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Occupational Stress of Nurses in a Private Hospital, Vellore City

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ABSTRACT

Purpose: The main aim of the study is to identify the dimensions and factors influencing the occupational stress of nurses' who are employees in a private hospital at Vellore, Tamil Nadu.

Methodology: A questionnaire was used to measure the professional stress among the nurses in the hospital. The sample of the research consists of 62 nurses working in a private hospital at Vellore, Tamil Nadu. The questionnaire contains two segments. The first portion deals with socio-demographic information and second segment consist of six dimension say death and dying(6 variables), conflict with physicians (4 variables), lack of support (3 variables), conflict with other nurses (4 variables), work load (4 variables) and uncertainty concerning treatment (4 variables). Distress

Implications: Majority of the nurses expressed their frustration about the conflict with their supervisors, inadequate manpower to cover the units and also complaint about the inadequate information provided by the physicians with regard to the treatment of the patients. The hospital management should employ adequate staff members for the smooth functioning of the work in each unit. They should also arrange meeting between physician and nurses as well as between nurses and supervisors wherein they discuss about all the issues in an amicable manner. Hence, this research paper report about the dimension influencing the occupational stress of nurses. The researchers confirmed from this study that the socio demographic factors of the nurses play a key role with regard to occupational stress.

Keywords: Occupational stress, Dimensions, Private hospital, Nurses, Hospital management.

1. INTRODUCTION

The current study is an attempt to identify the occupational stress of nurses in a private hospital. It is argued that the causes for dissatisfaction among nurses like role conflict, poor compensation, heavy work load, communication system, executing many work at the same time, dealing with tough patients and family members of the patients, more paper works and lack of carrier growth. The key factors identified for stresses were organization culture, career growth, and relationship with superior, colleagues and work-life conflict. These factors have significant influence on physical and psychological related problems to nurses (Rajan and Joseph, 2012). There were a significant inverse influence in the job stress and job insecurity among the employees working in private hospital when compared to the employees working in the public hospital (Ogunjimiet al.'s (2009). The most important and key sources of stress considered as heavy work load, shortage of manpower, failure or incapability to fulfil the patients' requirements, not able to manage the rough patients and lack of support from seniors or supervisors (Sylvia McNeely (1996). New to profession and lack of skill increased the stress level among the nurses. The other domain for the stresses were insufficient manpower, job burden, role stress, clash with patients, family members and co-workers (Boey, 1999; O'Brien-Pallas and Baumann, 2000; Taylor et al., 1999). The outcome of occupational stress - dropped in the quality of work, dissatisfaction, high staff resignation, frequently absent from job, dejection and somatic problems (Dewe, 1989; Humpeland Caputi, 2001; Taylor et al., 1999; Tyler and Ellison, 1994). The major stressful purviews were organizational culture, nature of the job, relationship among the nurses. The nurses reported that employed in the pediatric section found to be most stressful job (Yau Yu Sui et al. (2012). The work culture and the attitude of the hospital management identified as the primary sources for the occupational stress (Sveinsdottir, et al., 2006). The primary sources for the occupational stresses - lack of interaction, manpower shortage, lack of resources and hospital administrative pressure (Bekat et al., 2005). The current study identifies the effect of demographic factors affecting the occupational stress among nurses working in a private hospital at Vellore city.

1.1. Operational Definition

Stress is derived from the Latin word 'Stringere', connotation 'to draw tight', and was used in 17th century to describe hardships or sickness. During the late 18th century stress symbolized "force, pressure, strain or strong effort", referring mainly to an individual or to an individual's organs or mental powers (Hinkle, 1973). According to Selye (1956), "Stress like relativity, is a technical concept which has suffered from the diversified blessing of being too well known and too little understood". Stress is initiated when an Individual is subjected to special demands or external burdens and tension as internal pressures (Saunders, 1997). Occupational stress is a psychosocial illness which is the result of communication between the worker and his/her work environment (Kumar and Suresh, 2010).

