
“Counterproductive Work Behaviour”(CWB)	CWB 1	.70	.985	1.380	1.212
	CWB 2	.56	1.134	1.944	2.453
	CWB 3	.59	1.165	1.917	2.381
	CWB 4	.80	1.029	1.255	.925
	CWB 5	.76	.941	1.809	1.769

*Source: Primary survey*

#### **4.3 Exploratory Factor analysis (EFA) for Organizational Role Stress (ORS) scale:**

The application of the Exploratory Factor Analysis (EFA) method facilitates the identification of diverse dimensions of role stress within an organization. EFA is a statistical method that examines the correlations among variables in a given study to identify underlying factors that explain the observed patterns of interdependence. The techniques may serve as a means of data reduction, facilitating the elimination of variables that do not make a substantial contribution to our comprehension of the data. The present investigation employed principal component analysis with Varimax rotation to extract factors from a set of 50 questions. The aim was to assess whether the observed variables loaded as anticipated, exhibited adequate correlation, and met established standards of reliability and validity. The varimax method was selected due to the considerable size of the dataset, which comprised 480 observations. Varimax was deemed appropriate as it permits the identification of non-correlated factors, as suggested by Hair et al. (2010) and Nannally & Bernstein (1994).

#### **Sample Adequacy**

Bartlett’s test of sphericity and the Kaiser-Meyer-Olkin (KMO) metric were applied to

determine the adequacy of the data. The findings presented in Table 4.10 reveal that the Kaiser-Meyer-Olkin measure (KMO) yielded a value of 0.964, while Bartlett's test was statistically significant at a significance level of  $\alpha=0.000$ , with a corresponding Chi-square value of 15466.723.

Kaiser (1974) established that KMO values ranging from 0.5 to 0.7 are considered mediocre, those falling between 0.7 and 0.8 are deemed good, values ranging from 0.8 and 0.9 are regarded as great, and anything beyond 0.9 is categorised as outstanding. Thus, considering this criterion, the data exhibits excellence in terms of its suitability for performing exploratory factor analysis.

**Table 4.10 KMO and Bartlett's Test**

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.964
Bartlett's Test of Sphericity	Approx. Chi-Square	15466.723
	df	1225
	Sig.	0.000

### **Total Variance Explained**

The subsequent table (4.11) presents a comprehensive list of factors that can be extracted from the analysis, accompanied by their respective eigenvalues, the proportion of variance that can be attributed to each factor, and the cumulative variance of the factor in question and the factors that precede it. The process of factor extraction is predicated upon the Eigenvalue criterion, whereby only those factors possessing Eigenvalues exceeding 1 will be deemed to be the definitive factors of the investigation. The cumulative percentage of extracted factors reveals that the initial factor contributes to 7.54% of the variance, followed by the second factor with a contribution of 14.93%, and the third factor to 22.29%. The fourth-factor accounts for 29.61%, the fifth factor for 36.39%, the sixth factor for 43.16%, the seventh factor for 49.83%, the eighth factor for 56.48%, and the ninth factor for 63.06%. The combined effect of all ten factors can explain a total variance of 69.23%.

Ten factors were identified based on the criteria, as they exhibited an Eigenvalue exceeding 1.

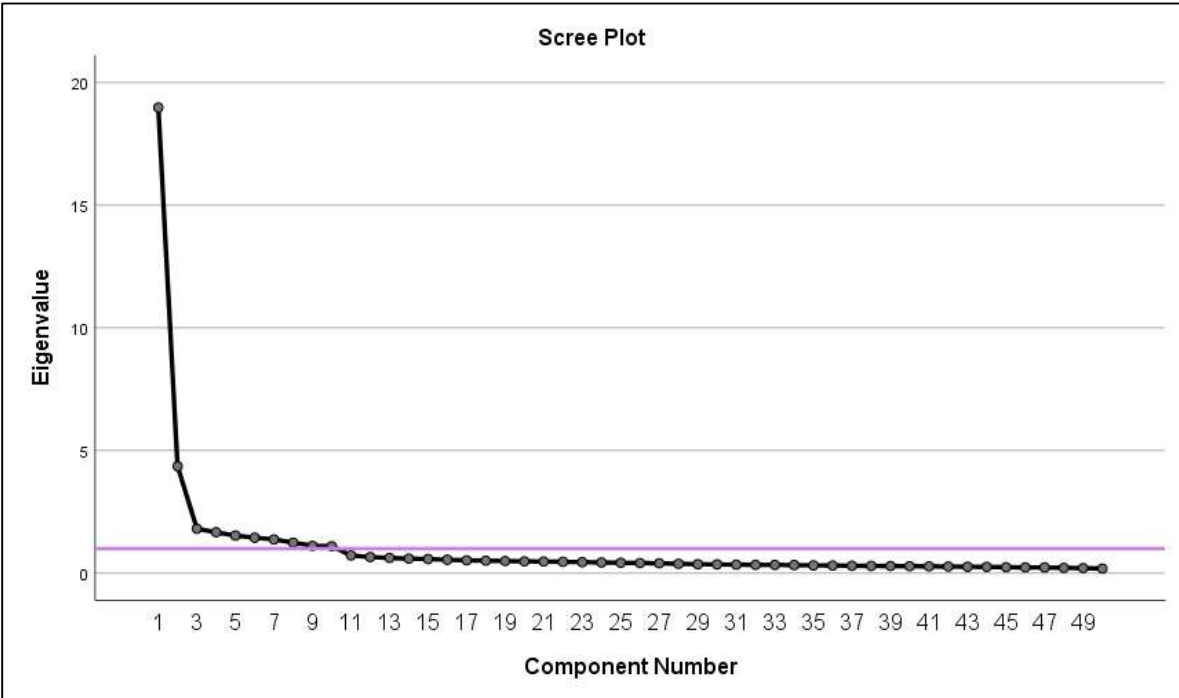
**Table 4.11 Total Variance Explained**

Component	Total Variance Explained								
	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	18.977	37.954	37.954	18.977	37.954	37.954	3.772	7.543	7.543
2	4.357	8.714	46.667	4.357	8.714	46.667	3.693	7.386	14.929
3	1.810	3.620	50.287	1.810	3.620	50.287	3.680	7.360	22.288
4	1.666	3.331	53.618	1.666	3.331	53.618	3.662	7.323	29.611
5	1.531	3.063	56.681	1.531	3.063	56.681	3.390	6.781	36.392
6	1.446	2.891	59.572	1.446	2.891	59.572	3.385	6.770	43.163
7	1.374	2.749	62.321	1.374	2.749	62.321	3.334	6.669	49.831
8	1.241	2.483	64.804	1.241	2.483	64.804	3.322	6.643	56.475
9	1.114	2.228	67.031	1.114	2.228	67.031	3.291	6.583	63.057
10	1.099	2.197	69.228	1.099	2.197	69.228	3.086	6.171	69.228
11	.722	1.444	70.673						
12	.656	1.313	71.985						
13	.622	1.244	73.229						
14	.593	1.187	74.416						
15	.575	1.150	75.566						
16	.546	1.093	76.659						
17	.521	1.041	77.700						
18	.506	1.013	78.713						

**Scree plots:**

This graph has the number of components on the x-axis and the eigenvalues on the y-axis. It is desired to have a cliff-like dramatic decline in the eigenvalue magnitude in a scree plot, with the remaining smaller eigenvalues acting as rubble. The scree plot criterion selects components at the 'elbow' of the curve, just as it is about to flatten. Only 10 components, with Eigen values greater than or equal to 1, are appropriate for extraction, according to the scree plot in Figure 4.1 (Cattell, 1966).

Figure 4.1 Scree plot of extracted factors



- **Rotated Component Matrix:**

In the present study, we conducted exploratory factor analysis employing principal component analysis and varimax rotation. A minimum factor loading threshold of 0.50 was established. Additionally, the researcher assessed the commonality of the scale to ascertain sufficient levels of explanation for each dimension. Our findings revealed that all commonalities surpassed the predetermined value of 0.50, signifying a satisfactory level of explanation. The individual items of extracted factors having factor loadings above 0.5 and not cross-loaded on other factors were retained in the study (Lai and Chen, 2011). Finally, 50 items were extracted into 10 factors or dimensions of ORS.

**Table 4.12 Extracted factors with factor loadings**

<b>Rotated Component Matrix</b>										
	Component									
	1	2	3	4	5	6	7	8	9	10
IRD1	.738									
IRD2	.741									
IRD3	.759									
IRD4	.720									
IRD5	.750									
RS1		.739								
RS2		.709								
RS3		.709								
RS4		.708								
RS5		.715								
PI1			.703							
PI2			.707							
PI3			.732							
PI4			.743							
PI5			.726							
RA1				.760						
RA2				.706						
RA3				.753						
RA4				.733						
RA5				.749						
RIn1					.749					
RIn2					.674					
RIn3					.628					
RIn4					.713					

RIn5					.656					
RE1						.660				
RE2						.664				
RE3						.745				
RE4						.674				
RE5						.652				
RO1							.653			
RO2							.639			
RO3							.681			
RO4							.652			
RO5							.700			
SRD1								.682		
SRD2								.676		
SRD3								.680		
SRD4								.667		
SRD5								.671		
REC1									.715	
REC2									.791	
REC3									.637	
REC4									.624	
REC5									.710	
RI1										.686
RI2										.662
RI3										.660
RI4										.627
RI5										.626
<p>“Extraction Method: Principal Component Analysis”.</p> <p>“Rotation Method: Varimax with Kaiser Normalization”.</p>										

a. "Rotation converged in 8 iterations".

**Correlation:**

The link between two variables is shown by the correlation analysis. The results of the correlation coefficient show that there is a positive relationship between each of the ORS dimensions. Given that the link is significant, the p-value is less than 0.05.

**Table 4.13 Correlations among ORS dimensions**

	IRD	RS	PI	RA	RIN	RE	RO	SRD	REC	RI
IRD	1									
RS	.494**	1								
PI	.519**	.669**	1							
RA	.619**	.473**	.516**	1						
RIN	.541**	.735**	.719**	.515**	1					
RE	.537**	.735**	.705**	.538**	.772**	1				
RO	.556**	.740**	.723**	.549**	.779**	.783**	1			
SRD	.676**	.598**	.594**	.681**	.605**	.622**	.676**	1		
REC	.675**	.527**	.528**	.633**	.558**	.560**	.593**	.698**	1	
RI	.608**	.740**	.731**	.547**	.763**	.753**	.792**	.695**	.654**	1

\*Correlation is significant at the 0.05 level, IRD= Inter-role Distance, RS= Role Stagnation, PI=Personel Inadequacy,RA=Role Ambiguity,RIn=Resource Inadequacy,RE=Role Erosin,RO=Role Overload,SRD=Self Role Distance,REC=Role Expectation Conflict,RI=Role Isolation

Source: Primary survey

#### **4.4 Exploratory Factor analysis (EFA) for Employee Performance Scale:**

Employee Performance is considered the main dependent variable of the study, which is considered a second-order factor and constitutes three components. A principal component analysis with varimax rotation was used to perform factor analysis. Eigenvalue above and equal to 1, results in the extraction of three factors from 18 questions, having KMO value =0.912. The three factors that contribute to employee performance are task performance(TP), counterproductive work behaviour (CWB), and contextual performance(CP); together, they can account for 63.12% of the total variance.

**Table 4.14 Rotated Component Matrix for Employee Performance Constructs**

	Component		
	1	2	3
CP1	.742		
CP2	.696		
CP3	.714		
CP4	.733		
CP5	.761		
CP6	.758		
CP7	.775		
CP8	.736		
CWB1		.784	
CWB2		.837	
CWB3		.828	
CWB4		.747	
CWB5		.833	
TP1			.796
TP2			.753
TP3			.723
TP4			.766
TP5			.709
“Extraction Method: Principal Component Analysis”.			
“Rotation Method: Varimax with Kaiser Normalization”.			
a. Rotation converged in 5 iterations.			



**Reliability of research constructs:**

Cronbach's alpha coefficient was applied to calculate the reliability for each of the criteria. Table 4.15 displays the Cronbach's alpha coefficient, which varied between 0.868 and 0.905. Although all of the alpha values are greater than the 0.7 cutoff, the data is reliable.

