

## **BURNOUT SYNDROME IN INTENSIVE CARE UNIT NURSES IN ZIMBABWE**

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### **Abstract**

**Introduction** Professional burnout is a unique type of stress syndrome that is characterized by emotional exhaustion. It leads to loss of energy and interest in one's job. According to literature review the hardest hit by burnout are the service providers like nurses, counselors and police officers. When a professional is affected by burnout they feel drained and used up and have little desire to return to work the next day. This problem is specific to the work context. It is generally perceived that Intensive Care Nurses are particularly exposed to burnout since they literally deal with life and death situations most of the time.

**Purpose of the Study** The purpose of this study was to investigate burnout and its associated factors on nurses working in Intensive Care Units in some major hospitals in Zimbabwe.

**Methodology** A descriptive study was conducted. The researchers gathered data directly from participants for the purposes of studying attitudes, characteristics, interactions of individuals in their natural setting. Descriptive research gives detail of a situation or phenomenon. In this study information was obtained from nurses working in intensive care units at selected three major hospitals in Zimbabwe.

**Results** Of the 23 participants, three were male and twenty were female. Eighty percent of the participants had less than five years working experience in ICU as more experienced personnel had migrated to the Diaspora in search of greener pastures. Only five nurses out of twenty three were ICU trained. Emotional attachment was found to be a contributory factor to burnout. 78% of the Intensive Care Nurses were caring for the dying while 43 % were involved in the end-of-life decisions. 13 % had not gone for vocational leave for the past six months. Spending prolonged periods in the ICU contributed to burnout. Emotional exhaustion with intensity of 39 to 40 % also contributed to burnout.

**Recommendations** Offer professional counseling services to the ICU nurses on a regular basis. Identify any issues that might be affecting ICU nurses early enough and recommend appropriate remedial action before a fully blown "burnout" feeling develops.

Have rest rooms that are away from the working area to give the nurses a feeling of rest during breaks. Grant compassionate leave on reasonable grounds when the nurse feels he/she cannot cope due to depleted emotional resources. Offer refresher courses and conduct campaigns by highlighting the role of the ICU nurse to the administrators and also the challenges they face. Offer adequate remuneration to try and reduce stress levels.

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**Keywords:** Burnout Syndrome, Care Units, Zimbabwe

### **Introduction**

In this paper, an overview of the research and why it was being conducted is highlighted

The study intended to find out about burnout amongst nurses working in Intensive Care Units (ICU's) in Zimbabwe. The ICU is highly mechanized with many machines that are used to monitor and check progress of the patients. There are artificial respirators used for those not able to breathe for themselves, cardiac monitors, oxygen machines and suction pumps which constantly make noises. The nurse often ends up being on the alert all the time. This can affect them even when they are supposed to be off duty. Burnout is a common problem which can often go unnoticed. Nurses often worry about how they are going to care for their patients without paying attention to their own emotional health. More so in the Intensive Care Unit which is a highly stressful area where the nurse is continually faced with life threatening conditions. Zimbabwe has been facing problems of brain drain due to harsh economic conditions resulting in staff shortages, which have compounded the stressful factors which face the Intensive Care nurse practitioner.

Before the harsh economic conditions, Zimbabwe has been facing recently, the Intensive Care Units used to be well staffed with qualified nurses or highly experienced personnel. In recent years, the bulk of the country's qualified personnel left for greener pastures. This has led to nurse shortages, which in turn leads to overworked nurses. At times the ICU nurse has just completed general nurse training and does not have proper ICU training. These factors above, and the economic hardships in the country can prove to be real stressors for the ICU nurses and can cause burnout.

Due to these stressful conditions, relationship problems with colleagues can result. This kind of nurse requires counseling services and other support services so as to be able to cope with stressful situations.

In most cases when the nurse displays signs of burnout they are mistaken for laziness or being insubordinate and instead of being referred for counseling or given support they may end up being reprimanded for inappropriate behavior.

It is the researchers' hope that in studying about burnout among the intensive care nurses, appropriate measures could be put in place to support the nurses working in these areas.

The economic hardships that bedeviled the country recently have led to a high staff turnover in the country's hospitals. Intensive care units in the hospitals under study have not been spared. Staff shortages, increased workload, economic hardships to a nurse who is already working in a stressful area, all have compounded the problem leading to burnout. The results would be poor patient outcomes, dissatisfied nurses and deteriorating standards of nursing.

### **Study Questions**

The study tried to answer the following research questions:

What are the main contributory factors of burnout in nurses working in the Intensive Care Unit?

What are the signs and symptoms of burnout in these nurses?

What strategies can be applied to reduce burnout in ICUs?

What are the other non-work related factors to burnout?

### **Purpose of the study**

The purpose of this study was to investigate burnout in nurses working in the Intensive Care Units at major hospitals in Zimbabwe. The significance of the study lies in that emotional issues concerning carers like nurses, cannot continue to be ignored. It has been a general assumption that, because nurses deal with people's health, they have no need for being cared for emotionally since "they know it all". The findings in this study can be used to develop appropriate intervention strategies and set up support systems and intervention

strategies for nurses working in ICU's. At present, there are no organized counseling support systems specifically for ICU nurses. Counseling services to nurses will not only be beneficial to them but to patients and the hospital. In addition, relatives of the patients will also benefit as they will be dealing with emotionally healthy nurses. This will greatly improve the efficiency of these units and improve the quality of care the patients get. The benefits of an emotionally healthy ICU nurse can be spread from patient to units and institutions.

It is also hoped that hospitals concerned will be made aware of the challenges facing ICU nurses and will be able to take measures to alleviate them. This research might provoke similar studies in other units so that this can lead to better client care. The researchers will also benefit by having a broadened understanding of burnout in nurses working in ICU's. This will in turn motivate the researchers to take greater interest in healthcare issues especially concerning counseling of ICU nurses and help support them.

### **Limitations**

The study was carried out at three major hospitals' ICUs. The population boundaries were drawn around the ICU's of these institutions only, i.e. the nurses. The three hospitals are in the city of Harare. The study is also limited to work related emotional and psychological problems faced by nurses working in ICUs. Non-work related factors that can lead to burnout were also isolated. The sample size was small. The researchers did not focus on all hospitals with intensive care units in Harare. Findings therefore, cannot be generalized to other ICUs in Harare or other cities in Zimbabwe. The researchers, having had some experience in ICU, could have introduced some degree of subjectivity or complacency. To avoid this, the researchers avoided discussions about the study with the nurses concerned before data collection. However, prior knowledge of medical terms and operations in the units enabled the researchers to give a more in depth study.

### **Research assumptions**

The researchers made the following assumptions:

That the participants would agree to participate in the research.

That the hospital authorities would cooperate with the researchers since the information gained will be useful to the organizations and their staff.

That permission would be granted by the Medical Research Council of Zimbabwe to carry out the study.

That relevant documents, for example, off duty schedules, would be made available to the researchers.

### **Definition of Terms**

In order to create a common understanding of this research, key terms used were defined as follows:

**Burnout** – Professional burnout is a psychological syndrome in response to chronic interpersonal stress on the job.

**Counselor** – is often a trained professional who is a unique helper who can empathise, is genuine and can encourage client positively. The qualities of a counselor will determine the quality of service rendered according to Chigwedere (2004).

**Counseling** – it is a form of psychological helping which values and seeks to identify each client's innate internal resources, coping abilities and strengths according to Hough (1998). Thus counseling is concerned with helping an individual to utilize his or her own coping resources as well as to develop problem solving skills.

**Emotional** – pertaining to the emotions, e.g. how the person feels.

**Highly mechanized** – for this study this means that in the Intensive Care Units, there are lots of machinery used on the patients as opposed to patients in the general wards i.e. in ICU they use cardiac monitors, oxygen sensors, artificial respirators, suction machines on most of the patients.