1.2. Nursing Shortages in India

Human resources for health (HRH) frequently comprise the people with different expertise reliant on the education and training undergone by them, and are involved in providing medical services to the patient. Most countries in the world are facing human resources scarcity in the health sector. An estimated gap of 7.2 million professional health workforces existed in 2012, which will increase to 12.9 million in another decade (GHWA, 2014). This shortage varies across countries, regions as well as between rural and metropolitan

areas. In India, there is mismatch between health requisites and lack of HRH, which is undergoing both nursing shortages and high disease burden (Gill, 2009). India is the second most populated nation in the world, with 17.5 per cent of the global population (Census of India, 2011). In comparison to the health needs, only 17 nurses were available for a population of 10,000 in India during 2006-2013 (WHO, 2014*b*). This nurse to population ratio is very low in assessment to the high income countries, where the regular nurse to population ratio was 86.9 nurses to a population of 10,000 for the same period. The nurse to population percentage found in India is even lower than the nurse to population ratios found in some of the other emerging countries in Asia. Malaysia and Thailand had nurse to population ratios of 20.8 and 32.8 nurses, respectively, per 10,000 populations in 2006-2013.

1.3. Nursing Reality

In spite of India being a good medical destination with low cost – updated technologies and best surgeries paving way to cure all ailments, nurses in India are hired for fewer pay scales with minimum skill sets, less growth and lack of conducive work environment. So, there is more of attrition and shortage of nurses. For every 30 patients there is only one nurse.

Though India boasts of being a medical destination, a haven for low-cost innovative surgeries and cure for all ailments, nurses here are hired at laughable pay scales, confined to minimum skill sets, straitjacketed in a profession with no room for growth and lack a conducive work environment and infrastructure facilities. So, it's no surprise that the profession has a high attrition rate and acute shortage. However, in India, there is only one nurse for 20 to 30 patients. Underneath is the data with respect to nursing institutions and nurses available in the state of Tamil Nadu.

Table 1
Snap shot of nursing careers in India and Tamil Nadu

<i>Details of Nursing</i>	<i>In India</i>	<i>In Tamil Nadu</i>
Number of nursing institutions	2,940	212
Number of general nursing and midwifery seats	1,18,914	10,070
Number of B.Sc nursing seats	84,275	9,650
Nurses available	9 million	NA*
Nurses needed in 2022	27 million	NA*

*Source: Janani, 2015. *Not available*

Case Study: Mala (name changed) is working in a government hospital-Tamilnadu. From the case study, it is very clear that even though she works in government hospital, she had occupational stress, now we think about nurses working in private hospital in India.

2. REVIEW OF LITERATURE

A few descriptive and empirical research studies are found in the domain of occupational stress of nurses in a private and public hospitals focusing on different aspects related to available literature collected from various reputed Scopus indexed journals that as summarized below. During the course of work everyone experiences stress. Positive stress leads to inspiration and success whereas negative stress often leads to dejection, psychological and physical problems (Lazarus & Folkman 1984; Lo, 2002; Malone et al., 1997).

Independency in the job increased work satisfaction among nurses (Louisell and Williams, 1999; Reid, 2000). The factors influenced the work stress related to job, working condition, relationship with co-workers, organization culture, and job insecurity, less remuneration, discrimination at the work place, poor appreciation, carrier growth and poor support of management considered as major source of job stress (Ali Mohammad Mosadeghrad 2014). The outcome of occupational stress - dropped in the quality of work, dissatisfaction, high staff resignation, frequently absent from job, dejection and somatic problems (Dewe, 1989; Humpeland Caputi, 2001; Taylor et al., 1999; Tyler & Ellison, 1994). The causes for job stress lesser experience, low level of education and job continuing education (Kirkcaldy and Martin, 2000; Lee and Wang, 2002). Nurses working in operating unit have more occupational stress when compared to their counterparts working in home care unit (Salmond and Ropis, 2005). The work culture and the attitude of the hospital management identified as primary sources for the occupational stress (Sveinsdottir, et al., 2006). The social problems among the nurses reduced when they focused on patients problems (Evans, 2002). The job stress negatively correlated with the performance of the nurses (Arbalisarjouet al. (2013). Hospital culture, economic factors, complexity of the nature of the job, competition in the profession and household problems identified as the most stressful domains (AkifLatifi Al Khasawneh and Aahar Mohammed Futa (2013).