**Table 4.15 Alpha value of factors**

<b>Factor</b>	<b>Items</b>	<b>Alpha value</b>
Inter role distance (IRD)	5	0.892
Role Stagnation (RS)	5	0.881
Personal inadequacy (PI)	5	0.891
Role ambiguity (RA)	5	0.890
Resource inadequacy (RIn)	5	0.889
Role erosion (RE)	5	0.875
Role overload (RO)	5	0.893
Self-role distance (SRD)	5	0.864
Role expectation conflict (REC)	5	0.870
Role isolation (RI)	5	0.898
Task performance (TP)	5	0.857
Contextual performance (CP)	8	0.905
Counterproductive work behaviour (CWB)	5	0.868

*Source: Primary survey*

**4.5 CONFIRMATORY FACTOR ANALYSIS (CFA)**

Before establishing causal relationships, it is imperative to create and authenticate the measuring instrument. The scale development process starts with the confirmation and validation of the constructs. Confirmatory Factor analysis (CFA) is used in this study to assess the measuring scale's validity.

“There are three-step procedures for evaluating the measurement model namely, individual item reliability, discriminant, and convergent validity” (Hulland, 1999). The reliability of individual items is a crucial factor in determining the overall validity of the measurement model. Item loading is a commonly used method to assess the reliability of individual items. It is recommended that all items in a research study should have a loading between 0.5 to 1.0. This ensures that the items are consistent and reliable in measuring the construct they are intended to measure.

Convergent validity, in the context of research, pertains to demonstrating the correlation between two distinct measurements of a single construct. In the present study, the convergent validity (CR) was assessed using composite reliability and the average variance extracted (AVE). These metrics were selected to assess the correctness and consistency of the gathered data.

### **Discriminant Validity**

It refers to the degree to which the measures used in a study are different from each other. Essentially, discriminant validity demonstrates that two measures that are not supposed to be related to each other are not related in reality. To assess discriminant validity, the researcher has used a statistical technique called Maximum shared variance (MSV). The MSV is calculated by determining the maximum amount of shared variance between two constructs. The average variance extracted (AVE), a measure of the amount of variance collected by construct elements, is usually regarded to be greater than the mean square variation (MSV).

### **Model Fit:**

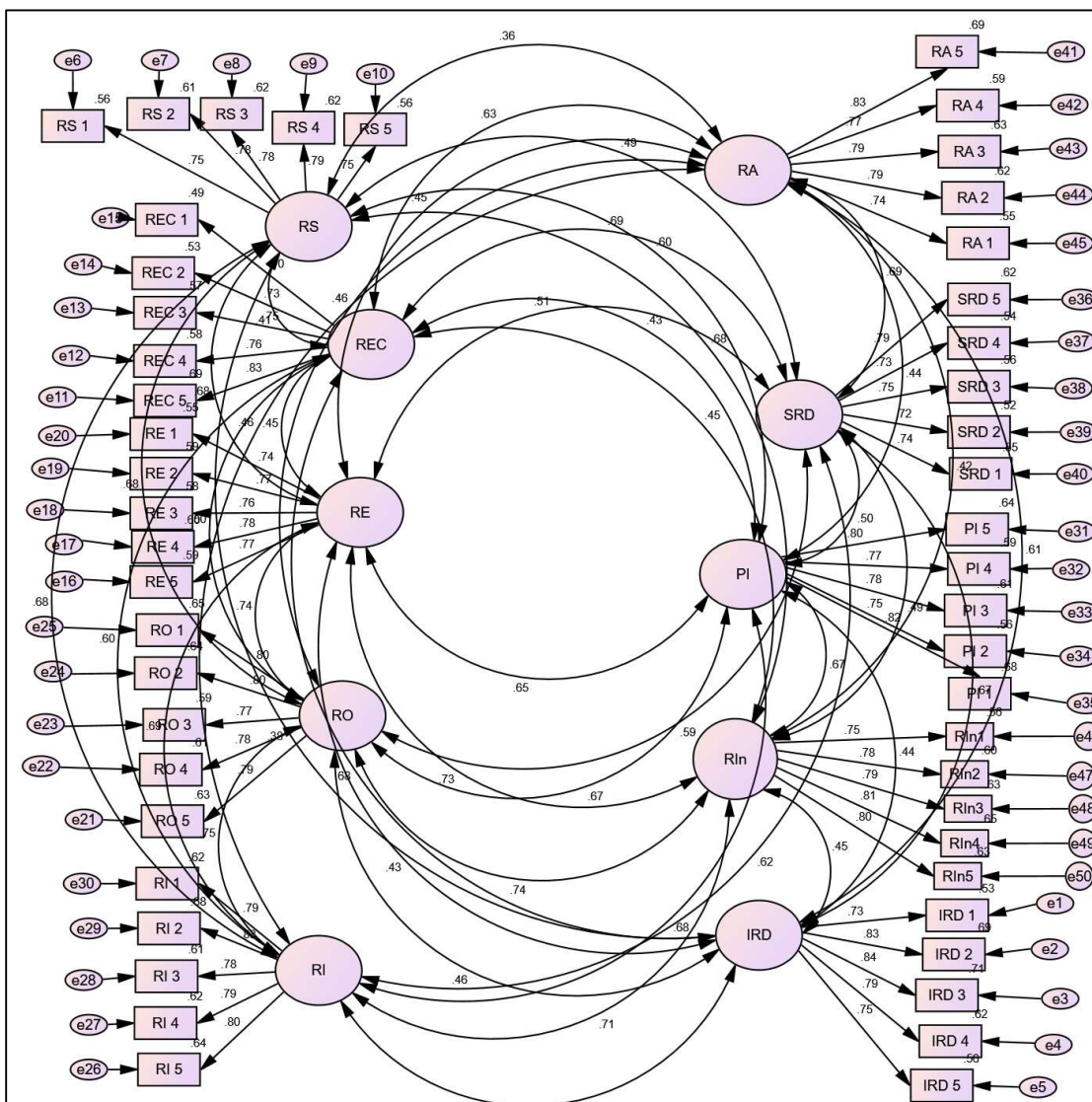
The statistical and substantive validity of estimates are frequently used to measure the goodness of fit. This is achieved by ensuring that the estimates fall within an acceptable range. For example, negative variances or correlations greater than one would be considered unacceptable. Additionally, estimates should have a clear theoretical interpretation. In other words, estimates with unexpected signs, estimation procedures that do not converge, models that are not empirically identified, parameters that are not statistically significant, and covariance matrices that don't fit well should be avoided.

- 1<sup>ST</sup> ORDER CFA FOR ORS DIMENSIONS

**Validation of Organization Role Stress Dimensions:**

For validation of the ORS scale, the first-order CFA has been applied. The ten dimensions of the ORS scale were considered as exogenous variables and covariates with each other.

**Figure 4.2 Measurement Model for Confirmatory Factor Analysis of ORS scale**



**Table 4.16 Overall model fit for 1st order CFA of ORS scale**

<i>Model-Fit Criterion</i>	<i>Acceptable</i>	<i>Model values</i>
Chi-square ( $\chi^2$ )		1178.261
Degrees of freedom(df)		909
<b>Absolute Fit Measure</b>		
Goodness-of-fit index(GFI)	0(no fit)to1(perfect fit)(ideal0.90)	0.901
Root-mean square residual(RMR)		0.042
Root-mean-square error of approximation (RMSEA)	<.05 perfect, <.08 good	0.025
Normed chi-square (CMIN/df)	<3	1.296
<b>Incremental Fit Indices</b>		
Normed fit index (NFI)	0(no fit) to1(perfect fit)(ideal0.90)	0.917
Non-normed fit index Tucker LewisIndex(TLI)	0(no fit) to1(perfect fit)(ideal0.90)	0.978
Comparative fit index (CFI)	0(no fit)to1(perfect fit)(ideal0.95)	0.979
Related fit index (RFI)	0(no fit)to1(perfect fit)(ideal0.90)	0.909
Goodness of fit index (GFI)	(0(no fit)to1(perfect fit)(ideal0.90)	0.901
Adjusted goodness of fit index (AGFI)	(0(no fit)to1(perfect fit)(ideal above 0.8)	0.887

*Source: Table structure from Hair et. al (2017)*

The total fit statistics essential to test the ORS scale are shown in Table 4.16. The normed Chi-square (Chi-square/df) is 1.296, indicating a good fit. Additionally, the CFI is 0.979, NFI is 0.917, and AGFI is 0.887, all of which are good indicators of fit. However, the RMSEA of 0.025 is a less favourable indicator. Overall, these measures suggest a good level of fitness. The model promises to offer an excellent overall fit, according to these diagnostics (Hair et al., 2010; Hu & Bentler P, 1999).

#### **Reliability and Validity of ORS scale:**

The results from Table 4.17 demonstrate that the AVE values range from 0.557 to 0.634. As

all the values exceed the recommended threshold of 0.50, it confirms the convergent validity of the measurement model. Furthermore, the CR value for all ten dimensions surpasses the threshold of 0.7. Additionally, all MSV values for ORS dimensions are lower than AVE and that confirms adequate discriminant validity (Fornell and Larcker, 1981).

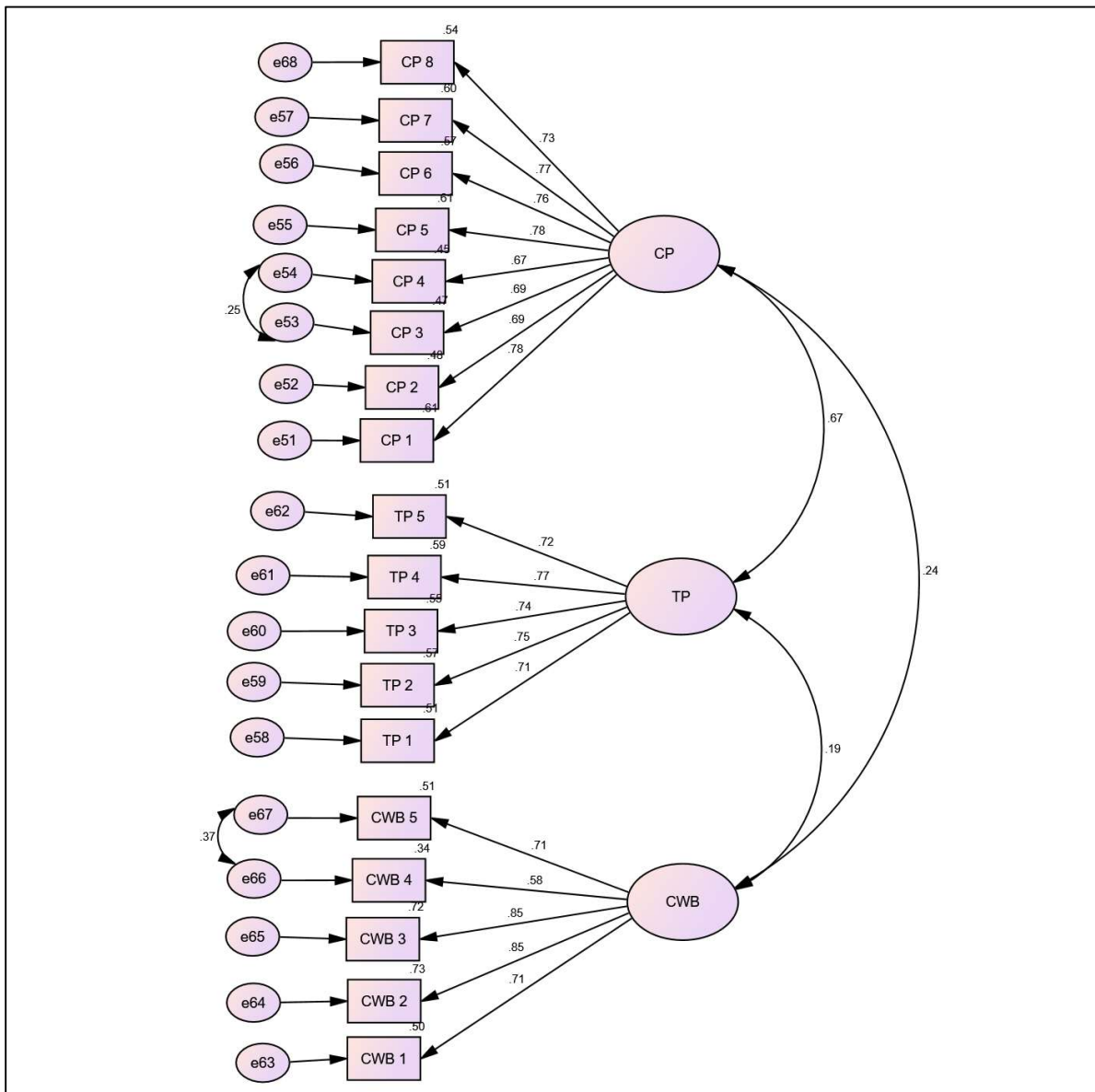
**Table 4.17 Reliability and Validity of ORS scale**