**Intensive Care Unit** – it is a critical care unit also abbreviated as ICU.

**I.C.N.** – Intensive Care Nurse

**Public Hospital** – Hospital run by the government.

**Private Hospital** – Hospital not run by government but by private company.

**Stress** – it is a term in psychology denoting one's total response to environmental demands or pressures. It can be mental or emotional. In this study it denotes inappropriate psychological response condition.

**R.G.N.** – Registered General Nurse

**AACCN** – American Association of Central Care Nurses

### **Review of related literature**

Literature about burnout in other parts of the world and narrowing it down to the local scene is explored. Perspectives from different authors are given and other related studies conducted on the subject are cited. Signs and symptoms associated with burnout and some strategies to reduce it are also discussed.

The subject of burnout is one that has raised some interest, mainly in work circles the world over especially in those jobs which provide human services. Many studies have been carried out on the subject of burnout to try and find intervention strategies to deal with the problem. A lot has also been done especially in Europe and America to find out more about burnout and how it presents in the workplace or in the affected individual. Many documented evidences of these findings have been presented either in the form of books or on the internet. On the local scene in Sub Saharan Africa, although studies on burnout have been carried out and documented, the subject has not been given as much attention to a large extent as has been the case on the international scene. Cries about 'who cares for the carers,' have been echoed locally but these do not seem to have been backed by appropriate action or strategies in human service professions to try and alleviate the problem of burnout.

In Africa as a whole some studies have also been carried out on burnout. There is need however to complement the studies done with further research to try and help professionals suffering from this syndrome to cope better. Most of the studies done in medicine were concerned with doctors and nurses in general with few documented studies done in South Africa on burnout in ICU nurses.

In Zimbabwe for example, other professionals have conducted studies on this subject e.g. in education but few studies have been done on medical professionals especially nurses in ICU. No documented studies done on burnout in intensive care nurses in Zimbabwe were found and this has prompted the researchers to conduct this study so as to provoke further studies in an effort to spearhead upgrading of the standards of ICU nursing and to improve patient outcomes in our hospitals and the country as a whole.

Burnout is a state of emotional exhaustion caused by long term involvement in emotionally demanding situations. According to Cordes and Dougherty (1993), it is a unique type of stress syndrome characterized by emotional exhaustion. It leads to loss of energy and interest in one's job. It is most commonly found in human service providers like nurses, teachers, counselors, police officers, lawyers and psychiatrists. These people in human service institutions interact with clients who have physical, psychological and social problems with no easy solutions at times. This becomes emotionally draining and therefore results in burnout. It is a gradual process over an extended period over time, i.e. it does not happen overnight.

### **Intensive Care Unit Environment**

The intensive care unit is an enclosed specialized area for critically ill patients. It is characterized by high nurse patient ratios, is highly mechanized, that is, there are lots of machinery, and very often, the work is too demanding and stressful. The environment itself has been recognized as stressful since its inception in the 1960's according to Stone and associates (1984) . There is high technological equipment like artificial respirators, cardiac monitors, oxygen sensors, infusion pumps, suction machines and many other high tech gadgets. It is therefore a fast paced and emotionally charged atmosphere. It is also noisy and filled with sounds of intricate machines which can often be heard in unison with patients moaning noises according to Stone et al (1984). This kind of atmosphere keeps the ICU nurse hyper-alert at all times and the noises can continue to affect them even when they are off duty. Patients' lives are at stake and every second is very important. The ICU nurse is also on her toes all the time to be able to give her expertise at the right second all the time. A split second delay could cost the patient his life. All this contributes to a highly charged and fast paced atmosphere where the nurse is faced with death and dying.

### **Death and Dying**

Intensive care nurses face death and dying and other ethical dilemmas on a regular basis. Their attitudes towards death and dying can be complex and could be related to their own fears, anxieties and personal attitudes towards death, Cox et al online document <http://members.cox.net/dinsw2/stressnicu.htm>. Some dying patients can linger on for long periods before death, and thus form a bond with the ICU nurse. In addition to providing vigilance to their patients, the nurses also interact with sometimes distraught family members of the patients. This can be very taxing for the ICU nurse who is already strained with working in a stressful area. In most cases, the family members will be asking questions that can be very confusing and can even blame the nurses that they are not doing enough.

In addition, the work itself requires heavy lifting at times because the ICU patient is very ill and cannot help themselves and the nursing care is wholly compensatory especially during procedures like, bed-bathing, changing linen or other procedures that require lifting. Most ICU patients are unconscious or semi-conscious.

### **Working Hours and Staff Shortages**

Long hours and shift work means the nurse is away from their families for long periods. Some nurses skip breaks or stay beyond 12 hours to complete their work. The ICU becomes like the second home where the nurse spends most of her time. Because of the nature of the patient's condition, usually the long hours are spent on their toes with very little time to rest in between procedures. If the nurse rests a bit physically, mentally they still are not rested. This type of nurse is usually somebody who is a high achiever and highly motivated. Debriefing meetings, retreats, appreciation from the supervisor and a lot of support will help the nurse to cope better when stress levels go overboard.

Nurse shortages have also been found to cause stress in ICU nurses and this is according to a research done by the American Association of Critical Care Nurses (2002). Whether the nurse shortage is caused by lack of enough ICU trained nurses or due to high staff turnover, this has to be established by further studies. An article by AACCN (2002), concur that working short staffed can increase a lot of pressure for ICU nurse. There have been unpublished reports among former ICU nurses that even after they have left employment they still felt guilty to be sitting in offices or in some places where it was normal to sit, because they were used to standing for long periods or were hyper-alert most of the time. They cannot relax. To them, sitting down would represent a carefree attitude towards a very ill patient. According to Chigwedere (2004) the guilty feeling results from a discrepancy

between reality and the perceived self concept of an ICU nurse who is expected to be on her toes all the time.

According to a study done by Foxall and associates (1996), intensive care nurses experience significantly more stress related to death and dying than other nurses working in other areas in hospitals. These nurses give so much to their patients because of the nurse patient ratios which are usually 1:1 or 2:1 nurse to patient. There is therefore some form of bonding with the patient coupled with high expectations of patient recovery. If after doing so much they lose the patient, stress levels become very high and they end up disillusioned.

In intensive care units, aggressive life saving measures are employed as compared to palliative care in other areas of hospitals. These procedures could also be traumatic to the ICU nurse.

Certain ambiguities related to the nurse's value system and can create an area of conflict with relatives or doctors, Yang and Mcilfatic (2001). A good example is where discontinuing of life support or prolonging the same can differ. The doctor might suggest discontinuing life support because of the medical findings at the particular time but this can conflict with what the nurse believes in concerning preservation of life. Even if the relatives are consulted and they agree, if there is a conflict in their belief system to the nurse's value system, this can create a very stressful situation for the nurse who might feel her efforts are going to waste, and at the same time feel that God is the ultimate decider of life.

### **Disillusionment**

Erlin and Sereika (1997), noted that sometimes nurse's decision making capacity in carrying out invasive procedures on patient's treatments is limited. This could be due to doctor's disregard for the opinions of nurses due to complexes that could arise preferably where the doctor feels that he is more knowledgeable and therefore holds more responsibility for the patient than does the nurse. The nurse can feel downtrodden and disillusioned. Involving the nurse in decision making and research activities on the unit can help give the nurse a sense of purpose. Poor relationships with physicians, supervisors or colleagues can also cause disillusionment. Debriefing meeting can also help to iron out differences.

