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A study of Factors Influencing Psychological Stress Among Health Care Workers Providing Palliative and Hospice Care in Nursing Department

Richard Yunxi Zuo & Lanye Wang

Abstract

A sample of 12 medical staff in the nursing department of a general hospital was interviewed in a semi-structured way using the Grounded Theory Analysis method, and the data obtained were compared and analyzed using Nvivo 11 software. The psychological stress factors of medical staff engaged in hospice and palliative care in the nursing department based on "emotion management" were obtained, and the main psychological stress factors were three dimensions: work, knowledge of death, and educational background, and the results of the study can be a reference for medical staff engaged in hospice care and palliative care to reduce their stress.

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About Author (s)

Richard Yunxi Zuo (Corresponding Author), Guangdong Experimental High School (GEHS), Guangzhou, China.
Lanye Wang, Guangdong Experimental High School (GEHS), Guangzhou, China.

1. Introduction

Hospice care and palliative care, are health services that are widely recognized internationally as a way to provide dignity and comfort to patients who are dying (Maze et al., 2022). This care focuses on the physical, psychological, and spiritual needs of the terminally ill, providing pain relief and improving quality of life. It also supports the patient's family by helping them understand and cope with the process of their loved one's dying and can provide the patient with a sense of love and respect, allowing them to pass their final days in a serene and peaceful manner while reducing the psychological burden on healthcare professionals and family members in the process of caring for them (Sharma, 2023). Mary et al. (2017) considers palliative care to be a specialized healthcare service for people suffering from serious illnesses, focusing on the alleviation of symptoms. Palliative care is a specialized healthcare service for people with serious illnesses that focuses on relieving symptoms and stress and improving the quality of life for patients and families. Psychological stress can have a significant negative impact on a person's physical and mental health. A study published in the Journal of the American Medical Association (JAMA) found that burnout is a pervasive problem among physicians in the United States, affecting approximately 45% of all doctors surveyed. High levels of stress contribute to the development of burnout, leading to emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment (Sharafelt, 2015). In addition, healthcare workers, especially nurses, and physicians, are at an increased risk of developing mental health disorders due to job stress (Sachdeva et al., 2022). Research published in the Journal of Nursing Care Quality examined the relationship between nurse burnout and patient safety (Kim et al., 2023). The study found a significant association between higher levels of nurse burnout and increased patient safety incidents, errors, and adverse events. Mental stress experienced by nurses can compromise their cognitive abilities, attention, and decision-making skills, thereby jeopardizing patient care (Tawfik,2018); furthermore, chronic stress among healthcare professionals has been linked to various physical health issues (Alfonsi et al., 2023). A study published in the Journal of Occupational and Environmental Medicine examined the relationship between job strain and cardiovascular disease risk among nurses. The research found that high job strain was associated with an increased risk of cardiovascular diseases, indicating the detrimental impact of work-related stress on physical health(Li, 2015). Therefore, studying the factors influencing the psychological stress of healthcare workers providing hospice services in the nursing department, understanding their stressors, taking targeted measures, providing better support and resources to reduce burnout and avoid mistakes, and focusing on the mental health of healthcare workers can help to establish a positive work environment, improve the morale and cooperation of the entire healthcare team and ultimately improve the quality and efficiency of healthcare services.

2. Research sample

2.1 Sample selection

Purposive sampling was used to select the interviewers. The interviewees were from the nursing apartment of a second-class hospital in the Guangdong-Hong Kong-Macao Greater Bay Area (GBA). The apartment has about 50 terminally ill patients and has formed a palliative care and hospice care team with doctors, nurses, and caregivers.

(1) Criteria for inclusion of physicians: licensed physician, experience working in a nursing department and caring for patients, ability to summarize the experience.

(2) Inclusion criteria for nurses: professional certification as a nurse, experience working in a nursing department and caring for patients, and the ability to summarize the experience.

(3) Inclusion criteria for caregivers: experience working in a nursing department and caring for patients, and the ability to summarize the experience.

2.2 General information about the study population

Interviews were conducted with twelve palliative care and hospice care providers, including two physicians, six nurses, and four caregivers. They had been practicing from four months to 18 years, with an average of three years in the field.

3. Research methodology and analytical process

3.1 Data collection

(1) Interview questions and outline. The study promised that all interviews would be used for research purposes only and the interview outline consisted of 8 questions. Interview outline: 1) What is your occupation? 2)What is your length of service? 3)Do you feel that you have stress at work? 4)What do you feel are the sources of your stress at work? 5)What do you feel are the factors affecting your stress? 6)Do you feel that you are emotionally stable? 7)Have you had any particularly impressive cases? 8)What is your usual way of relaxing?