The impact of stress leads to job dissatisfaction (Bianchi, 2004; Bradley & Cartwright, 2002; Chen, Chen, Tsai, and Lo, 2007). The most often quoted reasons for occupational stress employed in emergency care unit and pressure due to heavy work load (Li and Lambert, 2008). Nurses worked in operation theatre reported more stress than working in general ward (Salmond and Ropis, 2005). Handling the problematic patients, opinion about death and dying, conflicts with colleagues, managing work and family contributed to job stress (Adeb-Saeedi, 2002; McGrath, et al., 2003). Nurses with vast experience handled the patient's assignments and managed the heavy work load (Amos, 2001). Problem-focused coping and emotional-focused coping were the two broad categories of coping mechanisms. Policies of organization with regard to inadequate compensation, no training or poor training, insecurity job, lack of growth in the job be stressful events (McCann et al., 2009; Mosadeghrad, 2013; and Schmitz et al., 2000). The factors affected the workers were a) work related b) policy of organization c) job itself and d) environmental factors. The sources of job itself stress include responsibility and accountability, work pressure, difference in work pressure among the staff, role vagueness (McGowan, 2001; Michie and Williams, 2003; and Robinson et al., 2003). A noteworthy destructive association found between job stresses and working life of employees. Nursing profession is one of the stressful jobs. Often shared the information with regard to accident and death to their friends, relatives and family members (Snape, J. and Cavanagh, S.J.). The individualities natures affected their ability to handle the job stressors (Oginska-Bulik, 2006). The main reasons for occupational stress heavy work pressure, conflict with colleagues with regard to profession (McNeely E.). Three types of stresses were good stress, distress and severe distress. Good stress and distress increased the mental activities and physiological signs (Ganster DC). Employees occupational stress lead to physiological problem accountable for chronic ailment (McEwen BS). Anxiety perceived as a multifaceted and vigorous transaction between individual and his situation. The job stress effected the organization in terms of loss of efficiency and absenteeism. Stress lead to various diseases such as heart problems, hypertension, unhappiness, and resistant syndrome (McNeely E, 2005; Sun J, Wang S, Zhang J-Q, Li W. 2007). The main causes for distress organization culture, work pressure and difference of opinion among staff with regard to their profession (McVicar A). Work-family improvement and intention to leave the job had negatively associated (Wayne et.a., 2006), not found any significant association. Due to the family commitments many

married female professionals having significant conflicts between work and family. Less compensation and more work resulted in irritation, decline in job determination and excessive turnover among nurses (Salami, 2002). The job culture, regulatory authority and superior's encouragement and support considered as key variables to understand the stress among nurses (Vishwanath et. al. 2013). Work stress caused physical and psychological problems like eating syndrome (King et al., 2009), sleeping complications (Piko, 1999), severe headaches (Schaubroeck, J. and Fink, L.S. (1998), blood circulatory problems (Espnes and Byrne, 2008), inclination to suicide (O' connor et al., 2000) poor memory and attentiveness (Shapiro et al., 2005), sensitive fatigue (Coffey and Coleman, 2001).

2.2. Statement of problem and research gap

By reviewing the various literatures collected and presented above through national, international reputed journals and experts comments, the researchers wants to identify the research problems for the study. Varying perceptions about occupational stress notwithstanding, it always carries negative consequences, contributing to occupational stress such as frustration, anguish, irritability, intolerance, death and dying, conflict with physician, lack of support, conflict with other nurses, work load and uncertainty concerning treatment etc. This in turn may result in withdrawal of self from team work, patient care, negative attitude formation towards the institutional policy, poor quality in patient care, decreasing job satisfaction and even attrition among nurses in private hospitals in India. Usually overburdened with workload in compromised work environment, inadequate physical and structural facilities, power imbalances and inability to take decisions in ethical dilemmas raised during health care, nurses also suffer occupational stress. Factors influencing the occupational stress among government, public and private hospitals in India vary from culture, geographical factors, healthcare settings, health care facilitators and individual factors, position and measures available to address and resolve concerns related occupational stress. Nurses hold less authority and high responsibility in healthcare hierarchy; hence more commonly they are victims. Due to constraints in the practice environmental and lack of positive ethical climate nurses often find it difficult to enact their professional and ethical values especially in private hospitals in India. Occupational stress is associated with job dissatisfaction, turnover, mental anguish and decreased job morale. In the above background, more research were done on what contribute to occupational stress, measures for solution, work life balance of nurses, job satisfaction, nurse's turnover, attitude and their behaviour towards patient across India in general, but only few studies were conducted on occupational stress of nurses in private hospitals in India and that to no studies were conducted so far on this area in Vellore city that to by taking single leading hospital. So the researchers want to study entitled "occupational stress of nurses in a private hospital in Vellore city", Tamil Nadu, in order to fill the research gap for the study.