	CR	AVE	MSV	IRD	RS	REC	RE	RO	RI	PI	SRD	RA	RIn
<b>IRD</b>	0.891	0.622	0.462	<b>0.788</b>									
<b>RS</b>	0.879	0.593	0.467	0.381***	<b>0.770</b>								
<b>REC</b>	0.869	0.571	0.482	0.680***	0.412***	<b>0.756</b>							
<b>RE</b>	0.874	0.581	0.553	0.435***	0.684***	0.449***	<b>0.762</b>						
<b>RO</b>	0.892	0.624	0.558	0.458***	0.682***	0.496***	0.744***	<b>0.790</b>					
<b>RI</b>	0.897	0.634	0.558	0.539***	0.681***	0.596***	0.686***	0.747***	<b>0.796</b>				
<b>PI</b>	0.889	0.616	0.468	0.438***	0.602***	0.434***	0.649***	0.671***	0.684***	<b>0.785</b>			
<b>SRD</b>	0.863	0.557	0.482	0.669***	0.486***	0.694***	0.509***	0.592***	0.625***	0.501***	<b>0.746</b>		
<b>RA</b>	0.889	0.616	0.470	0.611***	0.365***	0.628***	0.452***	0.464***	0.459***	0.444***	0.685***	<b>0.785</b>	

<b>RI</b>	0.8	0.6	0.5	0.447	0.683	0.453	0.733	0.736	0.707	0.673	0.487	0.421	<b>0.783</b>
<b>n</b>	88	14	42	***	***	***	***	***	***	***	***	***	***

• **1<sup>ST</sup> ORDER CFA EMPLOYEE PERFORMANCE CONSTRUCTS:**

**Figure 4.3 Measurement Model for Confirmatory Factor Analysis of Employee Performance Constructs**



**Table 4.18 Model fit indices of Employee performance constructs**

<b>Model-Fit Criterion</b>	<b>Acceptable</b>	<b>Model values</b>
Chi-square ( $\chi^2$ )		280.779
Degrees of freedom(df)		130
<b>Absolute Fit Measure</b>		
Goodness-of-fit index(GFI)	0(no fit)to1(perfect fit)(ideal0.90)	0.937
Root-mean square residual(RMR)		0.045
Root-mean-square error of approximation (RMSEA)	<.05 perfect, <.08 good	0.049
Normed chi-square (CMIN/df)	<3	2.160
<b>Incremental Fit Indices</b>		
Normed fit index (NFI)	0(no fit) to1(perfect fit) (ideal0.90)	0.938
Non-normed fit index Tucker LewisIndex(TLI)	0(no fit) to1(perfect fit) (ideal0.90)	0.960
Comparative fit index (CFI)	0(no fit)to1(perfect fit) (ideal0.95)	0.966
Related fit index (RFI)	0(no fit)to1(perfect fit) (ideal0.90)	0.927
Goodness of fit index (GFI)	(0(no fit)to1 (perfect fit)(ideal0.90)	0.937
Adjusted goodness of fit index (AGFI)	(0(no fit)to1 (perfect fit) (ideal above 0.8)	0.917

**Table 4.19 Reliability and Validity of Employee Performance Scale**

	<b>CR</b>	<b>AVE</b>	<b>MSV</b>	<b>CP</b>	<b>TP</b>	<b>CWB</b>
<b>CP</b>	0.905	0.545	0.445	<b>0.738</b>		
<b>TP</b>	0.857	0.546	0.445	0.667***	<b>0.739</b>	
<b>CWB</b>	0.871	0.576	0.057	0.239***	0.187***	<b>0.759</b>

The findings of Table 4.18 revealed that the model fit for the measurement model of employee performance construct has all the indices of the goodness of fit within threshold criteria. The reliability and validity of Employee performance constructs as shown in table 4.19, assured that the employee performance scale is reliable as the AVE values for all three constructs above 0.5 and MSV values below AVE values.

#### **4.6 OBJECTIVE WISE TESTING OF HYPOTHESIS**

##### **4.6.1 TO IDENTIFY PROMINENT ORGANIZATIONAL ROLE STRESSORS AMONG HEALTHCARE PROFESSIONALS**

The first objective is to identify the prominent organizational role stressors that contribute to organizational role stress among healthcare professionals working under different working profiles. For this, data has been collected data from healthcare professionals of accredited and non-accredited hospitals. In order to accomplish this goal, the relationship between all the factors that contribute to organizational role stress in hospital employees has been studied. These factors include “IRD, RS, REC, RE, RO, RI, PI, SRD, RA, RIn”.

The instrument used in this study to measure role stress was the Organizational Role Stress (ORS) scale. The ORS instrument employed a 5-point Likert rating scale, ranging from 0 to 4, to assess the level of role stress experienced by participants. There were a total of 50 negative statements in the instrument, with each dimension represented by 5 unidirectional negative statements. The average scores for each dimension could theoretically range from 0 to 20, with higher scores indicating greater levels of role stress. Overall, the ORS instrument



provides a reliable and valid measure of role stress in this study.

The study has selected a mean score for testing this objective, based on the above discussion it is clear that the organizational role stressor with the highest mean score is considered as the most prominent stressor for health professionals.

**Table 4.20 Mean, Median, and SD Scores for different dimensions of ORS (N=480)**

	<b>Mean</b>	<b>Median</b>	<b>Std. Deviation</b>
IRD	7.47	6.00	4.866
RS	6.73	6.00	4.794
REC	6.33	5.00	4.667
RE	6.67	6.00	4.775
RO	7.10	6.00	4.976
RI	6.50	5.00	4.872
PI	6.11	5.00	4.747
SRD	6.43	5.00	4.856
RA	5.99	4.00	4.995
RIN	6.71	5.50	4.920

*Source: Primary Survey*

**Interpretation:**

Table 4.20 presents the descriptive statistics of the mean and median scores for ten distinct types of organizational role stressors. These scores were computed by aggregating the scores of individual role stressors. Notably, the mean and median scores of all ten role stressors were found to be approximately equal, thus indicating a normal distribution of data. This is a significant finding from a statistical analysis perspective, as it suggests that the sample data is representative of the population and can be used for further analyses.

The results indicate that healthcare professionals experience the highest stress related to Inter role distance (7.47) followed by role overload (7.10), role stagnation (6.73), resource inadequacy (6.71), role erosion (6.67), role isolation (6.50), Self-role distance (6.43), role expectation conflict (6.33), and then personal inadequacy (6.11) while the lowest stress is experienced concerning role ambiguity with a score of 5.99.

These findings proved that inter-role distance is a prominent organizational role stressor among healthcare professionals while role ambiguity is the lowest stressor.

## OBJECTIVE – 2

### **4.6.2 TO EXAMINE THE DIFFERENCE IN ORGANIZATIONAL ROLE STRESS LEVEL BETWEEN THE ACCREDITED AND NON-ACCREDITED HOSPITALS.**

The second objective of the study is to analyze and compare the levels of organizational role stress (ORS) between accredited and non-accredited hospitals. To achieve this, the study utilized an independent t-test to assess the mean values for all the factors contributing to organizational role stress and the overall ORS for both types of hospitals. The study established the criteria for selecting an alternate hypothesis based on a p-value less than 0.05 and a t-value greater than 1.96.

**Ho1: There is no significant difference in organizational role stress level between the accredited and non-accredited hospitals.**

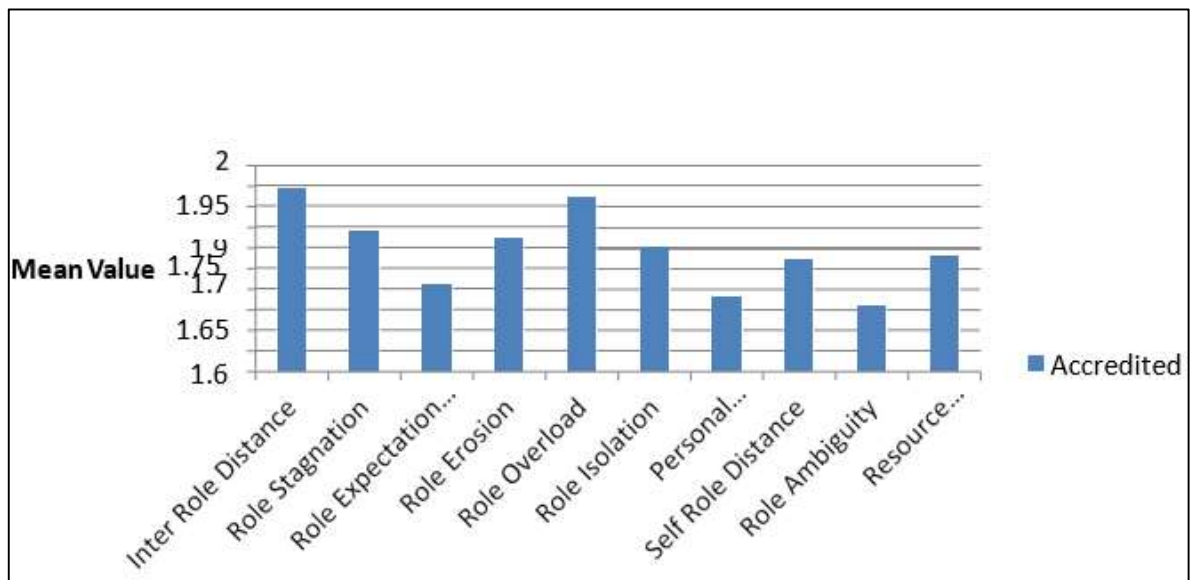
**Ha1: The organizational role stress level is significantly different for accredited and non-accredited hospitals.**

**Table 4.21 Independent t-test for ORS and its dimensions**

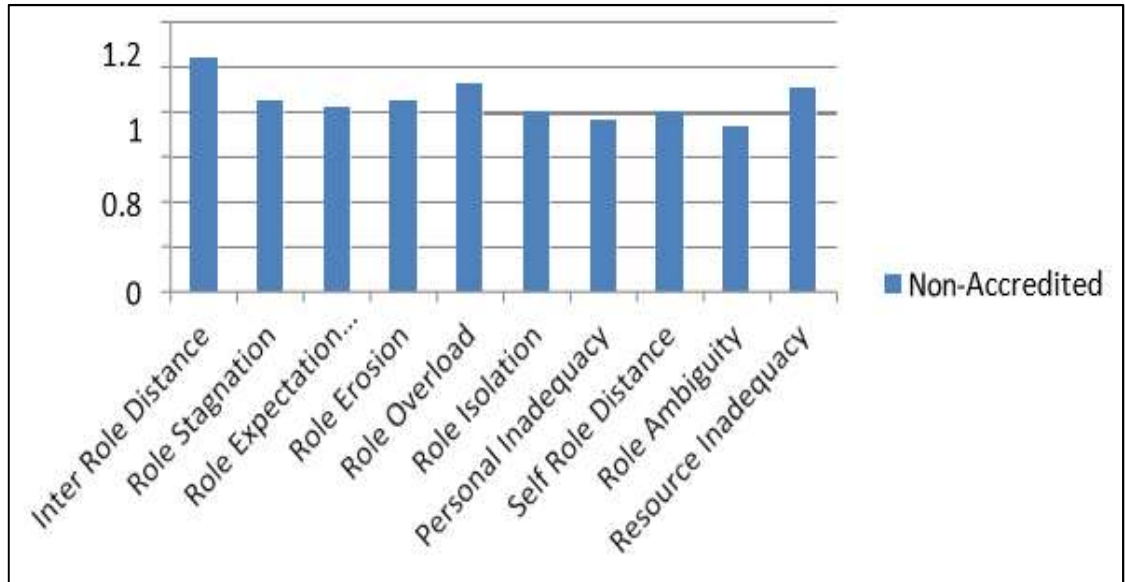
	Hospital	Mean (M)	t-test	Sig. (p-value)
Inter Role Distance	Accredited	1.94	11.444	.000
	Non-Accredited	1.04		
Role Stagnation	Accredited	1.84	13.289	.000
	Non-Accredited	.85		
Role Expectation Conflicts	Accredited	1.71	11.759	.000
	Non-Accredited	.82		
Role Erosion	Accredited	1.82	12.861	.000
	Non-Accredited	.85		
Role Overload	Accredited	1.92	12.808	.000
	Non-Accredited	.92		
Role Isolation	Accredited	1.80	13.134	.000
	Non-Accredited	.80		

