Chapter 1

Introduction

Background and Significance of Research Problem

Nowadays nurses are integral professionals in health care organizations. Of the healthcare professionals they spend the most time to contact and communicate with the patient (WHO, 1997). According to the WHO (1997), nurses care for patients, carry out procedures, collaborate with doctors and other team members, assess patients and solve their problems. They coordinate the work of others involved in caring for the patient, including patients' families. They also protect patients, working to prevent infection and ensure a safe, healthy environment in the hospital. They teach patients and their families about health related matters and promote patients' well-being in all situations, speaking for them, if necessary. Oftentimes, nurse-patient interaction is centered of patients' problems such as psychological, social, and physical problems (Maslach & Jackson, 1981). Moreover, every day nurses confront stark suffering, grief, and death as few other people do (Hingley, 1984). Therefore, they have to face with feelings of anger, embarrassment, fear, or despair (Maslach & Jackson, 1981). As a result, in the long-term these can lead them to an emotional condition that might make them feel exhausted.

Burnout is defined as a syndrome of emotional exhaustion, depersonalization, and personal accomplishment that can occur among individuals who do people-work of some

kind (Maslach, 1982). It consists of three key subscales as described by Maslach & Jackson (1981). Firstly, emotional exhaustion (EE) refers to a feeling of excessive emotional stress and being drained by contact with other people. Secondly, depersonalization (DP) is expressed as an insensitive and indifferent response to people who are usually the recipients of social services and care. Finally, personal accomplishment (PA) describes feelings of competence and successful achievement in one's work with people. People who feel more highly at EE and DP, and poorly at PA are experiencing high burnout.

Burnout can lead to a number of serious consequences for the staff, clients, and organizations. It can lead to deterioration in the quality of care or service that is provided by burned out staff (Maslach & Jackson, 1981). Moreover, burnout can be a negative factor of job outcomes (Van Bogaert, Clarke, Roelant, Meulemans, & Van de Heyning, 2010), higher burnout among staff leads to higher turnover rates, dissatisfaction, and low morale. Furthermore, low organizational commitment and absenteeism have been correlated with high nurse burnout (Leiter & Maslach, 2009). In addition, burnout directly or indirectly leads to nurses' health problems (Maslach, 2001) such as headaches, inability to concentrate, hypertension, and digestive problems. Furthermore, severe burnout gives rises to private life problems like lack of marital and familial harmony (Maslach, 1982; Maslach & Jackson, 1981). Consequently, it is essential to reduce burnout among staff in order to eliminate unwanted results as mentioned above.

From the literature, numbers of demographic and organizational factors have been related to burnout. Firstly, several demographic variables can influence burnout. For example, younger nurses experience higher burnout than elder nurses (Thanh, Khymyu, & Baramee, 2010), those with longer experience are less likely to feel burnout than those with less experience (Thanh, et al., 2010), and higher education reduces the likelihood of burnout (Lei, Hee, & Dong, 2010). Secondly, professional and working factors are associated with burnout including working areas (Gillespie & Melby, 2003), occupational stress (Maslach & Jackson, 1981), workload (Thanh, et al., 2010), and job satisfaction (Demir, Ulusoy, & Ulusoy, 2003).

In the early 1980s, the American Academy of Nursing (AAN) identified several factors in the practice environment which could retain and attract nurses. Hospitals that had that kind of nursing practice environment (NPE) were called magnet hospitals. Since then, practice environment has gotten much attention from health care scholars including nursing scholars. Lake (2002) defined NPE as the organizational characteristics of a work setting that facilitate or constrain professional nursing practice. According to Lake (2002), NPE consists of five dimensions. Firstly, nurse participation in hospital affairs refers to participatory roles and values status of nurses in a broad hospital context. It is shown by perceptions of involvement in policy decisions with the hospital, access to and visibility of senior nurse management and career development opportunities. Secondly, nursing foundation for quality of care refers the ability of nurses to access to continuing education and nursing standards that are based on a nursing model of care. Thirdly, nurse manager ability, leadership, and support of nurses refers to characteristics described as

key qualities of a nurse manager for being a good manager and leader. It describes how well senior nurse managers provided an environment that supported and recognized achievements of nursing staff and demonstrated quality leadership. Fourthly, staffing and resources adequacy refers to having adequate numbers of staff and support resources to provide quality patient care. Moreover, it shows nurses' perceptions to nurse-patient ratio levels and time allocation for patient care and peer communication. And finally, nurse-physician relations refers to characteristics of positive working relationships between nurses and physicians. It recognizes nurses' desire for collegial relationships with physicians. It conveys their views about teamwork and collaboration between the two professions. NPE is categorized into unfavorable, mixed, and favorable environments (Lake & Friese, 2006).