3. OBJECTIVES

The main objectives of the study are:

1. To identify the dimensions influencing the occupational stress among nurses in a private hospital at Vellore.
2. To understand the effect of demographic factors affecting the occupational stress among nurses working in a private hospital at Vellore.
3. To find out the level of stress among nurses employed in the private hospital.

3.1. Hypothesis

Hypothesis will be tested using independent sample t-test, chi-square and one way anova for the acceptance and rejection at significance level of 5% and 1%.

Ho1: There is no significant difference in the perception of nurses towards (a) death and dying (b) conflict with physicians (c) lack of support (d) conflict with other nurses (e) work load and (f) uncertainty concerning treatment dimensions across the age, educational qualification of the respondents.

1. **Ha1:** There is significant difference in the perception of nurses towards (a) death and dying (b) conflict with physicians (c) lack of support (d) conflict with other nurses (e) work load and (f) uncertainty concerning treatment dimensions- across the age, educational qualification of the respondents.
2. **Ho2:** There is no significant association between marital status of nurses and level of occupational stress.
3. **Ha2:** There is significant association between marital status of nurses and level of occupational stress.

4. RESEARCH METHODOLOGY

The descriptive study was conducted in a private hospital located at Vellore. In the hospital more than 200 nurses are working in triple shifts. Convenient sampling method was applied to select the respondents. The sample unit was nurses working in the private hospital. The researchers issued 100 questionnaires to the respondents and collected only 75, out these only 62 samples were taken in to account for analysis and the remaining 13 samples were not considered due to incompleteness of the questionnaire. For the study both primary and secondary data were used. A structured questionnaire was framed with Likert's scale ranging from 5 strongly agree to 1 strongly disagree. The final questionnaire was drafted with some modifications after pre-testing. The collected data was planned to be made informative by using statistical tools like frequency distribution, chi-square, one way Anova and Independent T test are used to interpret the data using IBM SPSS 20 version in order to fulfil the research objectives of the study.

4.1. Research Limitations

This study is purely related occupational stress among nurses in private hospital only. The maximum sample size taken to analysis was 62 only. The findings of the study may be influenced by the personal bias of the respondents.

4.2. Reliability Test

The following table 2 showed the results of the reliability test to measure the internal consistence among the classified parameters for the study.

Table 2
Reliability Test

<i>Construct Name</i>	<i>Cronbach Alpha</i>	<i>Number of items</i>	<i>Mean</i>	<i>Standard Deviation</i>
Death and Dying	0.93	6	2.92	0.93
Conflict with physician	0.90	4	2.84	0.97
Lack of support	0.88	3	3.06	0.98
Conflict with other nurses	0.73	4	3.95	0.95
Work load	0.74	4	3.00	0.90
Uncertainty concerning treatment	0.65	4	3.11	0.91

Source: Authors calculation

From the above table, the six dimensions namely death and dying, conflict with physicians, lack of support, conflict with other nurses, work load and uncertainty concerning treatment consists of 25 items which were tested for reliability using Cronbach Alpha. The Cronbach Alpha for death and dying was 0.93, for conflict with physicians was 0.90, for lack of support was 0.88, for conflict with other nurses was 0.73, for work load was 0.74 and for uncertainty concerning treatment was 0.65. This confirms a worthy and unbiased degree of internal reliability amongst the items. The highest mean is conflict with other nurses (3.95) and the lowest mean is conflict with physicians (2.84).

4.3. Analysis and Interpretation - Descriptive Statistics

The underneath table 3 depicted the data relating to factors influencing the occupational stress of nurses with age by applying descriptive statistics with one way Anova.