### **Emotional Attachment**

At times the ICU patient stays long in the unit and the nurse ends up bonding with the patient and relatives. This emotional involvement can be taxing for some nurses i.e. they feel intense feelings of grief and loss when the patient dies. This compassion and empathy can cause emotional fatigue. Calvie and Ter-Bagdasarian (2003) also noted in a study that nurses who are affected by these traumatic and critical events in ICU lose their capacity to perform well on the job, resulting in negative outcomes for their patients. It is sad to note how such normal humane feelings for patients can result being the very cause that result in the nurse being affected by stress. These feelings therefore need to have boundaries if the nurse is to cope well and strategies like periodic counseling and other intervention strategies can help the nurse to stay in touch with their self concept and become self aware without drowning in current problems.

Relationships with attending physicians and colleagues, verbal abuse coupled with condescending attitudes also inhibit collaboration in ICU Rosenstien (2002)<http://member.cox.net/dinsw2/stressnicu.htm>. Professionally the nurses values are geared towards 'care' and these disparities can be a source of conflict in the ICU if not handled well Greenfield (1999) Sudin-Huard and Faty-(1999). The physicians' values are geared towards 'cure' and these can present an area of conflict which can result in stress for the nurses especially in end of life situations.

According to the American Association of Critical Care Nurses Journal (2002), nurses are most of the time below what is required in terms of numbers. It takes longer to fill these posts because ICU nurses are fewer than general nurses Pierce (2001) Being short staffed in ICU increases pressure enormously for the remaining ICU nurse. This coupled with the need to have high nurse patient ratios becomes very difficult for the nurse or becomes 'mission impossible' as it were.

Amid the high technology mentioned earlier, there is ventilator alarms going off, infusion pump noises, alarms and oxygen saturation, all these are frequent occurrences which demand the nurses immediate attention, according to Smith and Associates (2001). In extreme cases the ICU nurse skips breaks and sometimes stays beyond their shifts to finish their work. In between, there is frequent interruption by the doctor, family or patient requiring the nurse's attention. If there is not enough support from supervisors or administration, the ICU nurse can end up being very stressed and this can lead to burnout. In some unpublished studies, this lack of support from administrators can be far reaching, especially where the administration feels that there is very little work in ICU because there are more nurses than patients. This lack of understanding by administration who do not fully understand how ICU works can be very retrogressive.

The results can be detrimental as errors are increased because the nurse is not able to make correct assessment or judgment as to the type of intervention that is required at that particular time. The patient care can be compromised because they cannot receive the type of care that they are supposed to receive and the nurse is incapable of performing their duties, resulting in the nurse having feelings of guilt and inadequacy and feels totally incompetent, Pierce (2001).

A survey done in September (2001) by the American Association of Critical Care Nurses, found that 70% of ICU nurses cited acute and chronic stress and overwork as their three top health and safety concerns. According to American Journal of Nursing of 2007 in November, on the same website, a survey was done, and half of the ICU nurses were found to be affected by burnout syndrome. It also included that preventing conflicts in ICU and participating in ICU research groups and paying attention to end of life care, lessens the risk of severe burnout syndrome in their contexts. The issue of participating in research groups can be tricky at times since most ICU's in our African context are not really involved in much research. Maybe if this was also introduced in our context it would be interesting to note the results especially in Zimbabwe.

### **Emotional Exhaustion**

Studies conducted in France by Embracio (2007) [http://www.pulmonaryreviews.com/07\\_may/burnout.html](http://www.pulmonaryreviews.com/07_may/burnout.html), concluded that heavy workload and strained duties as well as strained relationships amongst colleagues contributed to burnout in ICU nurses. These were documented in the American Medical journal of respiratory care. They concluded that 1/3 of the nurses working in ICU were found to have high levels of burnout and 24% of them had significant levels of depression as a result. This prompted another researcher Curtis, to write a question in the journal of that publication 'is there an epidemic in critical care'. Dr Curtis is a professor at the University of Washington in Seattle. He wrote that it was alarming that 40% of the medical personnel wanted to leave their jobs. Of significance in the studies of burnout are studies done by Maslach and Jackson starting from 1970 to 1980. These were done in many human service professions. They subsequently invented the Maslach Burnout Inventory, a tool that is widely used to ascertain presence of burnout in respondents.

In their studies they also noted that a key aspect in the burnout syndrome was increased feelings of emotional exhaustion. This in turn led to a sense of hopelessness in the worker due to depleted emotional resources. The worker feels that he cannot cope at

physiological level. They develop negative reactions to their clients and become cynical. Such negative reactions to clients may be linked to the experience of emotional exhaustion.

The problem of this attitude toward clients is that the nurse feels that the clients deserve to be in the problem they are in. Wills (1978) cited on <http://members.cox.net/dinsw2/stressinicu.htm>, states that this negative perception was found to be prevalent in human service professionals. The study done by Tracy (2000) cited in same on line document cited above, recommended that to reduce burnout, there is need to have integrated action between organization and employee. This includes better connection on workload, including adequate resources, work life balances to encourage staff to revitalize their energy, clear organizational values to which employees can feel committed, supportive leadership and meaningful relations with colleagues. Fairness is also recommended e.g. debriefing meetings to discuss and resolve perceived inequities on the job. The study revealed a reduction in exhaustion over time but did not affect cynicism and inefficiency indicating a broader approach is required. Neuton (2000) recommends stress management therapy for staff, social support, psychological support and other coping strategies.

Coming closer home in Zimbabwe, nurses are generally assumed to be callous and horrible to patients by the general public. However it is disheartening to note that some of the accusations landed against nurses for being callous and horrible, could actually be caused by burnout in the nurse in Zimbabwe. It could be a far cry by the nurse for help which she usually never gets. At times the nurse can be labeled to be difficult or to be lazy when they are in fact emotionally exhausted and psychologically stressed up that they have nothing more to give to their patients in terms of service delivery. This calls for knowledge about burnout issues on the part of the supervisors and administrators and the public as a whole. If they are not sensitive it can result in the rhetoric that one often hears in many of the Zimbabwe's hospitals 'nursing standards are deteriorating'. Strategies and measures need to be put in place to be able to care for these ICU nurses e.g. to give them time off, retreats, counseling services at the workplace and enough support and sensitivity from their superiors and colleagues according to Tracy (2000). Not only does the nurse benefit but better patient outcomes result.

In burnout the nurse can also experience feelings like self negative perception regarding their work and their patients, colleagues and family. This happens when the nurse is overwhelmed and often times, disillusioned because of probably the energy they put in versus the output i.e. patient outcomes, does not tally. They get overwhelmed and feel they are failing in their job. They end up being unhappy about themselves. That's when there is need to understand the importance of the interplay between exhaustion and disillusionment which affects the nurse. This phenomenon is so incapacitating and affects performance to a great extent.

Hans Selye (1997) <http://members.cox.net/dinsw2/stressinicu.htm>, conducted studies on stress on animals and noted that initially they had a period of adaptation, then they survived for long periods, but suddenly their resistance collapsed without any obvious direct cause. He also noted similar patterns in bomber pilots during the second world war. They would fly efficiently and accomplish missions, but would fall apart as fatigue set in. He likened this pattern of reaction to what happens in burnout. There is the initial energy, motivation and fervor for one's job and after a long period of stressful conditions, sudden exhaustion and disillusionment ensues.

### **Development of burnout**

Elliot and Pinnes (2000) cited on line, <http://members.cox.net/dinsw2/stressinicu.htm> noted that most of the people who get burnout are usually those who are highly committed to their work. Generally in life people work so hard at something for a longtime, and then later



life loses its flavor and the things we used to do with fervor become a drag. That is when exhaustion sets in and a break is needed to regain vigor. It is the disillusionment that damages the person more than the exhaustion. Exhaustion can be alleviated with rest but a deep seated disillusionment can be dangerous. Most people get their sense of identity and meaning from their work. They therefore regard their work with high motivation and passion. This is normal and is what drives achievers to succeed in their work. The problem comes when the demand for the work becomes too much. Exhaustion sets in from working too hard, performance becomes compromised, resources to cope might be unavailable. This coupled probably with absence of sensitive mentors and supervisors to support the work being done, could worsen the situation. The supervisor or the employers might not be supportive to the employees' ideals. Team members may be less cooperative and relatives, not appreciating.

