

CLINICAL INVESTIGATION

STAFF BURNOUT IN LONG-TERM CARE FACILITIES

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Background: A rapidly changing health and long-term care environment characterized by efficiency and cost-containment is resulting in changing roles and responsibilities among all levels of staff who work with seniors in long-term care facilities. More is being asked of all, and there are reports of health-care providers who are overworked, stressed-out and suffering from burnout. Little is known of the burnout experienced by staff in long-term care facilities. We investigated levels of burnout among nursing personnel who provide care to seniors in long-term care facilities in the Ottawa-Carleton Region.

Methods: Methods were exploratory and descriptive and employed the use of mail-back questionnaires from a random and proportional sample of 86 registered nurses (RNs), 92 registered practical nurses (RPNs) and 49 health-care aides (HCAs). The *Maslach Burnout Inventory* was used to gather data about respondents' perceptions of their level of personal accomplishment, emotional exhaustion, involvement and depersonalization.

Results: Mean scores were highest on measures of personal accomplishment (7.3) and emotional exhaustion (5.7). There were statistically significant differences between HCAs (7.0) and RPNs (5.2) or RNs (5.0) on levels of emotional exhaustion. Mean scores were lowest on measures of depersonalization (4.1) and involvement (5.0). HCAs (5.7) differed significantly from either RPNs (4.8) and RNs (4.6) on level of involvement.

Conclusion: Staff burnout does not auger well for the provision of high quality care to residents of long-term care facilities. Administrators should strive to reduce staff's level of emotional exhaustion and increase their level of personal involvement with residents, to ensure care that is caring and comprehensive.

Key words: Staff, burnout, long-term care facilities, frail elderly

INTRODUCTION

Approximately 3,500 frail seniors reside in long-term care facilities in the Ottawa-Carleton Region. They occupy approximately 90% of available long-term care beds. A substantial proportion (40%) is over the age of 85, and three-quarters have some

degree of dementia. In addition, various disorders, notably confusion or delirium, may be associated with other medical problems such as systemic infections, drug interactions, and the outcomes of trauma or surgery.¹ The broad range of clinical presentations, courses and complications found in seniors require a special approach to care on the part of health-care workers who face care requirements that are increasingly complex and demanding. They are, however, portrayed in the literature as stressed, overworked and burned out.²⁻⁴ Added to the physical burdens and lack of support associated with their work⁵⁻⁷ are more subtle responsibilities for the emotional well-being of residents and the maintenance, if not promotion, of functional and mental competence and prevention of deterioration. In addition, they must deal with difficult behaviours such as agitation, wandering and aggressive outbursts. Nursing personnel who are stressed, overworked and burned out cannot provide an optimal level of care.

The purpose of this project was to determine the level of burnout reported by nursing personnel in long-term care facilities in the Ottawa-Carleton Region. These data could then be used to develop recommendations to improve the quality of their work lives and ultimately the quality of care delivered.

METHODS

The study, which employed a descriptive exploratory design, used a secondary analysis of data from a larger study designed to explore the experience of providing formal care to seniors who live in long-term care facilities. The University of Ottawa Human Ethics Committee provided ethical clearance. An advisory committee representing a variety

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of health disciplines and long-term care facilities provided on-going direction for the study and helped to ensure its relevance and feasibility. In addition, the *Council on Aging of Ottawa-Carleton* and the *Seniors' Resource Centre of the University of Ottawa* were invited to participate, by bringing the perspective of seniors themselves and their families. A purposive two-stage procedure was used for data collection. A list of the 19 long-term care facilities in the Ottawa-Carleton Region was generated, and 9 facilities were invited to participate in the study. Facilities were selected to represent provincial patterns of size, rural/urban location, language, and type of ownership. Letters of information and questionnaires were mailed to a random and proportional sample of 126 registered nurses (RNs), 139 registered practical nurses (RPNs) and 94 health-care aides (HCAs). Consent was implied by return of the completed questionnaire to the investigators.

Measures

Demographic variables consisted of age, gender, marital status, education, occupational status and length of experience in the institution.