Table 3
Descriptive Statistics with one way Anova

<i>Dimension</i>	<i>Age</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F</i>	<i>Sig.</i>
Death and Dying	20-30 years	25.0000	1.87083	49.247	.000**
	30-40 years	19.5294	3.62487		
	40-50 years	14.3158	3.59092		
	Above 50 years	12.1538	2.07550		
	Total	17.5323	5.58311		

<i>Dimension</i>	<i>Age</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F</i>	<i>Sig.</i>
Conflict with Physicians	20-30 years	10.6923	4.92248	13.751	.000**
	30-40 years	15.2353	2.96920		
	40-50 years	11.2105	3.59906		
	Above 50 years	7.3077	.48038		
	Total	11.3871	4.32816		
Lack of support	20-30 years	12.4615	1.05003	25.615	.000**
	30-40 years	9.5294	1.94029		
	40-50 years	7.1579	2.14121		
	Above 50 years	6.5385	2.43637		
	Total	8.7903	2.94283		
Conflict with other nurses	20-30 years	6.8462	.98710	5.003	0.004**
	30-40 years	8.9412	1.67595		
	40-50 years	8.7368	1.96757		
	Above 50 years	7.7692	1.64083		
	Total	8.1935	1.80925		
Work load	20-30 years	15.0000	3.29140	9.892	0.000**
	30-40 years	13.1765	2.67477		
	40-50 years	10.7895	2.43992		
	Above 50 years	9.2308	3.78932		
	Total	12.0000	3.60328		
Uncertainty concerning treatment	20-30 years	11.8462	4.18023	9.167	0.000**
	30-40 years	14.0588	2.88250		
	40-50 years	11.4211	2.41099		
	Above 50 years	8.1538	2.85325		
	Total	11.5484	3.62902		

Source: Primary data,

**Significant at 1% level

4.4. Interpretation

For the first dimension's highest mean score is 25, which infers that the respondents in the age group of 20-30 years agreed that they got disturbed by death and dying of patients. The lowest mean score is 12.15, which infers that the respondents in the age group of above 50 years disagreed that they got disturbed by death and dying of patients. The second dimension's highest mean score is 15.24, which infers that the respondents in the age of 30-40 years agreed that they have conflict with physicians. The lowest mean score is 7.31, which infers that the respondents in the age group of above 50 years disagreed that they have conflict with physicians. In the Lack of support dimension the highest mean score is 12.46, which infers that the respondents in the age group of 20-30 years agreed that they do not get the support from co-workers. The lowest mean score is 6.54 which infer that the respondents in the age group of above 50 years disagreed that they do not get support from the co-workers. For the fourth dimension's highest mean is 8.94, which infers that the respondents in the age of 30-40 years agreed that they have conflict with their colleagues. The lowest mean score is 7.77, which infers that the respondents in the age group of above 50 years disagreed that they have conflict with their colleagues. For the fifth dimension's highest mean is 15.00, which infers that the respondents in the age group of 20-30 years agreed that they have heavy work load whereas the respondents in the age of above 50 years disagreed that they have heavy work load. The sixth dimension's highest mean is 14.05, which infers that the respondents in the age of 30-40 years agreed that they are uncertain concerning treatment of the patients whereas the respondents in the age group of above 50 years disagreed that they are uncertainty concerning treatment of the patients. In addition to above different dimensions influencing occupational stress among nurses, the researchers applied one way Anova. The result of calculated p (probability) value is less than 0.01, hence; null hypothesis is rejected at 1% level with regard to death and dying, conflict with physicians, lack of support, conflict with other nurses, work load and uncertain concerning treatment dimensions. So, there is significant difference among the age group with regard to above said dimensions.

4.5. Factors Affecting the Occupational Stress – T-test

Table 4
Independent Sample T-test

<i>Independent Samples Test</i>					
<i>Dimension</i>	<i>Qualification</i>	<i>Mean</i>	<i>Std. Deviation</i>		<i>Sig.</i>
Death and Dying	Diploma	20.8750	5.27777	6.270	.000**
	Baccalaureate Degree	13.9667	3.21079		
Conflict with Physicians	Diploma	11.6563	4.76282	.503	.617
	Baccalaureate Degree	11.1000	3.87165		
Lack of support	Diploma	10.6250	2.19604	6.598	.000**
	Baccalaureate Degree	6.8333	2.32057		
Conflict with other nurses	Diploma	8.1875	1.76777	.027	.979
	Baccalaureate Degree	8.2000	1.88277		
Work load	Diploma	13.1250	3.35771	2.659	.01*
	Baccalaureate Degree	10.8000	3.51744		
Uncertainty concerning treatment	Diploma	11.6875	3.97117	.309	.758
	Baccalaureate Degree	11.4000	3.28634		

Source: Primary data. Note: ** Significant at 1% level,

*Significant at 5% level

The data relating to factors affecting the occupational stress with demographic profile like education among nurses working in a private hospital at Vellore were measured by applying T-test were presented in table 4.