The ICU nurse sees little results for her efforts, becomes disillusioned, there is less satisfaction from job, and becomes fatigued with loss of energy and vigor. The drive and vision that motivated them in the first place gets lost. In extreme cases there is loss of a sense of purpose of what one is doing and the person becomes bitter with life which in turn becomes meaningless Elliot et al (2000). At this stage the nurse is no longer effective. If no counseling or support is offered to the nurse, this position can be detrimental to the patient.

According to an article which appeared in [http://www.Helpguide.org/mental/burnout\\_signs\\_symptoms.htm](http://www.Helpguide.org/mental/burnout_signs_symptoms.htm), it was noted that there are some associated factors to burnout, such as lifestyle and personality traits. These can also contribute to the problem. Nurses who had less support from their families did not cope better than those with adequate family support or in mutual loving relationships. The need to be valued by others is important in relationships according to Maslow (1971) cited in Hugh (1998).

This observation seems to suggest that family support can also be a factor in overall coping of the nurses from pressures at work. Also personality traits as mentioned earlier seemed to be associated with burnout as well as highly motivated achievers such as the type 'A' personality.

### **Studies done in Europe and United Kingdom**

Many studies on burnout in ICU nurses were done in Europe, United Kingdom, America and other Asian countries. Early researchers concluded by Kelly (1990) cited in Mims and Stanford, reported findings of burnout in critical care nurses. In one study, Azouley et al (2009) wrote in a critical care nurses journal (2009); 180, in their abstract that, the intensive care unit (ICU) is a highly stressful area, thereby concurring with other studies done by Stone and associates in 1984. He conducted a study in a French hospital ICU and concluded that, burnout was a real problem. He also said that, knowledge of demands faced by today's ICU nurse is critical for explaining how stress can be avoided in these areas. This will in turn lead to better patient outcome as a result of a nurse who is working with a healthy mental attitude. It can also benefit the hospital by reducing staff turnover and also having consistency in patient care.

Cordes and Dougherty (1993) concurred that burnout in the ICU can threaten the quality of care that the patient gets. Belner et al (2000) wrote an article cited on line on <http://members.cox.net/dinsw2/stressinicu.htm> on how nurses' working conditions in ICU and staff shortages mentioned earlier by other studies can also increase stress levels and therefore contribute towards burnout. In Zimbabwe this could be a real issue because most of our intensive care nurses left the country for greener pastures during the harsh economic conditions, leaving the intensive care units manned by very few nurses. Other writers on the same subject of burnout in ICU are Pomel et al, Toullie and Parpazian who wrote in an American journal of critical care nurses of 2006. They conducted a research on burnout in nurses in critical care. The article also cited conflicts in ICU thereby concurring with other

writers before them. They noted that burnout is rife in critical care nurses because they literally deal with life and death situations most of the time, thereby reiterating earlier studies by Stone and associates (1984). Moreover, the constant noise made by alarms and from different machines always keeps the ICU nurse on the alert all the time, thereby increasing stress levels. The hearing of noises can persist even when one is off duty. In some undocumented instances the ICU nurse carries this high impact highly stressful attitude of the environment with them, wherever they are. One ICU nurse reported answering her phone at home saying ‘ICU can I help you’ or refusing to be offered a seat in an office and feeling guilty about sitting as she was always on her toes at work.

Mims and Stanford cited in the literature review earlier on, did a study which concluded that, if critical care nurses were unable to adapt to their environmental stressors, levels of stress would raise leading to burnout. The use of effective coping skills to manage stress is a common way of adapting to the environment. Given the working conditions in ICU and stresses inherent with the work, there is need for further studies to be carried out so that intensive care nurses can benefit professionally. The resultant improvement in patient care and the benefits to the organization as a whole cannot be over emphasized.

### **African Perspective**

In Africa, although studies have been done on burnout, few well documented studies have been found regarding burnout in ICU nurses. Some documented studies have been done in South Africa, but most of them did not go deep into why ICU nurses end up with a high degree of burnout than other nurses working in other areas of hospitals .This probably is an area needing further inquiry.

Studies done in other Sub-Saharan countries may not have been well documented to give a wider overview of ICU nurse burnout in Africa. From the above literature review, it appears that it is important to conduct further studies into this syndrome in intensive care nurses. Maybe further studies can be done to try and establish strategies to help these professionals so that they can perform their duties in environmentally suitable ICUs with adequate support and mentoring from their supervisors and employers. This could result in a highly motivated ICU nurse who is not only an asset to the organization but to the patient, colleagues, family and the country as a whole.

Lack of ICU nurses due to migration to greener pastures has put the patients at risk, and often the remaining nurses are tired, unhealthy and plagued by low morale ,Tamar Khan (Jan 2009) <http://www.allafrica.com>

It is encouraging to note that the Zimbabwean government is supportive of work which looks to uplift the standards of health. Zimbabwe’s health care system was one to be proud of on the continent before the country faced the harsh economic conditions of the past decade. With the emigration of the highly qualified ICU cadres to greener pastures, the ICU units suffered and therefore need to be revived. The Vice President J Mujuru was reported in the Herald of 30 April 2010 encouraging more research in the health sector. She called for increased research so that service delivery can be improved in the health sector as she was speaking at the launch of the Centre for Health Strategies.

The Centre for Health Strategies is a private organization that has recently been launched by Dr Parirenyatwa, the Minister of Health. This Centre is geared at encouraging and spearheading research into the health sector so as to improve health delivery and take this country to higher levels of competences in healthcare delivery. She also noted that countries that have made significant strides in health delivery, invested heavily in research and development. Her call could not have come at a better time.

A study as this one might provoke further studies in this field as a step forward to taking the country’s healthcare system to greater heights resulting in better service delivery,

better patient outcomes, ICUs that can compete at international level and an ICU nurse cadre to be proud of.

### **Research Design**

Research design is the “blueprint” for fulfilling objectives and answering questions according to Cooper & Schindler (2003) cited in Leedy (1980). It is the key to obtaining valid and reliable information for decision making, Latif and Maunganidze (2003). A descriptive research was used in this study. In descriptive design, which is qualitative research, data is gathered directly from participants for the purposes of studying attitudes, characteristics, interactions of individuals in their natural settings. Descriptive research is aimed at giving details of a situation or a social phenomenon Neuman (1997) . Often a topic is first explored and then described. The researcher begins the topic with a specific definition to give a thorough description of that topic Neuman (1997). The outcome of the investigation should give a picture of the topic. This suited this research well because the topic under investigation was Burnout in I.C.U. nurses and the researcher hoped to give a picture of this phenomenon at end of research. In this study information was obtained from nurses working in intensive care units of three major hospitals of Zimbabwe to find out about burnout.

### **Population**

The participants in this case were the nurses working in the intensive care units. These formed the target population.

The sample was drawn from nurses who had worked in the intensive care unit for one year and above. According to Wilson (1993), sampling is a feasible and logical way of making statements about a larger group based on what the researcher knows about a smaller group.

Sampling method used was the convenient sampling method. The researchers selected those elements which were easily accessible until the sample reached the desired size. This is a non-probability technique used in social sciences according to Blero and Higson (1995). This suited this research well because of the nurses off duties as some were on night duty or nights off and were not easily accessible. A sample of 23 nurses was selected.