Personal Inadequacy	Accredited	1.68	12.097	.000
	Non-Accredited	.76		
Self-Role Distance	Accredited	1.77	12.605	.000
	Non-Accredited	.80		
Role Ambiguity	Accredited	1.66	11.539	.000
	Non-Accredited	.73		
Resource Inadequacy	Accredited	1.78	10.881	.000
	Non-Accredited	.90		
ORS	Accredited	1.79	13.921	.000
	Non-Accredited	.85		

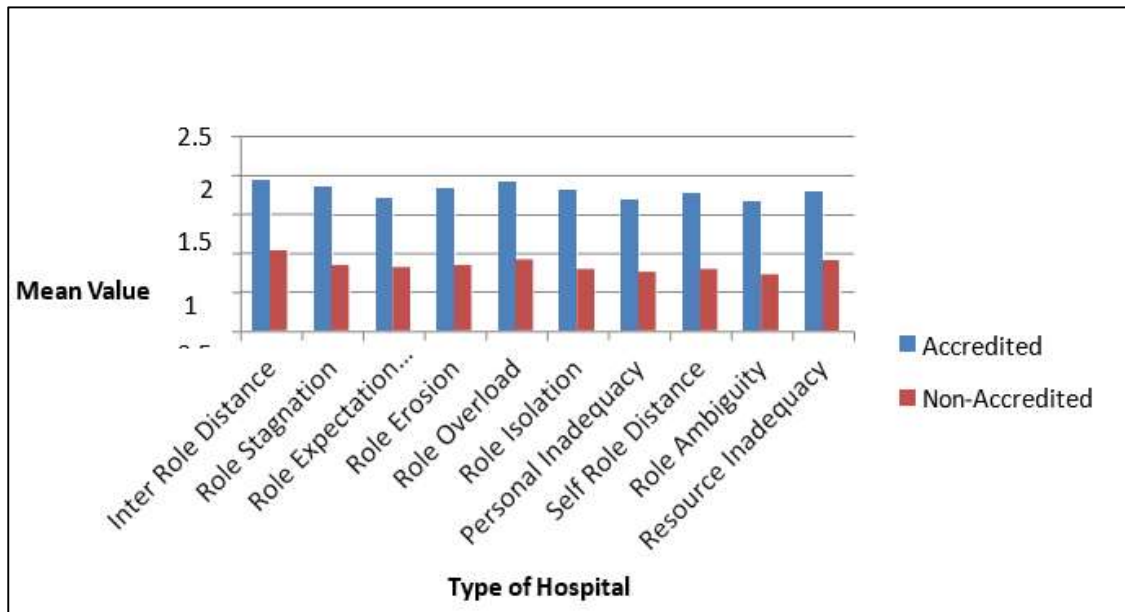
**Figure 4.4 Analysis of various factors contributing to ORS in Accredited hospitals.**



**Figure 4.5 Analysis of various factors contributing to ORS in Non-Accredited hospitals.**



**Figure 4.6 Comparison of factors contributing to ORS based on the type of hospitals.**



**Interpretation:**

According to the results displayed in T-table 4.21, there are noteworthy differences in ORS and its factors amongst health professionals belonging to accredited and non-accredited hospitals. Specifically, the independent t-test value for inter-role distance is  $T = 11.444$  with  $p = 0.000$ . As the p-value is less than 0.05 and the t-value exceeds the table value of 1.96, it confirmed a statistically significant difference between accredited and non-accredited hospitals for Inter role distance.

Based on mean values it can be inferred that Inter-role distance experienced by health professionals of accredited hospitals ( $M = 1.94$ ) is higher compared to non-accredited hospitals ( $M = 1.04$ ).

The t value in the case of Role Stagnation is 13.289 with  $p = 0.00$ . Since the p-value is less than 0.05 and the t-value above 1.96, there is a significant difference between accredited and non-accredited hospitals for Role Stagnation. The mean for accredited hospitals health professionals is significantly higher ( $M = 1.84$ ) compared to non-accredited ( $M = 0.84$ ).

The independent t-test values for Role Expectation Conflicts and Role Erosion are 11.759 ( $p = 0.000$ ) and 12.861 ( $p = 0.000$ ) respectively, since the p-value less than 0.05 and the value above the table value of 1.96, it is confirmed that there is a statistically significant difference between accredited and non-accredited hospitals professionals for Role Expectation Conflicts and Role Erosion. The mean values are higher for accredited (1.71 & 1.82) compared to non-accredited (0.82 & 0.85).

The t value in the case of Role Overload is 12.808 with  $p = 0.00$ . There is a substantial difference in role overload between accredited and non-accredited hospitals, as indicated by the p-value of less than 0.05 and the t-value above 1.96. The mean for accredited hospitals health professionals is significantly higher ( $M = 1.92$ ) compared to non-accredited ( $M = 0.92$ ).

Further, the t value for another stress dimension, Role Isolation is 13.134 ( $p = 0.00$ ). The mean values inferred the role isolation by accredited higher (1.80) compared to non-accredited hospitals (0.80).

The t value in the case of Personal Inadequacy is 12.097 with  $p = 0.00$ . There is a sub-

stantial difference in personal inadequacy between accredited and non-accredited hospitals, as indicated by the p-value of less than 0.05 and the t-value above 1.96. The mean for accredited hospitals health professionals is significantly higher (M=1.68) compared to non-accredited (M = 0.76).

The t value in the case of Self-Role Distance is 12.605 with p=0.00. There is a substantial difference in self-role distance between accredited and non-accredited hospitals, as indicated by the p-value of less than 0.05 and the t-value above 1.96. The mean for accredited hospitals health professionals is significantly higher (M=1.77) compared to non-accredited (M=0.80).

The t value for Role Ambiguity is 11.539 with p=0.00. There is a substantial difference in role ambiguity between accredited and non-accredited hospitals, as indicated by the p-value of less than 0.05 and the t-value above 1.96.. The mean for accredited hospital health professionals is significantly higher (M=1.66) compared to non-accredited (M=0.73).

The t value for Resource Inadequacy is 10.881 with p=0.00. There is a substantial difference in resource inadequacy between accredited and non-accredited hospitals, as indicated by the p-value of less than 0.05 and the t-value above 1.96. The mean for accredited hospitals health professionals is significantly higher (M=1.78) compared to non-accredited (M=0.90).

Finally, the independent t-test conducted for Organizational role stress that t value =13.921 above 1.96 and p value 0.000 (p<0.05) there is a statistically significant difference in accredited and non-accredited hospitals. Based on mean values it is concluded that health professionals of accredited hospitals are experiencing more Organizational role stress (4.1331) compared to non-accredited hospitals (3.6607).

The aforementioned t-tests indicate that, for each of the ten organizational role stress dimensions and overall role stress, health professionals at accredited and non-accredited hospitals differ significantly. The mean value proved that organizational role stress is higher in accredited hospitals. Therefore, the research hypothesis H1 is supported i.e., the organizational role stress level is significantly different for accredited and non-accredited hospitals.

### 4.6.3 STRUCTURAL EQUATION MODEL (SEM):

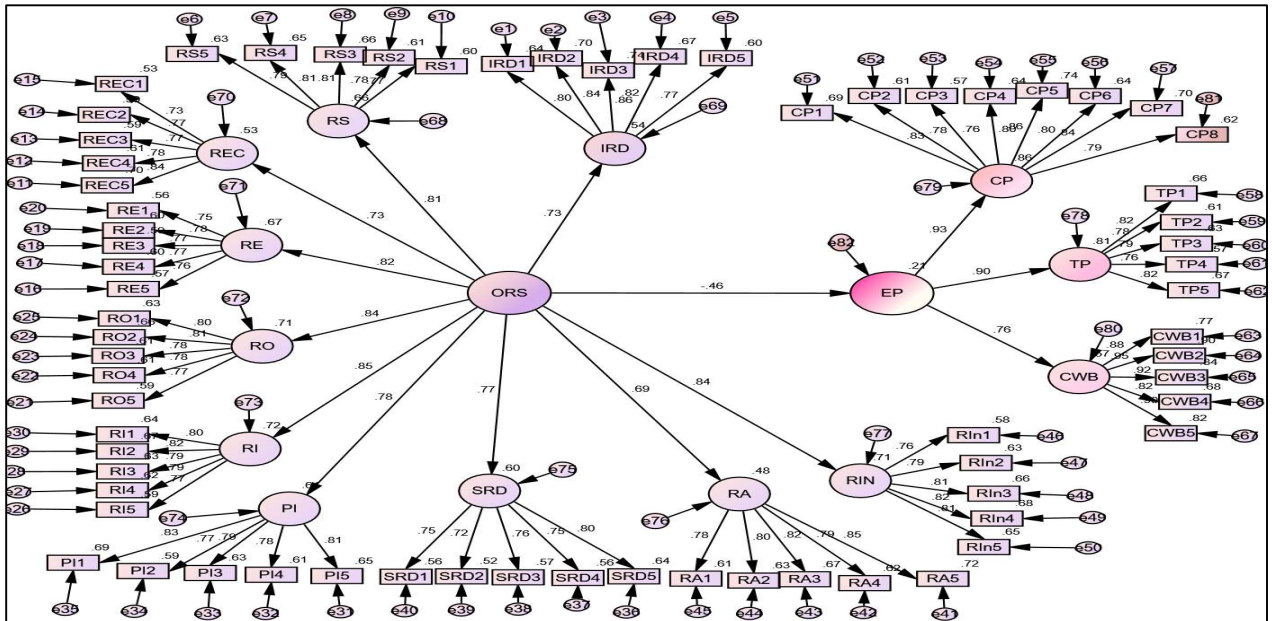
#### Impact of Organizational Role Stress on Employee Performance

Structural Equation Modelling (SEM) is a multivariate approach that is widely utilized for the assessment of hypotheses by means of structural theory to establish complex causal relationships between variables. The SEM concept comprises a collection of regression equations that establish a causal relationship between variables. Additionally, it includes a visual representation of these equations to facilitate a better understanding of the underlying theory (Byrne, 2010).

The present study employs SEM analysis utilizing the maximum likelihood method to examine the causal association between organizational role stress and employee performance within the healthcare sector. Here, ORS is a higher-order factor composed of 10 dimensions. Similarly, employee performance is also a higher-order factor consisting of 3 components.

H2: There is a significant influence of Organizational role stress on employee performance.

Figure 4.7 Structure Model for Impact of ORS on Employee Performance



Note: Here: ORS- Organizational Role Stress, EP- Employee Performance



### Hypothesis testing:

To test the relationships between the different variables in the structural model, the standardized coefficient and related p-value were used. The standardized path coefficient, which indicates the impact of a predictor variable on the dependent variable, was also taken into consideration. To determine whether the research hypothesis is accepted or not, a critical ratio (CR)/T-value above 1.96 and a p-value less than 0.05 at a 5% level of significance are used as a criterion.

According to the results obtained from the structural model illustrated in Figure 4.8 and the path coefficients presented in Table 4.23, it was found that organizational role stress has a significantly negative impact on employee performance. This was supported by the standardized regression weight ( $\beta$ ) of -0.459, CR of -9.838, and p-value of 0.000 ( $p < 0.05$ ), which provided sufficient evidence to accept hypothesis H2. This indicates that organizational role stress significantly influences employee performance, and the relationship is negative. The T-value being greater than -1.96 further supports this conclusion.

Finally, the coefficient of determination/  $R^2$  value 0.211, inferred that 21.1% of employee performance within the healthcare sector is explained by Organizational role stress.

**Table 4.22 Path coefficients for Structure model and hypothesis result**

	Path	C.R.	P	Path coefficient ( $\beta$ )	Result
H2	Organizational role stress $\rightarrow$ Employee performance	-9.838	***	-0.459	Accepted

**Table 4.23 Overall Fit Statistics in the Structural Model**

<b>Indices</b>	<b>Recommended criteria</b>	<b>Observed values</b>
Chi square ( $\chi^2$ )	pval>0.05	3443.287
Normed chi square ( $\chi^2/DF$ )	$1 < \chi^2/df < 3$	1.560
Goodness-of-fit index (GFI)	>0.90	0.906
Adjusted GFI (AGFI)	>0.80	0.818
Normed fit index (NFI)	>0.90	0.948
Comparative fit index (CFI)	>0.90	0.958
Root mean square error of approximation (RMSEA)	<0.05 good fit <0.08 acceptable fit	0.034
Tucker-Lewis index (TLI)	$0 < TLI < 1$	0.947

The results of the employee performance structural model were very promising, as the overall fit statistics, as shown in Table 4.23, indicated that the hypothesized model fits the sample data very well. The good indicator indices (AGFI, CFI, TLI) were all above the recommended criteria, which is a positive indication of the model's fit. The one bad indicator, RMSEA, was below the threshold of 0.08, which means that the SEM model is reasonably consistent with the data. Overall, these results suggest that the model is a good fit for the data and can provide useful insights into employee performance.