There are some differences between nurses' perception of their practice environment in various countries. Firstly, Gardner, Thomas-Hawkins, Fogg, and Latham (2007) studied 199 American nurses and revealed that all five dimensions including manager ability in leadership and management, nurse participation in hospital affairs, staffing and resources, the nurse-physician relations, and nursing foundation for high quality of care were good. The entire nursing practice environment was favorable. Secondly, Middleton, Griffiths, Fernandez, and Smith (2008) found that Australian nurses agreed that four of five dimensions of their practice environment were good (nurse participation in hospital affairs, nursing foundations for quality of care; nursing unit manager ability, leadership and support of nurses; and collegial nurse-physician relations). However, they scored staffing and resources for quality of care as poor.

Consequently, the total nursing practice environment was favorable. Finally, Chiang and Lin (2008) investigated 843 Taiwanese nurses. The findings showed that nurses rated nurse staffing and resources, and nurse participation dimensions as poor. Luckily, nurses rated nursing unit manager ability in leadership and management, and nursing foundation dimensions as good.

The relationships between NPE and burnout have been tested by several scholars. Firstly, Hanrahan, Aiken, and McClaine (2010) found that the emotional exhaustion and depersonalization subscales had negative low correlations with all dimensions of NPE. However, the personal accomplishment subscale had no relationship to all dimensions of NPE. Moreover, the total scores of the Practice Environment Scale of the Nursing Work Index (PES-NWI) had a significant negative weak association with the emotional exhaustion and depersonalization dimensions of the Maslach Burnout Inventory (MBI). Yet, the total NPE had no relationship with the personal accomplishment dimension. Secondly, Van Bogaert, Clarke, Roelant, Meulemans, and Van de Heyning (2010) showed that three dimensions (nurse-physician relation, nurse management at the unit level, and hospital management and organizational support) of the Nursing Work Index-Revised (NWI-R) had negative associations with emotional exhaustion and depersonalization subscales, and possitive associations with the personal accomplishment subscale. Furthermore, a better NPE was associated with low levels of emotional exhaustion and depersonalization subscales, and with a high level of the personal accomplishment subscale. In 2005, Friese found that nurse manager ability, leadership, and management dimension, staffing and resource adequacy dimension, and nurse-

physician relationship dimension had negative associations with nurses' emotional exhaustion; however, nurse participation in hospital affairs dimension and foundations for quality of care had no association with nurses' emotional exhaustion. After that, Laschinger, Finegan, and Wilk (2009) stated that NPE had a significant negative low relationship with emotional exhaustion. Lastly, Gunnarsdóttir, Clarke, Rafferty, and Nutbeam (2009) discovered that all dimensions of NPE including nurse-physician relations, staffing, philosophy of practice, unit level support and hospital level support were negatively influencing emotional exhaustion.

There are five central general hospitals which belong to the ministry of health in northern Vietnam. Those hospitals provide tertiary care including medical, surgical, pediatric, and obstetrics fields with 2,500 nurses. Central general hospitals have been complaining a lot of being overloaded, the occupancy rates are often higher than 150%, and in some hospitals or departments the rate is even higher than 200% (Quoc, 2011). Therefore, the hospitals and government are trying to reduce the pressure on their employees to ensure that they can provide the best quality of care for patients. For example, the government has enlarged and recruited more staff in central hospitals; the provincial and district hospitals' capability was enhanced in order to reduce the burden for the central level.

The Vietnam Nurse Association (VNA) was officially founded in 1990, and brought Vietnamese nurses to have a new title. Nowadays, nurses account for 21% of the health care human resources (MOH, 2007). The physician-nurse ratio is 1:1.85 at present;

meanwhile, the target of the MOH was 1:3.5 in 2010 (MOH, 2007). The education level among the nursing workforce is 82% atsecondary level (educated with 2-year nursing program), 10.5% for elementary level (educated with 1-year nursing program), 3.5% for diploma level (educated with 3-year nursing program), 4.0% for bachelor and master levels (MOH, 2007).