The criteria used to select sample was registered general nurses, or I.C.Ns who had the necessary skills to interpret the questionnaire since they had at least five ordinary level passes. Participants had to also have working experience of more than one year in I.C.U. for them to be able to appropriately assess the interplay between contributory causes and signs and symptoms over a reasonable period of having been exposed to the ICU environment.

The researchers used self administered questionnaires and interviews. The questionnaire was adopted and modified from the Maslach Burnout inventory. The Maslach burnout inventory is a well studied measurement of burnout, developed by Maslach and Jackson who first described the term burnout in the 1970s. The scale measures the variables in both intensity of feeling and frequency of outcome.

Specific lists of questions were asked as a way of getting responses from the participants. There are advantages and disadvantages associated with this method of information gathering.

Advantages of interviews is that questions can be standardized and the participants do not have to be literate. It is easy for the researchers to note non-verbal communication.

Interviews allow the researchers to establish rapport with respondents, which can benefit later communication if need be. Additional information could be obtained by asking follow up questions if the answer was ambiguous. However, disadvantages are that, there can be a problem of bias because of demographics eg. race, gender or age etc. Interviews can be

costly because it involves travel expenses, etc. If many interviewers are used, there is need for training. The sample is limited in size if one is using interviews.

A pilot study indicated that there could be a weakness from lack of control of the participants' environment. This was thwarted by ensuring that the right person completed the questionnaires by closely monitoring the distribution and receipt of the questionnaires. The research embarked on hand delivery of the questionnaires and collected the completed questionnaire.

### Data Collection

The researchers made appointments through letters and by telephone. Questionnaires with 10 sections were distributed to ICU nursing staff who were one year and above on the job. Face to face interviews were also used with head nurse. The respondents were given questionnaires to answer over a day since ICU is a busy place to allow nurses to care for their patients. The face to face interviews were conducted same day. Time was taken to visit each hospital on separate days.

### Data Presentation and Analysis Procedure

Ratings of demographic data, contributory factors of burnout in ICU, signs and symptoms of burnout, non-work related factors and strategies that can be applied to reduce burnout in the ICU were used in the questionnaire. This, together with responses from face to face interviews, helped to solicit the participants ratings to determine the presence of burnout in the nurses in ICU. The respondents marked their best answer as well as give yes, no, not applicable responses and also gave solicited responses. Collected data was analyzed in table form and graphs showing ratings and percentages.

### Results

Tables and graphs were used to further illustrate the information. The research questions were presented and answered according to findings. Some insight into the problem was given from the statements quoted from interviews carried out with the intensive care unit heads.

### Demographic Characteristics of the Nurses

The following presentations on demographics characteristics of the respondents will help as supporting factors or challenges in the trends that were shown in the findings.

Table 1, Distribution of Participants by Age  
N = 23

Age	No. Of Participants	Percentage
20 – 30	13	56.5%
31 – 40	9	39%
41 – 50	0	
51+	1	4.34%
<b>Total</b>	23	100%

Table 1 showed that most nurses working in the ICUs were within the age group of 20 – 30. This falls in the group which is in their childbearing age, or trying to establish relationships. They probably have a growing family, trying to balance family life and work. The group is still very active with a lot of ambitions both career wise, and high expectations in life. According to the literature review, if their high expectations careerwise are not met, they could end up being disillusioned or might even look for greener pastures or leave nursing because of burnout.

Table 2, Distribution of Participants by sex  
N = 23

Sex	No. of Participants	Percentage
<b>M</b>	3	13%
<b>F</b>	20	86.9%
<b>Total</b>	23	100%

From the above table 2 it shows that most of the Participants were female. The reason could be that it is assumed that most carers are females because of their maternal instincts.

Table 3, Distribution of Participants by Hospitals  
N = 23

Area of Speciality	Frequency	Percentage
<b>ICU 1<sup>st</sup> unit</b>	9	39%
<b>ICU 2<sup>nd</sup> unit</b>	13	56.5%
<b>ICU 3<sup>rd</sup> unit</b>	1	4.34%
<b>Total</b>	23	100%

The significance of table 3 was to find out if there are peculiar problems associated with a particular area of specialty. This would help to identify factors and recommend strategies that can exacerbate or reduce burnout in these units.

Table 4, Distribution of Participants by Experience  
N = 23

Period of Experience ICU	Frequency (f)	Percentage
<b>1 – 5 yrs</b>	17	73.9%
<b>5 yrs+</b>	6	26.1%
<b>Total</b>	23	100%

The above table illustrates that the bulk of nurses working in ICU have less than 5 years experience. In Zimbabwe there has been migration of experienced nurses who left for greener pastures at the height of harsh economic conditions that prevailed in the country in recent years as cited in the literature review.

Table 5, Distribution of Participants by qualification  
N = 23

Qualification	Frequency	Percentage
<b>ICN &amp; RGN</b>	5	21.7%
<b>RGN only</b>	17	73.9%
<b>OTHER</b>	1	4.34%
<b>Total</b>	23	100%

Table 5 sought to find out whether there was any specific or peculiar problems associated with nurses who are lacking in other qualification or with different qualifications from others. It also helped to find out whether competency factors due to under qualification could play a role in burnout due to feelings of inadequacy.

Table 6, Distribution of Participants by educational level  
N=23

Level of education	Frequency	Percentage
<b>O' Level</b>	14	60.8%
<b>A' Level</b>	8	34.7%
<b>Other JC</b>	1	4.34%
<b>Total</b>	23	100%

The study sought to find out whether there was any association between burnout and level of education. The responses show that the bulk of the Participants received at least O' Level education and as such level of education was insignificant.

Table 7, Distribution of Participants by position at work  
N = 23

<b>Senior sister</b>	8	34.7
<b>Junior sister</b>	14	60.8%
<b>SCN</b>	1	4.34%
<b>Total</b>	23	100%

The bulk of the participants were junior sisters which contributed 60.8% of the sample and position at work was not significant.

The key in Table 8 was used to rate participants feelings in both intensity and frequency.

The feelings were rated on a scale of 1 – 3 according to both frequency and intensity. Although not all concepts from the Maslach burnout inventory were used, concepts of frequency and intensity were retained.

Table 8, Key to interpretation of graphs

<b>Item score</b>	<b>(f) frequency</b>	<b>Intensity</b>
<b>1</b>	A few times a year	Mild
<b>2</b>	A few times a year	Moderate
<b>3</b>	Nearly every day	Severe

The following were found to be the main contributory factors of burnout in nurses at the three selected hospitals.