Level of burnout was measured by adapting the *Maslach Burnout Inventory* (MBI), the most widely used standardized measure of burnout.⁹ This inventory consists of 25 items that are designed for use with human services professionals. There are four subscales relating to emotional exhaustion (9 items), depersonalization (5 items), personal accomplishment (9 items) and involvement (3 items). The MBI was modified from the original in that the response scale was a likert scale rather than the response scales eliciting frequency and intensity of each item. The MBI has satisfactory reliability and validity with a variety of employee populations.^{10,11} A Chronbach's alpha of 0.78 has been reported.¹² The reliability coefficient for all items in this study was 0.81. MBI scores were classified on the basis of cutoff points recommended by the developer of the scale and are consistent with other studies on burnout.^{13,14}

Analysis

Descriptive statistics were employed to analyze the major variables of the study. Analysis of variance and Sheffe's test served to compare the responses among categories of respondents.

Sample

A total of 275 health-care providers from 9 long-term care facilities responded to the questionnaire, for an overall response rate of 63%. Forty-eight questionnaires were incomplete and therefore not entered into the analysis. The specific response rates were as follows: health-care aides (HCAs 52%), registered practical nurses (RPNs 66%) and registered nurses (RNs 68%). The typical respondent was female and married. Most had children. Just under half worked on a full-time basis with seniors who were cognitively impaired. The majority of RNs provided care of a direct (hands-on) and indirect (managerial and administrative) nature. The majority of HCAs and RPNs provided direct hands-on care only. Respondents were, in large measure, long-term employees, having worked an average of 12 years at their current place of employment.

RESULTS

Feeling of Burnout

Table 1 presents respondents' scores, which on average were moderate (5.5). The personal accomplishment subscale described feelings of competence and successful achievement at work. Mean scores ranged from a low of 7.0 (HCAs) to a high of 7.7 (RPNs). No statistically significant differences emerged among categories of staff with respect to feelings of accomplishment. The emotional exhaustion dimension of the burnout scale referred to feelings of being overextended and exhausted by one's work. Mean scores ranged from a low of 5.0 (RNs) to a high of 7.0 (HCAs). HCAs reported statistically significantly more emotional exhaustion when

Table 1. Feelings of Burnout

Variables	(Low = 1; High = 10)					
	RNs (N=86)		RPNs (n=92)		HCAs (N=49)	
	x	SD	x	SD	x	SD
Personal						
Accomplishment	7.2	1.6	7.7	1.5	7.0	1.2
Emotional						
Exhaustion*	5.0	1.2	5.2	1.5	7.0	1.2
Involvement**	4.6	2.5	4.8	2.0	5.7	1.5
Depersonalization	3.6	2.5	4.0	1.8	4.8	1.5

*p<0.01 for difference between HCAs and RPNs or RNs.

**p<0.05 for difference between HCAs and RPNs or RNs.

compared with RNs or RPNs.

The involvement subscale described the degree to which respondents were involved with residents who were recipients of their care. Mean scores ranged from a low of 4.6 (RNs) to a high of 5.7 (HCAs). HCAs were significantly more involved with residents than were RNs or RPNs. The depersonalization subscale assessed feelings of callousness towards clients, excessive detachment, and the tendency to treat clients like objects. Mean scores ranged from a low of 3.6 (RNs) to a high of 4.8 (HCAs). There were no statistically significant differences among categories of staff with respect to feelings of depersonalization.

DISCUSSION

A rapidly changing health and long-term care environment, characterized by efficiency and cost-containment, is resulting in changing roles and responsibilities and feelings of uncertainty among all levels of staff who work with seniors in long-term care facilities. In addition, the care required by residents is becoming more complex and demanding, as levels of physical and mental acuity and dependency increase. Our project derived from concerns about the quality of care provided by front-line workers, who are portrayed in the literature and popular press as stressed, overworked and burned out. The purpose was to investigate the level of burnout reported by nursing personnel who provide care to seniors in long-term care facilities and to develop approaches to prevent and ameliorate such feelings and create a work environment supportive of high quality care for residents.