In a survey of Thanh (2008), two thirds of new nurses stated that they had high expectation to be a nurses while in nursing school, but they have been disappointed since beginning the work, sighting little independence, and so many routine jobs; above all, they hardly apply their knowledge in their daily work, and patients and organization barely recognize their work. Tam (2008) stated that, in the work, nurses face much pressure from inappropriate behaviors of patients' relatives when their expectations were not met. A survey of Medical Labor and Environment Hygiene Institute (2002, as cited in Tam, 2008) showed that 23% of all staff in the ICU rated high score of stress, 42% of them rated moderate levels due to prolonged high workload and psychological pressure. Moreover, Thanh et al. (2010) found that there was a moderate level of burnout among nurses working in ICU in general hospitals southern Vietnam.

Additionally, high workload really is a problem in health care professions. Nurses often have to work 45-50 hours per week without receiving extra money (Thanh, et al., 2010). During the night shift, one nurse takes care of 20-30 patients depending on each department, and during daytime, the nurse-patient ratio is about 1:10 (Thanh, 2003). Moreover, insufficient staffing is widely complained about in health organizations. Muc

(2009) reported that Vietnam needs about 145,000 nurses to fulfill needs of both public and private hospitals. Luu (2011, as cited in Dung, 2011) asserted that because of the severe nursing shortage in hospitals, nurses could not provide thorough care to patients. Muc (2011, as cited in Dung, 2011) stated that 20% of the nursing workforce are doing non-nursing tasks in hospital, and 50% of the time is spent on paperwork or financial issues. Furthermore, all health organizations use only fulltime nurses, an apparent difference with Western or developed countries in which part-time and on-call nurses are popular. Therefore, when nurses get sick, the remaining nurses must cover their jobs. The caring model in Vietnam has been gradually changing from task-oriented to patient-oriented with patients as the center of care. However, with the poor condition of the health care system, the quality of health service has not met the growingly diversified needs of the people (MOH, 2006). As mentioned previously, high workload and high requirements progressively drain nurses' energy and passion leading to exhaustion (Lei, et al., 2010).

There was dissatisfaction about patients towards nurses' attitude while giving care. According to Loan's (2006) report, 11.2% of nurses do not smile while they admit patients, administer medicine or fluids, or take care of patients. In addition, 6.5% of nurses were reported as not answering or giving unclear answers when patients asked or wondered about their diseases. Moreover, 8.7% of nurses were said to have answered patients' questions inappropriately. Another survey about patients' opinions of ethical performance among nurses at central general hospital of Nam Dinh province (Yen, 2002) reported that 22.2% of nurses occasionally talked to patients, 10.8% of them

perfunctorily talked to patients, and unbelievably 80% of nurses did not answer or answered perfunctorily to patients. Those numbers showed that negative and unwelcome attitudes apparently exist in various contexts.

Fortunately, the nursing profession in Vietnam is undergoing many great changes. Nowadays, the nursing profession is getting more concern from health care leaders (VNA, 2010). In 2007, Trieu (the Minister of Health) stated that although Vietnamese nurses have many great improvements there are still some limitations which need to be made good such as: professional autonomy in working, self-study spirit in order to update knowledge and skills, and especially, enhance communicative skills, and a polite serving style to patients. He also asserted that MOH will collaborate with other ministries to solve problems of promotion policies, work conditions to nursing profession and nurses in order that nurses bring their potential into play, and contribute to the mutual mission of health care profession to take care of patients and people. In 2008, MOH encouraged all health care organizations to have at least one position for nurses to be one of the top managers (vice director, vice president) and enlarge activity areas of nurse in order that they can contribute more in serving patients.

Hospital-wide, staff nurses can usually participate in some decisions such as determining internal expenses, and evaluating managers' performance. However, for important decisions, a board of directors and department leaders has responsibility for, and staffs only report their performance regarding the decisions (Lieu, P. T., personal communication, July, 2011). With the increasing opportunity of getting higher education, encouragement and open policies, nurses are becoming more active in delivering care to

patients than they have ever been before. In 07-Circular (MOH, 2011), every hospital must build an independent nursing system to manage and evaluate nursing performance. Moreover, nurses must be able to easily contact or talk with the nurse director of hospital (Toan, N. N., personal communication, July, 2011). In addition, the hospitals also encourage nurses to continue or enhance their education, both formal and informal, by giving nurses flexible schedules, and rewarding for excellence study results (Trinh, Thinh, Huong, & Phuong, 2010). However, Van found that Nurses in general hospitals of Vietnam participated in continuing education at a low level. This could be due to workload, personnel shortage, and ineffective legislation for continuing education (Van, 2010).