**Involvement/Emotional Attachment**

**Questions asked = 5**

**N = 23**

**Expected Responses: 115**

Figure 1

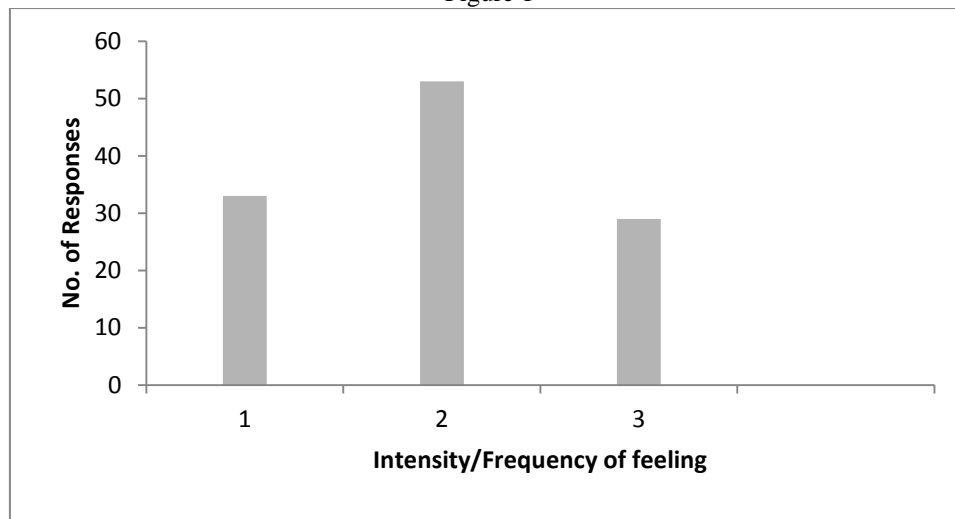


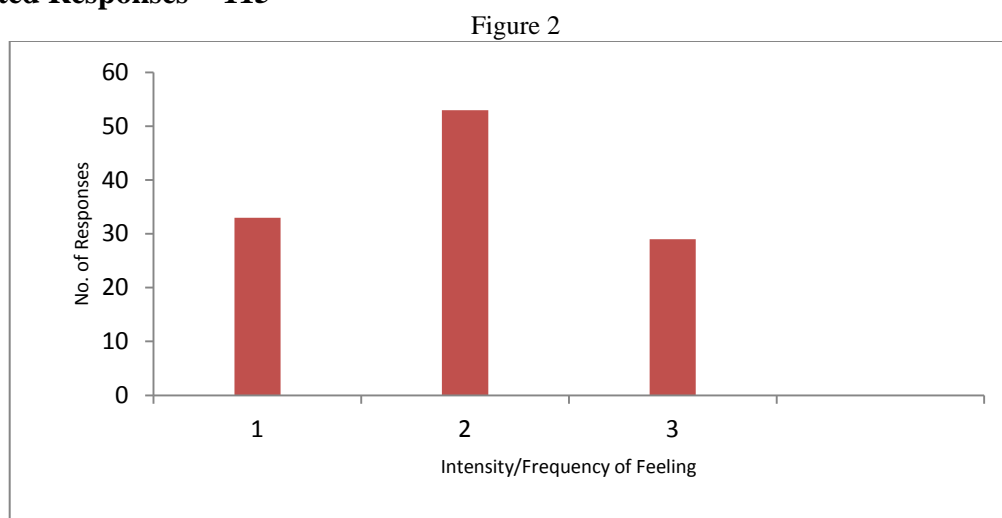
Fig. 1 represents involvement/emotional attachment and was included to try and demonstrate the emotional attachment and level of involvement of the nurse with their work and patients. There is evidence of emotional attachment from the evidence shown in the graph from mild 28% of responses, moderate 26% to severe involvement 26%, with a peak in the moderate category. The fact that there was severe level of emotional attachment also indicates that there is a possibility of these nurses in this category suffering from burnout.

## Disillusionment

Questions asked = 5

N = 23

Expected Responses = 115



The presence of disillusionment is demonstrated in the above graph. The levels range from mild accounting for 28%, moderate 46% to severe 26%. This seems to be in line with the literature review where Erlin and Sereka (1997) concur that nurses can be disillusioned if their colleagues, supervisors or superiors disregard their contributions in the unit and this can lead to burnout.

Table 9, Death and Dying

N = 23

Activity	Number	Percentage
Caring for dying patient	18	78%
End of life decisions	10	43%

From the responses in Table 9, 78% of the nurses were caring for dying patients and 43% were involved in end of life decisions. Literature reveals that death and dying are issues that can affect nurses and result in burnout.

From the illustrations and tables above, there is a clear demonstration that death and dying issues could be contributing to burnout in nurses at the selected major hospital of Zimbabwe.

## Working Hours

Working hours for ICU nurses in both hospitals were found to be the same. They all work a 40 hour week. Night duty is done on a rotational basis in both units. The nurses in charge do not do night duty.

The following is an illustration of some of the complaints about the working hours and off duties that came out from some of the responses.

Table 10, Complaints on working Hours

N = 23

Complaints of unfair off-duty schedule	7	30.4%
Off duties not done according to wish	4	17.3%
Changed too often	6	26%
Had gone on vacation in the past six months	3	13%
Happy with off duties	3	13%

However, from the data collected and shown in table 10 above, only 3 (13%) of the participants had gone on vacation in the past 6 months. In the literature review this has a bearing on emotional exhaustion and fatigue from constantly being in the unit for prolonged periods of time without vacation. The figures also illustrate varying levels of unhappiness with the off duties.

From the above findings, there was no demonstration of age, sex, educational level, work experience being a factor in contributing to burnout, neither did qualifications and position at work. The factors that have been presented above as contributing to burnout seemed to be found in all the ICU population.

The following signs and symptoms of burnout were found to be present in the nurses at Harare Hospital, Avenues Clinic and Baines Avenue Clinic:

**Emotional Exhaustion**

**Items assessed = 5 part**

**N = 23**

**Expected responses = 115**

Figure 3

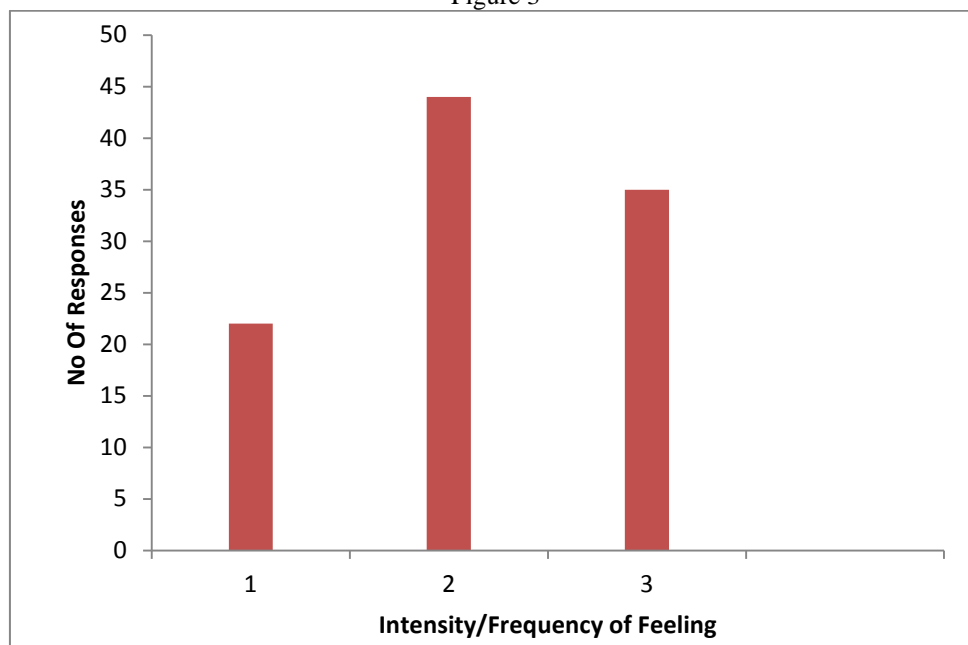
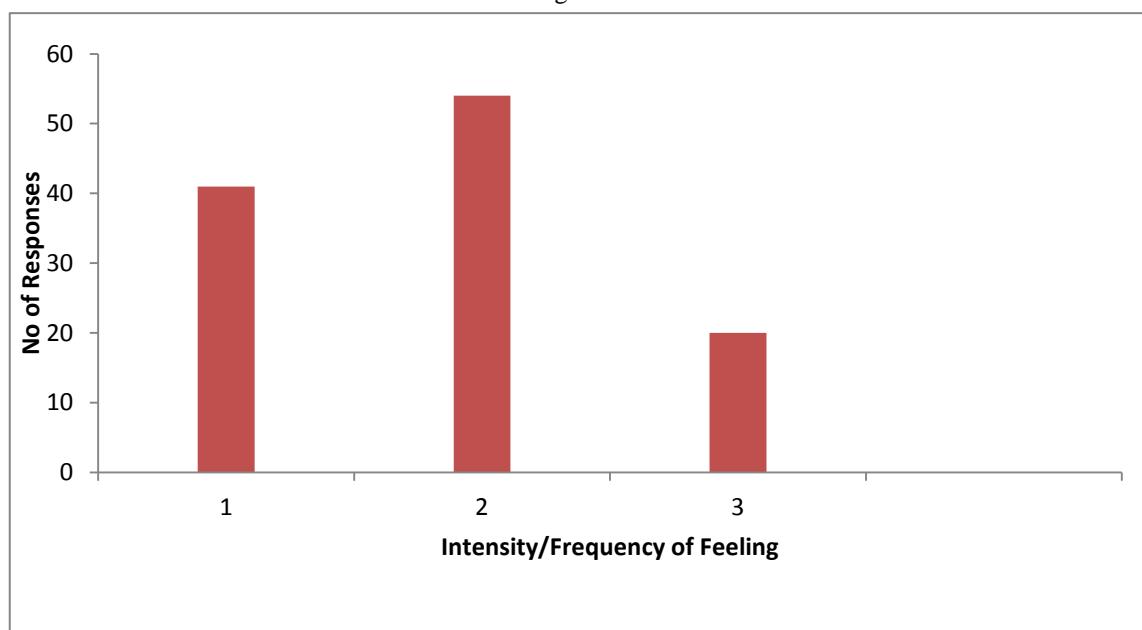