#### **4.6.4 OBJECTIVE 3**

**TO ASSESS THE IMPACT OF ORGANIZATIONAL ROLE STRESS ON MANAGERIAL-LEVEL EMPLOYEE PERFORMANCE AMONG ACCREDITED AND NON-ACCREDITED HOSPITALS.**

**H<sub>03</sub> There is no significant impact of organizational role stress on managerial-level employee performance in accredited and non-accredited hospitals.**

**H<sub>a3</sub> There is a significant impact of organizational role stress on managerial-level employee performance in accredited and non-accredited hospitals.**

For testing the above objective, the study has undertaken regression analysis. The number of managerial-level healthcare professionals is 82. In regression analysis, ORS is taken as an independent variable, while employee performance is considered as dependent variable. The major findings of regression analysis include an ANOVA table which indicates whether the proposed model can predict the outcome variable or not, and another table indicates the summary of the model which highlights the percentage of variations in the outcome variable explained by the predictor variable. The most important result is regression coefficients which are used for testing the hypothesis. If the p-value is less than 0.05 then an alternative hypothesis will be accepted.

**Table 4.24 Descriptive Statistics**

Hospital Type		N	Minimum	Maximum	Mean	Std. Deviation
Accredited	ORS	42	.27	2.58	1.0231	.65205
	EP	42	.17	3.36	2.2355	.86378
Non-Accredited	ORS	40	.36	3.45	1.2774	.77183
	EP	40	.17	3.05	1.2948	.50836

**Table 4.25: Model summary**

<b>Model Summary</b>					
Hospital Type	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
Accredited	1	.439 <sup>a</sup>	.193	.173	.78555
Non-Accredited	1	.415 <sup>a</sup>	.172	.150	.46858
a. Predictors: (Constant), ORS					

**Table 4.26 ANOVA for Managerial Performance**

<b>ANOVA<sup>a</sup></b>							
Hospital Type	Model		Sum of Squares	df	Mean Square	F	Sig.
Accredited	1	Regression	5.907	1	5.907	9.572	.004 <sup>b</sup>
		Residual	24.684	40	.617		
		Total	30.591	41			
Non-Accredited	1	Regression	1.735	1	1.735	7.904	.008 <sup>b</sup>
		Residual	8.343	38	.220		
		Total	10.079	39			
a. Dependent Variable: EP							
b. Predictors: (Constant), ORS							

**Table 4.27: Regression coefficients for Managerial Performance**

		Coefficients <sup>a</sup>					
Hospital Type	Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	
		B	Std. Error	Beta			
Accredited	1	(Constant)	2.831	.227		12.445	.000
		ORS	-.582	.188	-.439	-3.094	.004
Non-Accredited	1	(Constant)	1.644	.145		11.369	.000
		ORS	-.273	.097	-.415	-2.811	.008

a. Dependent Variable: EP

**Interpretation:**

The F-test values for accredited = 9.572 and non-accredited = 7.904 with a significance level of  $p < 0.05$  ( $p=0.000$ ) in the ANOVA table 4.26 indicate that the regression model is statistically significant in predicting employee performance (dependent variable).

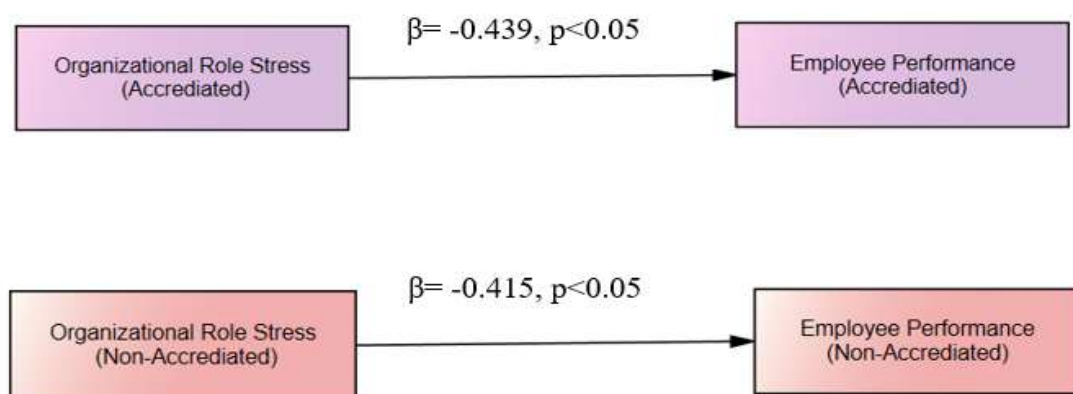
From Table 4.25, The R-value represents the simple correlation between ORS and employee performance for accredited hospitals is 0.439, which indicates a moderate degree of correlation.  $R^2 = 0.193$ , which means that the ORS, explains 19.3% of the variability of the dependent variable, performance, in accredited hospitals.

Similarly, the correlation between ORS and performance for non-accredited is 0.415 with  $R^2 = 0.172$ , confirming 17.2% variations in performance by ORS for non-accredited hospitals.

Coefficients of a simple linear regression model explained the impact of ORS on managerial-level employee performance for accredited and non-accredited hospitals as shown in Table 4.27. Unstandardized coefficients B value explains the relationship between a dependent variable and independent variable as one unit change will affect B value change in, the dependent variable, a positive sign denotes an increase in the dependent variable or a negative indicates a decrease in the dependent variable. The standardized coefficient ( $\beta$ ) values inferred the impact of the independent variable on the dependent variable, the higher the value more the impact.

The findings of Table 4.27 confirmed that ORS has a significant effect on managerial-level employee performance for both types of hospitals, as the p-value is less than 0.05. The standardized coefficient ( $\beta$ ) value for accredited is -0.439 with  $p = 0.004$  and  $T = -3.094$ . Similarly, the  $\beta$  value for non-accredited is -0.415 with  $p = 0.008$  and  $T = -2.811$ . As the p-value for ORS impact on EP for accredited and non-accredited hospitals is less than 0.05 and the T value above -1.96, assured the acceptance of hypothesis H3 i.e., there is a significant impact of organizational role stress on managerial-level employee performance in accredited and non-accredited hospitals. The negative sign indicates that an increase in ORS leads to a corresponding decrease in employee performance. This suggests that as employees experience higher levels of stress related to their organizational roles, their ability to perform effectively diminishes. Based on the standardized coefficient, it can be stated that the impact of ORS on EP for managerial professionals is higher for accredited hospitals compared to non-accredited hospitals.

**Figure 4.8 Regression results for Managerial level employee performance**



#### **4.6.5 OBJECTIVE 4**

#### **TO ASSESS THE IMPACT OF ORGANIZATIONAL ROLE STRESS ON OPERATIONAL-LEVEL EMPLOYEE PERFORMANCE AMONG ACCREDITED AND NON-ACCREDITED HOSPITALS.**

For testing the above objective, the study has undertaken regression analysis. The number of operational-level healthcare professionals is 398. In regression analysis, ORS is taken as an independent variable, while employee performance is considered as dependent variable. The major findings of regression analysis include an ANOVA table which indicates whether the proposed model can predict the outcome variable or not, and another table indicates the summary of the model which highlights the percentage of variations in the outcome variable explained by the predictor variable. The most important result is regression coefficients which are used for testing the hypothesis. If the p-value is less than 0.05 then an alternative hypothesis will be accepted.

**H<sub>0</sub>4 There is no significant impact of organizational role stress on operational-level employee performance in accredited and non-accredited hospitals.**

**H<sub>a</sub>4 There is a significant impact of organizational role stress on operational-level employee performance in accredited and non-accredited hospitals.**

**Table 4.28 Descriptive Statistics**

Hospital Type		N	Minimum	Maximum	Mean	Std. Deviation
Accredited	ORS	42	.27	2.58	1.0231	.65205
	EP	42	.17	3.36	2.2355	.86378
Non-Accredited	ORS	40	.36	3.45	1.2774	.77183
	EP	40	.17	3.05	1.2948	.50836

**Table 4.29 Model Summary**

Model Summary					
Hospital Type	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
Accredited	1	.412 <sup>a</sup>	.170	.166	.74550
Non-Accredited	1	.540 <sup>a</sup>	.292	.288	.62210

a. Predictors: (Constant), ORS

**Table 4.30 ANOVA for operational level employee performance**

ANOVA <sup>a</sup>							
Hospital Type	Model		Sum of Squares	df	Mean Square	F	Sig.
Accredited	1	Regression	22.317	1	22.317	40.154	.000 <sup>b</sup>
		Residual	108.932	196	.556		
		Total	131.249	197			
Non-Accredited	1	Regression	31.609	1	31.609	81.675	.000 <sup>b</sup>
		Residual	76.628	198	.387		
		Total	108.236	199			

a. Dependent Variable: EP

b. Predictors: (Constant), ORS



**Table 4.31 Regression coefficients for Operational level employee performance**

Coefficients <sup>a</sup>							
Hospital Type	Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
			B	Std. Error	Beta		
Accredited	1	(Constant)	2.906	.099		29.459	.000
		ORS	-.515	.081	-.412	-6.337	.000
Non-Accredited	1	(Constant)	2.131	.088		24.302	.000
		ORS	-.501	.055	-.540	-9.037	.000

a. Dependent Variable: EP

**Interpretation:**

The F-test values for accredited = 40.154 and non-accredited = 81.675 with a significance level of  $p < 0.05$  ( $p = 0.000$ ) in the ANOVA table 4.30 indicates that the regression model is statistically significant in predicting the performance of operational level employees.

From Table 4.29, The R-value represents the simple correlation between ORS and employee performance for accredited hospitals is 0.412, which indicates a moderate degree of correlation.  $R^2 = 0.170$ , which means that the ORS, explains 17% of the variability of the dependent variable, employee performance, in accredited hospitals.

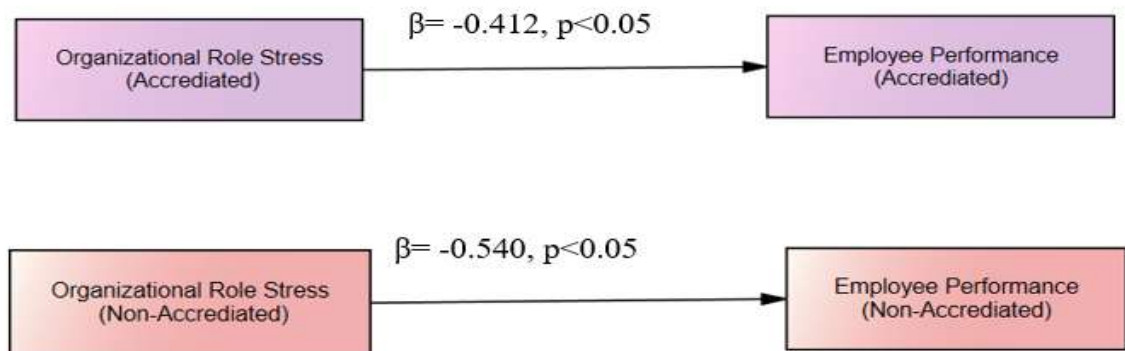
Similarly, the correlation between ORS and performance for non-accredited is 0.540 with  $R^2 = 0.292$ , confirming 29.2% variations in performance by ORS for non-accredited hospitals.

The findings of Table 4.31 confirmed that ORS has a significant effect on operational-level employee performance for both types of hospitals, as the p-value is less than 0.05.

The standardized coefficient ( $\beta$ ) value for accredited is -0.412 with  $p = 0.00$  and  $T = -6.337$ . Similarly, the  $\beta$  value for non-accredited is -0.540 with  $p = 0.000$  and  $T = -9.037$ . As the  $p$ -value for ORS impact on EP for accredited and non-accredited hospitals is less than 0.05 and the  $T$  value above -1.96, assured the acceptance of alternate hypothesis  $H_4$  i.e., there is a significant impact of organizational role stress on operational level employee performance in accredited and non-accredited hospitals. The negative sign indicates an increase in ORS results in a decrease in employee performance.

Based on the standardized coefficient it can be stated that the impact of ORS on EP for operational-level professionals is higher for non-accredited hospitals compared to accredited hospitals.