Findings were both encouraging and disconcerting. Respondents scored highest on measures of personal accomplishment and emotional exhaustion. There were no statistically significant differences among categories of staff with respect to feelings of personal accomplishment. This is an encouraging finding that augers well for quality health-care in long-term care facilities. The high level of personal accomplishment reported signals interest in and concern for residents by nursing personnel of long-term care facilities. However, HCAs were significantly more emotionally exhausted than were RNs or RPNs. This is a troublesome finding, because the bulk of the hands-on care dealing with the immediate daily needs of residents in long-term care facilities is provided by HCAs. The work of

HCAs is both physically and emotionally challenging, and their status and level of remuneration in the health-care hierarchy is low. There is confirmation in the literature of the association between the challenges of the job, including dealing with physical and psychological aggression, and the number of working hours, on levels of emotional exhaustion among nursing personnel.^{2,15,16} The emotional exhaustion of HCAs may ultimately negatively affect the quality of care available to residents. There are also reports that perceived environmental uncertainty, such as that existing in current health- and long-term care environments, is predictive of burnout among nursing personnel.¹⁷ A relationship between high levels of emotional exhaustion is also commensurate with considerations of alternative work situations.¹³ Such considerations do not auger well for residents of long-term care facilities, who are dependent upon nursing personnel for many aspects of their care and well-being. Strategies need to be developed to moderate the emotional exhaustion experienced by staff in long-term care facilities.

Respondents scored lowest on measures of personal involvement (involvement with residents who were the recipients of care) and depersonalization (feelings of callousness towards residents, excessive detachment, and the tendency to treat residents like objects). Personal involvement requires the investment of the self in the well-being of others. It may be that a task-based approach to care, which is present in many long-term care facilities,¹⁸ precludes a high level of personal involvement on the part of staff. Such an approach focuses on the completion of tasks, rather than on the overall well-being of residents. A more person-centered approach that goes beyond task performance may allow for the personal involvement of staff with residents and result in care that is characterized by caring and comprehensiveness and is cognizant of the biographical history of residents. It is encouraging, however, that staff reported low scores on measures of depersonalization. This finding augers well for the potential of nursing personnel to care for residents with caring and compassion.

Recommendations for Policy and Practice

Burnout is a complex, multidimensional construct that is identified most often by the symptoms it pro-

duces. The findings from this project suggest that it is important for long-term care facilities to:

1. Reduce situations that create emotional exhaustion among staff members. Caring for seniors who are in their last phase of life is challenging, both physically and emotionally. A great deal is asked of nursing personnel who are responsible for ensuring the physical and emotional well-being of residents. Medical and nursing technology is changing on an almost daily basis, and staff is hard-pressed to keep up with these changes. Long-term care facilities would be well-advised to be observant of the level of fatigue and morale of staff in an effort to prevent emotional exhaustion and its sequelae among staff. Providing continuing education that is relevant to the changing approaches to the care of seniors will also contribute to the development of a knowledgeable and skilful staff, that is confident in its ability to provide caring, competent and comprehensive care. Creating a supportive work environment that allows for adequate staffing, flexibility and choice with respect to assignment, participation in clinical decision-making, adequate resources and recognition for work well done will help to prevent emotional exhaustion among staff members.
2. Increase opportunities for personal involvement with residents. On the one hand, the unique personal and historical biographies of residents who have lived long and varied lives, can serve as the basis for interesting and caring relationships between staff and residents. On the other hand, the day-to-day activities associated with the care of frail residents are substantial and are frequently carried out in a task-based fashion. Such an approach to care, which is present in many long-term care facilities, can result in the routinization of relationships between staff and residents and detract from the personal involvement of staff with residents. A person-based approach, which includes but goes beyond, task performance and focuses on comprehensive care that addresses the social-emotional needs of residents, has a greater potential of increasing the personal involvement of staff and the establishment of meaningful and caring relationships between staff and residents. Such an approach requires biographical knowledge of the resident and the provision of person-

alized care that recognizes the uniqueness and idiosyncrasies of the resident. A person-centered approach to care will help to make residents feel at home in the long-term care facility and recognize that they are cared for by staff who are knowledgeable, skilful and caring.

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