Fig 3 indicates that there was presence of emotional exhaustion with most responses in the moderate range in both frequency and intensity i.e. 39%, to severe feelings of emotional exhaustion which accounted for 40% of the responses. A smaller group of responses, i.e. 21%, indicated mild emotional exhaustion. Emotional exhaustion is one of the cardinal signs and symptoms of burnout. According to Maslach et al (1980), burnout is a syndrome of emotional exhaustion and cynicism where the nurse could end up even viewing themselves negatively resulting in depression.



**Depersonalisation****Questions asked = 5****Expected Responses = 115****N = 23**

Figure 4



The above figure indicates that the majority response to the feeling of depersonalization were in the moderate feelings category i.e. 46.9%. Mild depersonalization accounting for 35.6% as well as feelings of severe depersonalization on 17.3%. This showed that feelings of depersonalization were present in nurses working at these ICU's.

From the responses demonstrated in the tables and figures, there was no demonstration showing the relationship between signs and symptoms found in the participants and their demographic characteristics. The feelings of emotional exhaustion that were illustrated in the findings were in line with the literature review, where Calvie Ter – Bagdasarian (2003), notes that feelings of emotional exhaustion result from intense feelings of compassion and empathy especially after losing a patient which the nurse has formed a bond with. The nurse then gets emotionally fatigued.

The figures and tables shown illustrated that 30.43% of participants indicated severe emotional exhaustion, 26% indicated severe disillusionment and 17.3% indicated signs of severe depersonalization. This indeed is cause for concern.

**Possible strategies can be applied to reduce burnout in these ICU's**

From the findings in the questionnaires and from the interviews conducted during data collection, certain areas were identified where steps could be taken to reduce burnout.

From the literature review, the service professionals who usually get burnout are those high achievers who are so involved in their work and are accomplishees. Disparities between their feelings of personal accomplishment and involvement with their patients and disillusionment if they don't feel they have accomplished, was shown to result in chronic stress resulting in "burnt out" feeling. Debriefing meetings on the units between physicians and nurses could be a way of trying to iron out these disparities and help the nurses re-ignite their sense of purpose. These help to dispel misconceptions according to Serecka & Erlin (1997) , and make nurses feel a sense of purpose and reduce disillusionment. From the

responses from the hospitals and interviews, debriefing meetings were not held regularly and at times not done for long periods.

The long shift of 12 hours could be reduced to try and give the nurse more time away from the ICU. Some nurses who do shift work tend to be away from home for long periods and this could affect family relationships according to literature review. The supervisor could also be more flexible when scheduling off duties so as to accommodate preferences of nurses. This is not to disregard that proper staffing of the unit. This has to be prioritized so that patients get the care they need. Measures need to be put in place also to help meet transport needs where the nurses work shift work and long hours.

The researchers mentioned in the literature review, that allowing nurses to go on retreats also helps them to refocus and regain some of their vigor. From the responses, only 3(13%) of the nurses had taken vacation during the past six months. It would seem to help if nurses could go on vacation more frequently, as long as the units are well staffed.

The ICU environment is intensely stressful and nurses need to have periods of rest during their break times. Nurses need rest rooms where they can rest during their break times where there is no continuous ticking of respirators or monitors.

In some of the ICU's the rest rooms are not restful enough and they are inside the unit where the nurse can still hear the ventilators and monitors ticking. Only one hospital rest room had a conducive rest room for their nurses.

Counseling of nurses working in ICU needs to be done because some of the nurses indicated that they are facing family and financial problems. Counseling helps the nurses to deal with their unfinished business, reduce stress levels and help them to function more effectively. This in turn also improves patient outcomes in the unit. From the responses, there is no counselor for these special units at either hospital ICU's.

Refresher courses also help to make nurses feel confident in their work and help remove a sense of inadequacy which can result when the nurse feels they lack in competency. Participation in ICU research groups can also help nurses regain a sense of purpose e.g. they could pick any research topic and start research in the ICU. This also needs to be supported by supervisors and employers.

In times when the nurses' resources are depleted the supervisor or employer could help by granting compassionate leave.

Adequate equipment will also relieve the ICU nurses' stress and therefore reduce burnout e.g. enough ventilators, monitors, and suction apparatus etc.

Adequate remuneration since some of the participants cited financial hardships, could be a way of trying to reduce stress levels since the Participants are mostly in the child bearing ages and could be having problems with growing families. The findings indicated 47.8% had too heavy family responsibilities.

### **What are the non – work related factors of burnout?**

This question sought to find out whether non-work related factors in ICU nurses had anything to do with burnout in these nurses.

34.7% of participants reported conflict with family members, 47.8% reported family responsibilities were too heavy. Only 17.5% seemed to be content where non-work related factors were concerned. This is understandable in Zimbabwe currently as the country is still recovering from financial problems that have bedeviled it in the past few years. With nurses salaries in the public sector falling below the poverty datum line, this is bound to add more stress on a carer who is already facing other stressful situations at work.

Family conflicts can come in various forms, either due to financial problems or other psychologically and emotionally related problems. Major problems can arise in intimate relationships due to boredom as a result of a sense of predictability, Corey (1983). This

problem in relationships and need to be valued by others is very important, Maslow (1970) cited in Hough (2003). This can also contribute a lot to stress and contribute to burnout in nurses.

According to the findings in the questionnaire there was no set pattern that emerged to indicate that demographic characteristics of the ICU nurses had any bearing on the contributory factors of signs and symptoms of burnout that were noted.

There was evidence of burnout among nurses working in ICU in major hospitals of Zimbabwe. The findings revealed mild to moderate levels of burnout in these nurses as illustrated figuratively and diagrammatically. However the factors contributing to burnout in these nurses were also given as well as identifying the signs and symptoms of burnout in the nurses. Strategies to try and reduce burnout were documented as well as non-work related factors.

While the topic of burnout might be generally assumed to be far fetched in Zimbabwe, conducting this research proved that it was a silent problem that could be affecting a lot of nurses. From the results and the conclusions that were drawn from the findings, it was evident that some of the nurses working in the intensive care units showed some signs and symptoms of burnout and there was need to help them cope with their work.