**Figure 4.9 Regression results for Operation level employee performance**



#### **4.6.6 OBJECTIVE 5**

**TO ANALYZE THE MODERATING EFFECT OF HOSPITAL TYPE IN RELATION BETWEEN ORGANIZATIONAL ROLE STRESS AND EMPLOYEE PERFORMANCE.**

**H<sub>05</sub> The type of hospital does not influence the relationship between ORS and EP.**

**Ha<sub>5</sub>: Hospital type moderates the relation between organizational role stress and employee performance.**

The moderating effect of hospital type was calculated using multi-group analysis in AMOS. The data was divided into two groups: accredited and non-accredited hospitals. Firstly, the study used an Invariance test by calculating the Chi-square difference to check the difference in the group at the model level. In the case of the invariance test, if the difference is significant then the difference in the group was tested at path level followed by pairwise comparison.

#### **Invariance test using Chi-square difference:**

In the first phase, the hypothesized relationship parameters are unconstrained; In the second step, the parameters are fully constrained. If the difference between the two models is significant ( $p < .05$ ), the variable used for splitting the sample moderates the relationship (Jimenez-Jimenez & Sanz-Valle, 2011). The results revealed that the relationship between organizational role stress and employee performance is significant for the constrained and unconstrained models. A significant Chi-square difference indicates hospital type plays the moderator role at the model level as there is variance between both models.

**Table 4.32 Invariance test using Chi-square difference**

<b>Relation: Organizational role stress → Employee performance</b>			
Chi-Square for Unconstrained	6289.784 =4414)	(df	p=0.000
Chi-Square for Fully Constrained	6296.048 =4415)	(df	p=0.000
Chi-Square difference	6.264		p=0.012

- **Multi-group analysis pairwise comparison**

The researcher employed a multi-group analysis to examine how hospital type influences the relationship between organizational role stress and employee performance. For evaluating the impact of the moderator, the difference in path coefficients of the two models was used as the invariance test discussed above was found significant.

As presented in Table 4.33 and Figures 4.10 & 4.11, the moderation results show that the impact of organizational role stress on employee performance is more for accredited hospitals having  $\beta = -0.515$  with  $p = 0.000$ . However, in the case of non-accredited hospitals  $\beta$  is  $-0.327$  with  $p = 0.000$ . Since the path difference is significant as a p-value is less than 0.05 highlighted the significant role of hospital type as a moderator. Moderation results conclude that hospital type moderates the relationship between Organizational role stress and Employee performance, therefore, hypothesis H5 was accepted.

**Table 4.33 Statistical Comparison of Paths**

<b>Paths</b>	<b>Accredited hospital</b>		<b>Non-accredited hospital</b>		<b>Path difference (<math>\Delta Z</math>)</b>
	<b>Path coefficient</b>	<b>Z-value</b>	<b>Path coefficient</b>	<b>Z-value</b>	
Organizational role stress → Employee performance	-0.515	-8.061 (p=0.000)	-0.327	-4.623 (p=0.000)	2.652 (p=0.000)

Figure 4.10 SEM model for Accredited hospital

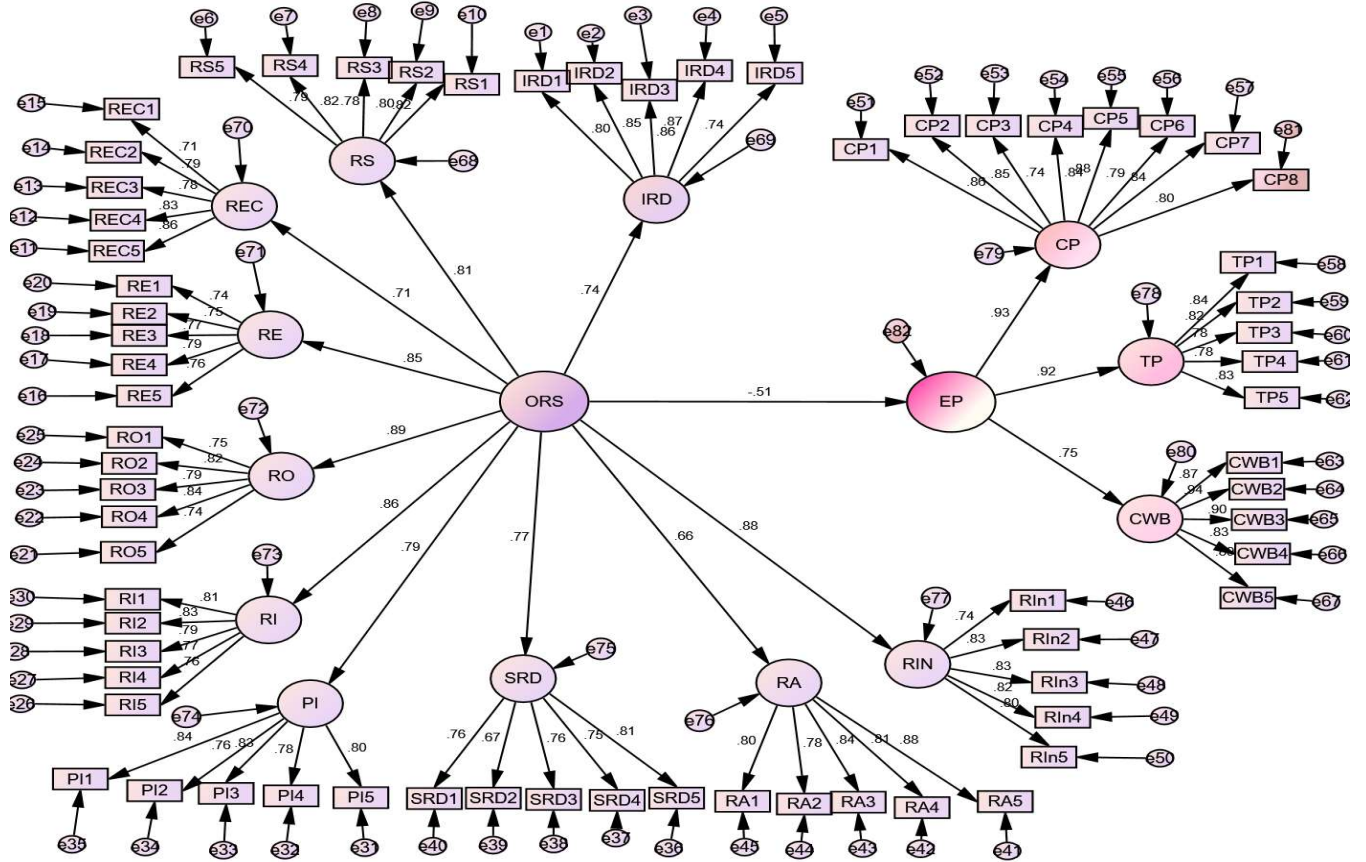
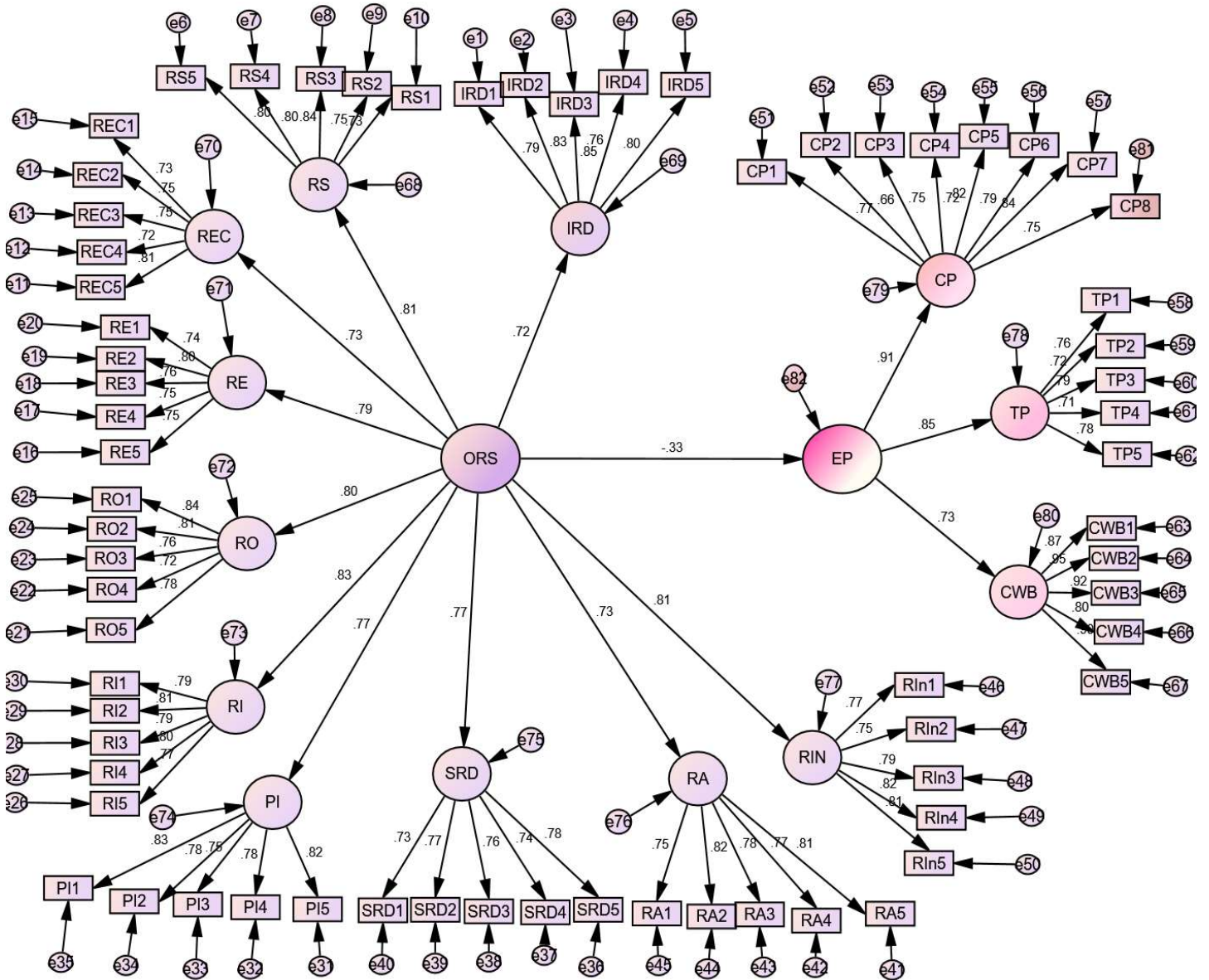


Figure 4.11 SEM model for Non-Accredited hospital



## CHAPTER 5

### SUMMARY AND CONCLUSION

This chapter provides a succinct overview of the research outcomes, implications, and recommendations based on the study results. However, to gain a more comprehensive understanding of the research findings, it is crucial to delve deeper into the conclusion, limitations, and potential avenues for future research. The conclusion of the study suggests that the results are consistent with the research hypotheses and support the proposed research questions. To expound further, it is pertinent to discuss the conclusion, limitations and future research directions. The research findings are primarily divided into two sections, based on which a detailed analysis is presented. The limitations of the study are also discussed to provide an accurate understanding of the research scope and its constraints. Lastly, possible directions for future research are presented, which may help fill the existing research gaps and further enhance the knowledge in the field.

1. First related to general characteristics of data.
2. Another section focused on data analysis results of research objectives.

#### **5.1 Findings related to general characteristics:**

- Demographic details of Healthcare Professionals indicate that out of the total 480 respondents, 34.2% were male and 65.8% were female.
- In terms of the level of professional qualification, it was observed that most of the respondents hold diplomas (46%), followed by graduation and post-graduation.
- It has been observed that the most frequent age group of health professionals was from 25-35 years which had 57.9% of respondents followed by the age group under 25 years, between 36 to 45 years of age, and the age group above 45 years.
- 53.1% were married and 46.9% were unmarried.
- Based on working experience, it is found that professionals working more than 24 months in hospitals constitute the highest percentage of data (60.2%).
- The findings related to the nature of work in hospitals highlighted that professionals from the operational category are more (82.9%) compared to administrative.

## **5.2 Objectives Based Findings:**

Objectives-wise findings are discussed below:

### **5.2.1 Findings related to the first objective.**

#### **To identify prominent organizational role stressors among healthcare professionals.**

The exploratory factor analysis employed in the current study results in the extraction of ten factors that are considered as determinants or dimensions of organization role stress. These factors are IRD, RE, REC, RO, RI, PI, RA, SRD, RIn, RS. It has been observed that all ten factors significantly contribute to the constitution of Organizational role stress. The research results revealed that the most significant components of ORS among healthcare professionals are Inter-role distance and role overload, as deduced from the mean values. The study results are consistent with the past research studies as the findings corroborated with Sinha,(2012); Dasgupta,(2009); Ratna,(2013); Monika Mittal, (2018); Sinha,(2018); Jimmy,(2018); Kanayo et al., (2016); Roohangiz Karimi et.al., (2014); Osman M. Karatepe, (2008); Gayathri Band, (2016); and Dhulla, (2021). The highest role stress among healthcare professionals was experienced for Inter role distance. Role overload, role stagnation, resource inadequacy and role erosion are among the other important role stressors for healthcare professionals. This objective result suggests that healthcare professionals frequently feel that: they are not able to devote much time to different responsibilities and family life due to organizational roles, and they have either too many or too high expectations from the role which they are unable to fulfil in the timeframe, they lack sufficient resources, facilities, and financial support from higher authorities, leading to an excessive workload and limited opportunities for future growth.