The nursing tasks and job description are well written in the 07-Circular and other documents (MOH, 2011). In the document, nurses are giving more responsibilities and areas of practice. The quality of nursing staff and quality of care are required to meet the agreement of recognition of nursing care among ASIAN countries as the government signed. That is the significant step of the government to boost nursing care to approach the international standards of care. However, nurses have little time to advance and update their knowledge because they have to do so much non-nursing job like paperwork, collecting hospital fees from patients, and entering data into computer. Moreover, nurses were reporting that they more clearly understood medical knowledge than nursing knowledge (Yen, 2002). All of these things, in the long term, might decrease nurses' knowledge and attitude to their own profession.

A report of the Nursing Section of Ministry of Health (NSMH) (2010) illustrated that there are 6,758 head nurses working in hospitals, 18.1% of them hold bachelor degree, 9.8% hold diploma degree, and 71.9 hold secondary degree. Among those, nearly 50% have participated in at least one leadership and management course (NSMH, 2010). In addition, staff nurses reported that they got little recognition from their superiors in their work, and they feared to report their problems to nurse managers because they did not want to be complained (Thanh, et al., 2010).

Expectedly, the new government regulations have focused on the relationship between physicians and nurses, it emphasizes that nurses and physicians have to collaborate and cross-check each other in order to avoid medication-errors and bring best care for patients (MOH, 2011). Sometimes, nurses cannot read physicians' prescription because of bad handwriting, but they hesitate to ask physicians for the feeling of disturbing them. Moreover, some physicians often undervalue nurses' assessments, suggestions, and advices (NBND, 2010).

In summary, it has not been previously known about the category of nursing practice environment, the level of burnout, and the relationship between the two in Vietnam, specifically the northern region. Subsequently, there has been a need to investigate about that information. Moreover, understanding nursing practice environment and burnout might help nurse managers develop appropriate strategies, and help future researchers to have further interventions to improve the nursing practice environment and burnout among nurses. Therefore, the researcher explored those

questions by conducting a study to examine nursing practice environment, burnout, and the relationships between nursing practice environment and burnout among nurses in general hospitals, The Socialist Republic of Vietnam.

Research Objectives

1. To examine nursing practice environment as perceived by nurses in central general hospitals, The Socialist Republic of Vietnam.

2. To examine burnout as perceived by nurses in central general hospitals, The Socialist Republic of Vietnam.

3. To examine the relationships between nursing practice environment and burnout among nurses in central general hospitals, The Socialist Republic of Vietnam.

Research Questions

1. What is the category of nursing practice environment as perceived by nurses in central general hospitals, The Socialist Republic of Vietnam?

2. What are the levels of burnout and its subscales as perceived by nurses in central general hospitals, The Socialist Republic of Vietnam?

3. Are there relationships between nursing practice environment and burnout among nurses in central general hospitals, The Socialist Republic of Vietnam?

Definition of Terms

Nursing practice environment refers to the organizational characteristics of a work setting that facilitate or constrain professional nursing practice. Nursing practice environment includes five dimensions: (1) nurse participation in hospital affairs; (2) nursing foundations for quality of care; (3) nurse manager ability, leadership, and support of nurses; (4) staffing and resource adequacy; and (5) nurse-physician relations (Lake, 2002). They were measured by the Practice Environment Scale of the Nursing Work Index developed by Lake (2002).

Burnout refers to a syndrome of emotional exhaustion, depersonalization, and personal accomplishment that can occur among individuals who do people work of some kind. it consists of three subscales: (1) emotional exhaustion, (2) depersonalization, and (3) personal accomplishment (Maslach & Jackson, 1981). It was measured by the Maslach Burnout Inventory developed by Maslach & Jackson (1981).

Nurse refers to a person who holds either master degree, bachelor/diploma degree or secondary level (educated with 2-year nursing program), and has worked as staff at least one year in central general hospitals, The Socialist Republic of Vietnam.

Central General Hospital refers to the government health care setting at the central level, which have more than 500 beds and provide services in medical, surgical, pediatric, obstetrics, gynecology, and cardiac care. In this study they included five hospitals: Bach Mai Hospital; Viet Duc Hospital; Vietnam-Sweden Hospital; Thai Nguyen Central General Hospital; and Vietnam-Cuba Dong Hoi Friendship Hospital.