The main concern of the research was to try and research the subject of burnout in nurses with the aim of highlighting possible strategies that could be put in place to help and support these nurses to cope with their work by trying to reduce burnout. The value of a possible reduction in burnout and the resultant levels of positive outcomes, benefits to the organization cannot be over emphasized.

Theoretical views were given from the literature review and empirical evidence given with the aim of enhancing understanding of the issue of burnout in these nurses.

In carrying out the study, a few challenges were met. Some institutions declined to have the study carried out at their hospitals and also some nurses were not available as they had gone on nights off. A sample of 23 nurses working in ICUs, and only those nurses who had completed at least a year in the intensive care units were selected.

Basic research questions were raised as a way of giving objectives to the research. These were:

What are the main contributory factors of burnout in nurses working in the intensive care units?

What are the signs and symptoms of burnout in these nurses?

What possible strategies can be applied to reduce burnout in these nurses?

What are the non-work related factors in burnout?

### **Demographic factors**

The research found that the majority of respondents at the hospitals 56.5%, were in the age range 20 – 30 years old. This group is still very active and ambitious, career wise with high expectations in life. According to the literature review, if their high expectations are not met they could end up with disillusionment which is a contributory factor to burnout.

The study also found out that 86.9% were female nurses.

The study discerned the 73.9% of the respondents were five years in the unit, with only 26% having above five years. This agrees with the literature review that assumed most of experienced nursing staff left for greener pastures.

The bulk of the nurses i.e. 73.9% were RGN's only with no other qualification and 21.7% with formal ICU training. Although literature review cites feelings of inadequacy could affect nurses where there was inadequate knowledge the findings did not associate this with the finding at any of the hospitals.

What are the main contributory factors of burnout in the nurses?

The factors that were found to contribute to burnout in the research were death and dying, unfavourable working hours, emotional involvement/attachment, disillusionment and emotional exhaustion. The research showed that among the respondents, 39% had severe feelings of emotional exhaustion and 40% showed moderate feeling of emotional exhaustion, it showed 21% to have mild emotional exhaustion. This agrees with the findings in the literature review where Cordes & Dougherty (1993) described burnout as being characterized by emotional exhaustion is an important indicator of burnout.

78% of the respondents were caring for dying patients and 43% were involved in end of life decisions. This showed that this could be affecting the nurses at these institutions because literature review (cox et al sars cited on <http://members.cox.net/dinsw2/stressnicu.htm>) concurs that death and dying issues can be taxing for the ICU nurse who is already facing other stresses on the job. Exposure to death and dying can also contribute to burnout.

The issue of disillusionment is illustrated by that 26% of the respondents showed severe disillusionment, 46% moderate and 28% mild. According to the literature review Erlin & Sereka (1997) also agree that disillusionment forms imbalances in relationships of physicians and nurses or nurses and supervisors can cause disillusionment which can result in burnout. This was illustrated that 17.3% had severe feelings of depersonalization i.e. they had become cynical in their work.

Working hours were also found to be a contribution factor with 30.4% responses complaining of unfair off duty schedules.

What are the signs and symptoms of burnout in these nurses?

The major signs and symptoms of burnout that were demonstrated from the findings were in emotional exhaustion 21% mild, 40% in moderate range to 39% having severe emotional exhaustion. Depersonalization showed that 35% were in the moderate range, mild accounting for 46.9% and severe on 17.3% and disillusionment showed 28% in the mild range, 47% moderate and 26% severe. These were rated on a two dimensional rating of both frequency of occurrence and intensity of feeling.

What possible strategies can be applied to reduce burnout in the nurses?

From the findings in the research it was found that debriefing meetings between physicians and nurses and between supervisors and nurses were not done on a regular basis. This could be introduced on a regular basis to try and dispel misconceptions between the different cadres. The long shift of twelve hours could be reduced to give nurses more time away from the ICU and more time with their families. This could help to improve family relationships and reduce conflicts in their families. However the units have to be well staffed.

Measures to help nurses with transport, especially during shift work and long hours could also go a long way in reducing burnout. Counseling services, staff support and other intervention strategies eg. Compassionate leave etc, can also be introduced to try and reduce burnout. Nurses also need to be involved in research and continuing education in forms of refresher courses. Comfortable restrooms for staff during break periods where there is no continuous noise of the ICU environment could also help the nurses. Adequate equipment and also to look into the remuneration of nurses. The ICU's themselves can also organise open days for the staff and senior administration to come and see what really goes on in the ICU so that they are sensitive to their requests and grievances.

What are the non- work related factors:

The non-work related factors that emerged were family conflicts and financial hardships with 34.7% reporting conflicts with family members and 47.8% reporting family responsibilities too heavy. This agreed with the findings in the literature review which cites that family support can also be a factor in overall coping of the nurses from pressures at work.

## **Conclusion**

The study concluded that there is burnout in nurses working in ICU's at the selected major hospitals in Zimbabwe. Although the levels of burnout differed from mild to severe forms, the fact that it was demonstrated would indicate that remedial measures need to be taken by the responsible authorities at these institutions to try and alleviate the situation.

The research was able to demonstrate the social and institutional variables that either promote or reduce the occurrence of burnout. Such information will have the practical benefit of suggesting modifications in the recruitment, training needs and job design that may alleviate this serious problem.

## **Recommendations**

The researchers recommended that the authorities at the hospitals, i.e. the principal nursing officers, look into offering of professional counseling services to the ICU nurses on a regular basis so as to identify any issues that might be affecting them early enough and recommending appropriate remedial action before a full blow "burnout" feeling develop.

It is also recommended that the matrons at these hospitals work with the administrators to ensure that the intensive care units have rest rooms that are away from the working area to give the nurses a feeling of rest during breaks. The sisters in charge working together with the principal nursing officers need to be able to grant compassionate leave on reasonable grounds when the nurse feels he/she cannot cope due to depleted emotional resources. This requires a great deal of support from the employer and the supervisor to adjust staffing levels so that patient care is not comprised.

The sister in charge in consultation with the matrons can make arrangements for nurses to go on retreats as individuals or as groups. This could help the nurses to refocus and regain some of their lost vigor during such outings. The sister in charge of the ICU could arrange awareness campaigns by highlighting the role of the ICU nurse to the administrators and also the challenges they face so as to allow them to gain some insight into the nurses problems and thereby be supportive in times of need according to literature review. This could even be in the form of open days for administrators to come and see ICU nurses at work and ask challenges that they face.

The manpower department in consultation with matrons needs to look into the issue of affording adequate remuneration to try and reduce stress levels associated with financial difficulties of their work. The sister in charge of the intensive care unit needs to arrange for regular de-briefing meetings between doctors and nurses and between nurses and supervisors also helps to dispel misconceptions and negative attitudes that can develop during the course of their work.

The sister in charge of ICU needs to arrange for refresher courses also as a way of stimulating waning interest by helping the nurse feel more confident, thereby removing feelings of inadequacy and non accomplishment which can contribute to burnout. The nurses need encouragement to engage in self development and avoid stagnation.

Intensive care nurses need to be encouraged by the sister in charge and matrons to participate in ICU research groups so as to help the nurse regain a sense of purpose whilst keeping them abreast with modern trends in care. It can be quite revitalizing if the supervisors, doctors and employers support it as well.

Given the negative effects of burnout in nurses cited in the literature review to the patient, the nurse and the organization as a whole, any progressive organization would want to nip the problem in the bud.

### **Future research**

The subject of burnout in ICU was not exhausted at all because other members of staff were not included in the study, for example the doctors and nurse-aides. There is therefore need to carry out further research to find out the impact of this phenomenon on the whole spectrum of ICU staff. There is also need for a follow up to evaluate the effectiveness of the strategies to try and reduce burnout recommended above.

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