### **5.2.2: Findings related to the second objective.**

**To investigate the difference in organizational role stress level between accredited and non-accredited hospitals.**

**H1: The organizational role stress level is significantly different for accredited and non-accredited hospitals.**



The independent t-test conducted for Organizational role stress that t value =13.921 above 1.96 and p value 0.000 ( $p < 0.05$ ) indicates that there is a statistically significant difference in accredited and non-accredited hospitals. Based on mean values it is concluded that health professionals of accredited hospitals are experiencing more Organizational role stress (4.1331) compared to non-accredited hospitals (3.6607). Hence, H1 is accepted. It is observed that in accredited hospitals prominent organization role stressors are: Inter role distance and role overload. The study findings align with previous research, confirming similar results with Sinha,(2012); Dasgupta Hirek,(2009); Tankha,(2006); Sinha,(2018); Sinha and Subramanian,(2012); Jimmy,(2015); Purohit and Vasava,(2017). Additionally, the remaining role stressors caused moderated levels of stress to healthcare professionals. In non-accredited hospitals, there is a notable presence of role stressors like inter-role distance, role overload, and resource inadequacy, while other stressors are relatively less prevalent. For resource inadequacy results findings are similar to the past research studies as results are in line with Dasgupta,(2009); Jimmy,(2015); Kaur et al.,(2021); and Purohit and Vasava(2017). The findings of the independent t-test conducted for all the ten organizational role stressors between accredited and non-accredited hospitals proved that ORS dimensions significantly vary with the type of hospital. The results confirmed that the value of ten ORS dimensions is higher in the case of accredited hospitals. It is concluded that healthcare professionals working in accredited hospitals experience higher levels of organizational role stress compared to those in non-accredited hospitals.

The findings indicate that healthcare professionals in accredited hospitals often feel that they are unable to balance their work responsibilities with their personal and family life. They believe that the expectations placed on them are too high and they struggle to meet them in the given time frame, leading to work overload and limited opportunities for their career advancement. The differences between these roles can often lead to conflicts in a society where individuals are involved in multiple organizations and groups (Pareek, 2004). Additionally, healthcare professionals employed in non-accredited hospitals often express concerns about their inadequate access to essential resources and facilities, as well as the insufficient financial support they receive from higher authorities. This lack of support hampers their ability to deliver quality care to patients and meet the demands of their roles effectively.

### **5.2.3: Findings related to the third objective.**

**To examine the impact of organizational role stress on managerial-level employee performance among accredited and non-accredited hospitals.**

**Ha3 ORS has a significant impact on managerial-level employee performance in accredited and non-accredited hospitals.**

The coefficient of correlation results indicates a moderate level of association between ORS and employee performance. The study findings confirmed that ORS has a significant effect on managerial-level employee performance for both the cases of accredited and non-accredited hospitals, as the p-value is less than 0.05. Hence Ha3 is accepted. The study findings are consistent with the previous research studies as results are similar to Gunhild Bjaalid et.al., (2020); Tankha,(2006); and Sinha and Subramanian,(2012). Middle-level managers demonstrated the greatest degree of inter-role distance conflict, significantly impacting their effectiveness. This issue was less pronounced among high-level and low-level managers operating within private-sector multinational corporations in India, who experienced varying levels of conflict in their roles(Sinha and Subramanian, 2012). The linear regression model results revealed that the impact of ORS on the performance of managerial-level employees is significantly negative for both accredited as well as non-accredited hospitals. It is observed that the influence of ORS on EP for managerial professionals is higher for accredited hospitals compared to non-accredited hospitals.19.3% of the variability of employee performance, in accredited hospitals is explained by ORS. 17.2% of variations in the performance of managerial-level employees are explained by ORS for non-accredited hospitals.

### **5.2.4: Findings related to the fourth objective.**

**To assess the impact of organizational role stress on operational-level employee performance among accredited and non-accredited hospitals.**

**Ha4 ORS has a significant impact on operational-level employee performance in accredited and non-accredited hospitals.**

Organizational role stress has a substantial influence on operational-level staff performance in both types of hospitals, as demonstrated by a p-value of less than 0.05. Hence Ha4 is accepted. The study results are consistent with the past research studies as results corroborated with Shu-Fen Su et al.,(2008); Esther Chang et al.,(2003); Ramli et al., (2018); Revenio Jal-

agat (2017); Ankita Chaturvedi, (2017); Warraich Usman Ali et al., (2014); Nasrin Arshadi et al., (2013); Laiba Dar et al., (2011); and Priscilla Higashi et al., (2013). The ANOVA tables show a significant F-test, indicating the predictor variable can predict the outcome variable. The findings of the linear regression model confirmed that ORS negatively influences the performance of operational-level employees. Based on the standardized coefficient values it is observed that the impact of ORS on EP for operational-level professionals is significantly higher in non-accredited hospitals when compared to accredited hospitals. 17% of the variability of employee performance in accredited hospitals is explained by ORS. 29.2% of variations in the performance of managerial-level employees are explained by ORS for non-accredited hospitals.

#### **5.2.5: Findings related to the fifth objective.**

**To analyze the influence of hospital type in the relation between ORS and employee performance.**

**Ha5: Hospital type moderates the relation between organizational role stress and employee performance.**

The Invariance test conducted using Chi-square difference assured that the influence of organizational role stress on employee performance varies with the type of hospital. The findings of the multigroup analysis reveal that there are significant path differences between hospital types, confirming that hospital type plays a significant role in moderating the relationship between organizational role stress and employee performance. Since the path difference is significant as a p-value is less than 0.05 highlighted the significant role of hospital type as a moderator. The study findings are consistent with the previous literature as results similar with Geraldine Robbins et al., (2021); Ibrahim Al-Faouri et al., (2018); and Gary Elkins et al., (2010). It is also observed that based on path coefficients the strength of the impact of organizational role stress on employee performance is higher for accredited hospitals, confirming that health professionals working in accredited hospitals are experiencing high stress and their performance is low compared to non-accredited hospitals.

### **5.3 IMPLICATIONS**

#### **5.3.1 POLICYMAKERS**

The present research results demonstrated that healthcare professionals experience role stress predominately in inter-role distance, role overload, role stagnation, resource inadequacy and

role erosion. These stressors collectively contribute to a decline in the performance of healthcare professionals. In healthcare settings, reduced performance is directly associated with lower quality of care, which is unacceptable as it compromises patient outcomes and overall healthcare standards. This underscores the critical need for addressing role stress to maintain high-quality healthcare delivery. Inter-role distance arises when a person is unable to balance between the two different roles. Decision makers and policy formulators can use the study findings to properly assess the causes of this stressor and make a policy to reduce the stress for healthcare professionals working across different capacities. Ensure that healthcare professionals have the necessary resources, tools, and support to fulfil their roles effectively. This includes access to adequate staffing levels, appropriate equipment, and technology. Adequate support from the organization can help healthcare professionals manage their workload more efficiently, reducing stress caused by role overload. Another factor includes the lack of opportunities for personal growth, such as inadequate preparation for higher roles and future responsibilities and insufficient time to prepare for upcoming challenges. To overcome this problem policymakers must prepare and formulate policies for healthcare professionals to engage them in continuous learning to enhance knowledge and skills in their respective fields. Designing targeted interventions to reduce role stress is essential for preventing burnout, which in turn enhances performance and retention (Purohit and Vasava, 2017). Organise conferences, workshops, or online courses relevant to their profession. Continuous learning fosters professional growth, boosts confidence, and improves performance.

### **5.3.2 ACADEMIC**

This work contributes significantly to the current corpus of literature by investigating the link between Organizational Role Stress and healthcare professional's performance. Specifically, it seeks to explore any variations in the performance of healthcare professionals working in hospitals which are either accredited or non-accredited. This might be the first study to highlight the major role stressors in both types of hospitals as well as their influence on the performance of healthcare professionals. Further, this research highlights the various organizational role stressors that affect the performance of healthcare professionals working in different healthcare settings. Previous research has primarily focused on staff nurses. In contrast, our current study aims to enhance the robustness of the findings by including a diverse array of healthcare professionals. This encompasses individuals in both clinical roles and those engaged in operational and administrative functions. By broadening the scope of participants, this study will provide a more comprehensive understanding and significantly enrich the

existing body of literature. The current research advanced the existing work by comparative analysis of healthcare professionals working in two different settings. The current study makes a novel attempt to test these variables with the moderating effect of the type of hospitals.

### **5.3.3 SOCIETAL**

The societal implications of research refer to its potential or capacity to visibly affect society. Research results can influence society in various ways. In healthcare research, various stakeholders play crucial roles, each contributes in significant and different ways. Everyone is interconnected to each other in direct or indirect ways. Such as healthcare professionals who deliver the healthcare services to the patients. Ensuring that healthcare providers experience minimal stress is essential for delivering superior care. This approach not only enhances patient outcomes but also bolsters the community's trust and confidence in the healthcare system.

### **5.4 SUGGESTIONS AND RECOMMENDATIONS**

The results of the study have shown that inter-role distance is the main cause of organizational role stress in both types of hospitals. However, other factors such as RS, REC, RE, RO, RI, PIn, SRD, RA, and RIn also contribute significantly to organizational role stress. Healthcare professionals have reported moderate to high levels of organizational role stress, which can negatively affect their overall work performance. Additionally, organizational role stress has a negative impact on employees in both types of hospitals. This presents a significant challenge for management and policymakers, as it signifies a critical issue within the healthcare sector. The presence of role stress among healthcare professionals can lead to decreased performance, job satisfaction, increased burnout and reduced quality of patient care. Given the vital role that healthcare professionals play in providing essential services, addressing the issue is of utmost importance. Immediate corrective and preventive measures are necessary to mitigate the adverse effects of role stress and to ensure the high performance of individuals. By understanding the specific stressors and challenges faced by healthcare professionals, management and policymakers can implement sustainable solutions that promote a healthier and more resilient workforce within the healthcare system.

- The healthcare professional experienced the highest level of stress related to the IRD i.e. Inter-role distance, which refers to the imbalance between two different roles. To overcome or reduce such stress factors, healthcare professionals can create to-do lists, set re-

- alistic deadlines or prioritize their work so that they can efficiently utilize their available time and finish assigned tasks within the stipulated time. By doing so, they can save time for their extra organizational roles.
- Role overload is reported as another prominent role stressor among healthcare professionals. To address this issue, work should be assigned to team members based on their abilities. This approach can maximize the benefits of a multidisciplinary team, reduce overload, and improve individual efficiency through shared experience. Over time, this will enhance everyone's learning. Delegating tasks to capable team members and empowering them to take ownership of their roles can help distribute the workload and alleviate pressure on administrative professionals.
  - An additional significant role stressor reported is resource inadequacy which refers to the inadequate resources available to accomplish the given tasks. Lack of resources, insufficient staffing, and limited decision-making authority have been identified as stressors among healthcare professionals Demir et al.,(2003) and Eley et al.,(2010). Taking this into account, it is the responsibility of the management to provide all the necessary resources, raw materials, machines & equipment and human resources to accomplish the assigned tasks efficiently and timely. This includes overseeing the availability of materials, maintaining the functionality of machines and equipment, and ensuring that the right personnel are in place to carry out the tasks on time. This will lead to the successful completion of projects and enhance the productivity of an organization.
  - Other role stressors reported by healthcare professionals are role stagnation and role erosion which contribute to higher role stress. It indicates that healthcare professionals often feel that they have less opportunity for their growth, being assigned less responsibility, and role functions assigned to other roles. It is important to create a culture in healthcare that values and appreciates the contributions of all professionals, regardless of their role. This can be achieved by recognizing and respecting the different expertise and perspectives that each role brings to the organization. In order to promote this culture, it is recommended to implement acknowledgement programs, team-building activities, and inclusive decision-making processes.
  - The study results revealed an interesting conclusion that operational-level employees in non-accredited hospitals experienced a greater impact of organizational role stress on their performance compared to their counterparts. On the other hand, managerial-level

employees in accredited hospitals experienced a higher impact of organizational stress on their performance compared to their counterparts. Accordingly, respective hospital management has to take necessary steps after identifying the underlying causes of the stress.