4.6. Interpretation

Since the calculated *p* value in table 4 is less than 0.01, the null hypothesis is rejected at 1% level of significant with regard to death and dying and lack of support dimension. Based on mean score the nurses having diploma qualification agree that they have feel about the death and dying of patients and also agree that there is lack of support from co-workers. Since the *p* value is less than 0.05 the null hypothesis is rejected at 5% level of significant with regard to work load dimension. Hence, there is significant difference between the educational qualification of nurses and work load. Based on mean score the nurses having diploma qualification agree that they have heavy work load. There is no significant difference between the educational qualification of nurses with regard to conflict with physicians, conflict with other nurses and uncertainty concerning treatment dimensions. Since, the *p* value greater than .05. Hence, the null hypothesis is accepted at 5% level with regard to above said dimensions.

4.7. Level of Stress among Nurses – Chi Square Test

The details pertaining to the level of stress and their marital status among nurses in a private hospitals were measured by using chi square test were presented in table 5 for quick reference.

Table 5
Cross tabulation with Chi square test

<i>Variable</i>		<i>Marital status</i>		<i>Total</i>	<i>Pearson Chi Square</i>	
		<i>Unmarried</i>	<i>Married</i>			
Level of occupational stress	Low	Count	7	5	12	0.042
		% within marital status	36.8%	11.6%	19.4%	
	Medium	Count	9	22	31	
		% within marital status	47.4%	51.2%	50.0%	
	High	Count	3	16	19	
		% within marital status	15.8%	37.2%	30.6%	
Total	Count	19	43	62		
	% within marital status	100.0%	100.0%	100.0%		

Source: Primary data

4.8. Interpretation

Since the P value is less than 0.05 the null hypothesis is rejected at 5% level of significant. It is concluded that there is significant association between marital status of nurses and level of occupational stress. Based on row percentage 36.8% of unmarried nurses have low level of occupational stress where as 47.4% of unmarried nurses have medium level of occupational stress and 15.8 % of unmarried nurses have high level of occupational stress. Based on row percentage, 11.6% and 51.2 % of married nurses have low and medium level of occupational stress respectively whereas 37.2% of married nurses have high level of occupational stress.

5. FINDINGS

1. There is a significant difference in the perception of nurses towards (a) death and dying (b) conflict with physicians (c) lack of support (d) conflict with other nurses (e) work load and (f) uncertainty concerning treatment dimensions- across the age of the respondents.
2. There is no significant difference in the perception of nurses towards conflict with physicians, conflict with other nurses and uncertainty concerning treatment dimension across the educational qualification of the respondents.
3. There is significant difference in the perception of nurses towards the death and dying, lack of support and work load across the educational qualification of the respondents.
4. There is significant association between marital status of nurses and level of occupational stress. When compared to unmarried nurses, the married nurses have high level of occupational stress.
5. The dimensions contributing to occupational stress are conflict with co-workers, followed by excess work load and uncertainty concerning treatment.
6. The factors influencing occupational stresses of nurses are conflict with their supervisors, inadequate manpower to cover the units and complain about the inadequate information provided by the physicians with regard to the treatment of the patients.

6. CONCLUSION

The concerned management should employ adequate staff members for the smooth functioning of the work in each unit. They should also arrange periodical meeting between physician and nurses as well as between nurses and supervisors wherein they discuss about all the issues in an amicable manner. The management should also employ counsellors to have an interaction with the nurses who need counselling. Hence an administrative officer should be appointed to carry out these activities for the smooth operation of the work. It is evident that if these issues not taken care by the management it will have an adverse impact in the quality of service provided by the nurses.

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