- The process of hospital accreditation involves a professional team from the accrediting agency comparing the hospital's standards against pre-established ones. This process creates extraordinary stress on healthcare professionals, affecting their physiological, psychological, and emotional well-being Elkin G. et al.,(2010); Al-Faouri et al.,(2019). Based on the research findings, it is evident that the type of hospital plays a role in influencing the relationship between organizational role stress and employee performance. This suggests that employees at accredited hospitals tend to experience higher levels of organizational role stress compared to their counterparts. Accredited hospital authorities should address role stress in the workplace promptly to improve employee performance which will further lead to demonstrating commitment to quality of care, continuous improvement, patient safety, and community confidence. This proactive approach can also help hospitals remain competitive and reduce re-accreditation costs.

## **5.5 LIMITATIONS**

Every study has certain drawbacks, and the present research is not an exceptional case. During the field visits for the current study, questionnaires were given out to respondents to collect the primary data. Although we have given each component of the study the utmost consideration, the following areas may still have limitations:

The research study's findings suggest that healthcare professional's performance is negatively impacted by role stress in both types of hospitals. However, it is important to acknowledge that the study has a few limitations, which are outlined below:

- The current study is limited to data collected from three regions of Punjab state which are Majha, Malwa, and Doaba only so generalization can be a limitation. Future studies can use the methodology to study the phenomenon at the national level.
- The study's sample unit is restricted to medical professionals employed in private hospitals that are either accredited or not.
- By design, the study is cross-sectional.
- This study is limited to only private hospitals in Punjab.

## **5.6 FUTURE RESEARCH SCOPE**

- Undertaking a longitudinal study can help determine if accreditation program practices contribute to organizational role stress in employees over an extended period of time.
- Future studies can elaborate on the impact of various organizational role stressors on the performance of different sector employees.
- Future research should consider pre and post-accreditation programs to identify the underlying factors causing stress and to evaluate employee performance before and after the accreditation process. This approach may provide a comprehensive understanding of the accreditation impact on employees.
- Future research endeavours in this area could potentially expand the scope of the investigation to include additional outcome variables such as job satisfaction, employee engagement, and turnover intentions. Moreover, it would be worthwhile to explore the impact of stressors on these variables to gain a more comprehensive understanding of the relationship between stressors and employee well-being.
- Future research delves deeper into the relationship between role stressors and demographic variables such as age, gender, income, and position of health professionals working in hospitals. This could help provide more insights and understanding into how these factors impact work-related stress experienced by healthcare workers, and in turn, inform the development of effective interventions and policies to support their well-being.
- The current study has examined the role of hospital type as a moderator between ORS and employee performance, but the same model can be used by considering mediating variables such as perceived organization support, organization commitment, and work-life balance.
- Future studies can be done by taking government hospitals and teaching or research institutes as a sample.

## **5.7 CONCLUSION**

In the fast-paced and demanding healthcare industry, healthcare professionals commonly face a variety of stressors that can be attributed to their job roles. Specifically, ten role stressors are most frequently experienced in this field. These include inter-role distance, where professionals feel disconnected from different roles; role stagnation, where they feel like their roles are not evolving over time; role isolation, where they feel disconnected from colleagues and peers; role



expectation conflict, where they experience conflicts with role expectations; role ambiguity, where they face uncertainty about their roles; role erosion, where they feel like their roles are being diminished; role overload, where they experience an overwhelming amount of responsibilities; personal inadequacy, where they feel inadequate personally; self role distance, where they feel disconnected from their own roles; and resource inadequacy, where they do not have sufficient resources to perform their job duties effectively. These stressors are significantly linked with overall organizational role stress. The ORS resulting from these stressors is affecting healthcare professionals' performance and overall effectiveness in delivering quality healthcare. The research utilized a thorough framework to evaluate role stress among healthcare professionals in private hospitals in India. Key stressors such as inter-role distance, role overload, role stagnation, resource inadequacy, and role erosion were identified as significant factors affecting healthcare professionals. The findings emphasize that healthcare professionals not only experience stress due to inter-role distance, role overload, role stagnation, resource inadequacy, and role erosion but also other stressors that require further research attention. This study is one of the first efforts in India to emphasize significant role stressors beyond the commonly examined role ambiguity and role expectation conflicts identified by researchers in the past. Moreover, the evidence suggests that the organizational role stress experienced by healthcare professionals in accredited hospitals is generally on the higher side as compared to professionals working in non-accredited hospitals. Previous research has predominantly concentrated on staff nurses. However, our current study seeks to augment the findings by incorporating a comprehensive range of healthcare professionals, including those in operational and administrative capacities. The process of accreditation in healthcare introduces a set of new expectations, compliance requirements, and administrative burdens that can significantly increase stress levels for healthcare professionals. This phenomenon highlights the importance of understanding and addressing the stressors that accompany the accreditation process, as they can have a significant impact on the overall well-being and performance of healthcare professionals. Therefore, creating supportive work environments that foster the physical and mental well-being of healthcare professionals is crucial for maintaining a high level of performance and job satisfaction when undergoing the accreditation process. Future research should continue to investigate the specific stressors that healthcare professionals face during the accreditation process and explore strategies for effectively mitigating their impact.

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## **QUESTIONNAIRE**

**Dear Sir/Madam,**

I am a Ph.D. Research Scholar of Mittal School of Business, Lovely Professional University, Phagwara, Punjab. I am conducting research on “**Organizational Role Stress and Employee Performance: A Study of Role of Accreditation in Select Hospitals of Punjab**”. This is a perception-based study. You are free to choose any of the given options. Please spare your valuable time to respond valuably to the various questions mentioned in the questionnaire. The questionnaire will not take more than 15 minutes to complete. The questionnaire is completely anonymous: your answers will not be seen by your senior(s) or colleagues. This information shall be kept strictly confidential and used for academic purposes only. Your participation in the study will be very much appreciated.

**Tejinder Singh Rana**

**Research Scholar, 11617225**

**Lovely Professional University**

**Punjab.**

### Section: 01 Basic information

Sr.No	Question	Response
1	Name of the Hospital	
2	Designation	
3	Name of the Respondent(Optional)	
4	Mobile no. / E-mail	
5	Employee ID	

### Section: 02 Demographic detail

Sr.No	Question	Response	Coding
1	Hospital type	Accredited = 1 Non-Accredited = 2	
2	Working experience in accredited/non-accredited hospital	Less than 6 months = 1 7-12 months = 2 13-18 months = 3 19-24 months = 4 Above 24 months = 5	
3	Gender	Male = 1 Female = 2 Others = 3	
4	Age		
5	Marital Status	Married = 1 Unmarried = 2	
6	Educational Qualification	Diploma = 1 Graduation = 2 Post-Graduation = 3 Others(specify) = 4	-
7	Nature of Work	Administrative = 1 Operational = 2	
8	Monthly Income ( In Rs)	Less than 10,000 = 1 10,001-20,000 = 2 20,001 – 30,000 = 3 30,001 – 40,000 = 4 More than 40,000 = 5	

## Section: 03

### Organizational Role Stress Scale (ORS)

People have different feelings about their roles(Jobs). Statements describing some of these feelings are given in the following. Read each statement and indicate how often you have the feeling expressed in the statement in relation to your role(Job) in your organization. Use the numbers below to indicate your own feelings. If you find that the category does not adequately indicate your feelings, use the one which is closest to the way you feel. Do not leave any item unanswered. **Answer the items in the order given below and tick the appropriate box accordingly.**

- 0** If you **never or rarely** feel this way
- 1** If you **occasionally** feel this way
- 2** If you **sometimes** feel this way
- 3** If you **frequently** feel this way
- 4** If you **very frequently** feel this way

S.No	Statements	0	1	2	3	4
1	My role(Job) tends to interfere with my family life.					
2	I am afraid, I am not learning enough in my present role(Job) for taking up higher responsibility.					
3	I am not able to satisfy the conflicting demands of various people above me.					
4	My role has recently been reduced in importance.					
5	My work load is too heavy.					
6	Other role occupants do not give enough attention and time to my role.					
7	I do not have adequate knowledge to handle the responsibilities in my role(Job).					
8	I have to do things in my role that are against my better judgement.					
9	I am not clear on the scope and responsibilities of my role(job).					
10	I do not get the information needed to carry out the responsibilities assigned to me.					
11	I have various other interests (social, religious, etc.) which remain neglected because I do not get the time to attend to these.					
12	I am too preoccupied with my present role(Job) responsibility to be able to prepare for taking up higher responsibilities.					
13	I am not able to satisfy the conflicting demands of my peers and juniors.					
14	Many functions that should be a part of my role(Job) have been assigned to some other role.					

15	The amount of work I have to do interferes with the quality I want to maintain.					
16	There is not enough interaction between my role and other roles.					
17	I wish I had more skills to handle the responsibilities of my role(Job).					
18	I am not able to use my training and expertise in my role(Job).					
19	I do not know what the people I work with expect of me.					
20	I do not get enough resources to be effective in my role(Job).					
21	My role(Job) does not allow me enough time for my family.					
22	I do not have time and opportunities to prepare myself for the future challenges of my role(Job).					
23	I am not able to satisfy the demands of clients and others, since these are conflicting with one another.					
24	I would like to take on more responsibility than I am handling at present.					
25	I have been given too much responsibility.					
26	I wish there was more consultation between my role and others' roles.					
27	I have not had right training for my role(Job).					
28	The work I do in the organization is not related to my interests.					
29	Several aspects of my role(Job) are vague and unclear.					
30	I do not have enough people to work with me in my role(Job).					
31	My organizational responsibilities interfere with my extra-organisational roles.					
32	There is very little scope for personal growth in my role(Job).					
33	The expectations of my seniors conflict with those of my juniors.					
34	I can do much more than what I have been assigned.					
35	There is a need to reduce some parts of my role(Job).					
36	There is no evidence of several roles (including mine) being involved in joint problem-solving or collaboration for planning action.					
37	I wish I had prepared myself well for my role(Job).					
38	If I had full freedom to define my role, I would be doing some things differently from the way I do them now.					
39	My role(Job) has not been defined clearly and in					



	detail.					
40	I am rather worried that I lack the necessary facilities needed in my role(Job).					
41	My family and friends complain that I do not spend time with them due to the heavy demands of my work role.					
42	I feel stagnant in my role(Job).					
43	I am bothered with the contradictory expectations different people have from my role(Job).					
44	I wish I had been given tasks that are more challenging to do.					
45	I feel overburdened in my role(Job).					
46	Even when I take the initiative for discussions or help, there is not much response from the other roles.					
47	I need more training and preparation to be effective in my work role.					
48	I experience a conflict between what I have to do in my role and my values.					
49	I am not clear what are the priorities in my role.					
50	I wish I had more financial resources for the work assigned to me.					
51	When I must choose between the two, I usually dress for the fashion, not for comfort.					
52	An important part of my life and activities is dressing smartly.					
53	A person should try to dress in style.					

## Section: 04

**Instructions:** The following questions relate to how you carried out your work during the past three months. To get an accurate picture of your behaviour at work, you must complete the questionnaire as carefully and honestly as possible. If you find that the category does not adequately indicate your feelings, use the one which is closest to the way you feel. Please do not leave any items unanswered.

Responses shall be recorded on a five-point Likert scale ranging from seldom to always. Please select an appropriate response against each statement.

**0 = Seldom, 1= Sometimes, 2 = Regularly, 3 = Often, 4 = Always**

S.No	Statements	0	1	2	3	4
1	I was able to plan my work so that I finished it on time.					
2	I kept in mind the work result I needed to achieve.					
3	I was able to set priorities.					
4	I was able to carry out my work efficiently.					
5	I managed my time well.					
6	On my own initiative, I started new tasks when my old tasks were completed.					
7	I took on challenging tasks when they were available.					
8	Please select often if you are reading this.					
9	I worked on keeping my job-related knowledge up-to-date.					
10	I worked on keeping my work skills up-to-date.					
11	I came up with creative solutions for new problems.					
12	I took on extra responsibilities.					
13	I continually sought new challenges in my work.					
14	I actively participated in meetings and/or consultations.					
<b>Response</b>	<b>0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Regularly, 4 = Often</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
15	I complained about minor work-related issues at work.					
16	I made problems at work bigger than they were.					
17	I focused on the negative aspects of a situation at work instead of the positive aspects.					
18	I talked to colleagues about the negative aspects of my work.					
19	I talked to people outside the organization about the negative aspects of my work.					