(2) Execution of Interviews. The interviews were conducted between July 16, 2023, and July 18, 2023 by the researcher. The interviews lasted approximately 10 to 15 minutes. The interviewer was made aware of the purpose of the study and the purpose for which the interview data was being used for academic purposes; the interviewer recorded the entire interview with the consent of the interviewee. Interviews were conducted in a semi-structured interview format. Interviewers were trained in interviewing techniques such as repetition, clarification, follow-up questions, maintaining neutrality of language, and multiple interviews based on results.

(2) Organization and analysis of interview data. The interviews were converted into textual information within 24 hours and checked sentence by sentence and word by word against the recordings. The collected data were initially coded using the Chinese version of Nvivo.

(3) NVivo is a specialized qualitative data analysis software used to support data management and analysis in the field of social science and qualitative research. The researcher's coding followed the sequence of pen coding, spindle axis coding, and selective coding: the researcher formed concepts by generalizing the phenomena, then further categorized the concepts with similar attributes; analyzed the relationship between the categories and the concepts they belonged to in the data; and finally, generated the core categories to derive the theoretical framework. The core category includes all categories and can represent the core phenomenon of the whole study. In the process of collecting and analyzing data, the original data, phenomena, concepts, and categories are constantly compared, and new codes are constantly generated and compared with the existing codes so that the resulting theory can explain the original data.

3.2 Open coding

The statements in the interview text that were useful for this study were selected and given a code to make them a node (Allsop et al., 2022). For example, in an interview with a nurse, she mentioned that "when you go to work, for example, you definitely think about the condition observation, and you're worried that there's going to be some sudden changes in condition that you're not paying attention to, and that causes the patients to have a possible adverse event or something else too late to resuscitate, and it causes some of these problems." The researcher could have edited this text for human factors-related changes in condition; following this logic, the text was coded sentence by sentence. This study ended up obtaining 10 nodes, which were refined to form 9 concepts, and finally, similar concepts were categorized into the same categories. The final 9 categories were obtained and are shown in Table 1.

Table 1: Scope of open coding analysis formation

Serial Number	Scope	Conceptual Number
a1	Perception of death	1
a2	Patient's condition	1
a3	Working environment	1
a4	Handover of work	1
a5	Job familiarity	1
a6	Interpersonal relationship	2
a7	Palliative care and hospice care education experience	1
a8	Match between specialty and job content	1
a9	Communication at work	2

3.3 Spindle Axis Coding

After uncovering the underlying logical relationships between the categories, the research data were regrouped and the open coding results were further analyzed, categorized, combined, and abstracted to obtain the three main categories, as shown in Table 2.

Table 2: Main categories extracted

Serial Number	Main Category	Scope	Conceptual Number
A1	Perception of death	a1	1
A2	Work-related factor	a2 a3 a4 a5 a6 a9 a10	9
A3	Educational background	a7 a8	2

3.4 Selective coding

Selective coding summarizes the core category from the main category. A core category is a category that encompasses and explains the main category to some extent. The core category was summarized as "emotion management". The structure of the framework and the relationship between the effects of stress on medical staff providing end-of-life care in the nursing department are shown in Figure 1.

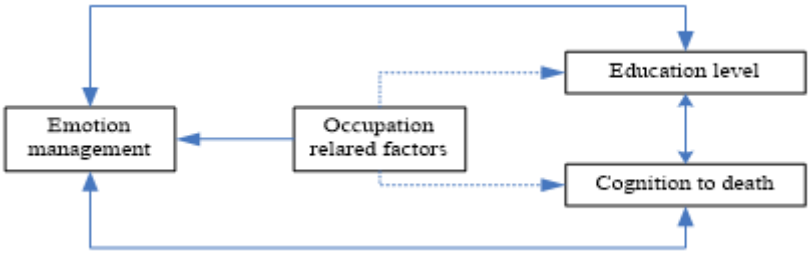

Figure 1: Impact Framework of Psychological Stress

3.5 Theoretical saturation test

The researcher re-interviewed two interviewees and used the same research methodology using Nvivo11 to organize, code, and analyze and not to find new nodes, thus completing the construction of a framework of factors affecting the psychological stress of medical staff providing hospice care and palliative care services in the nursing department, as shown in figure 2.

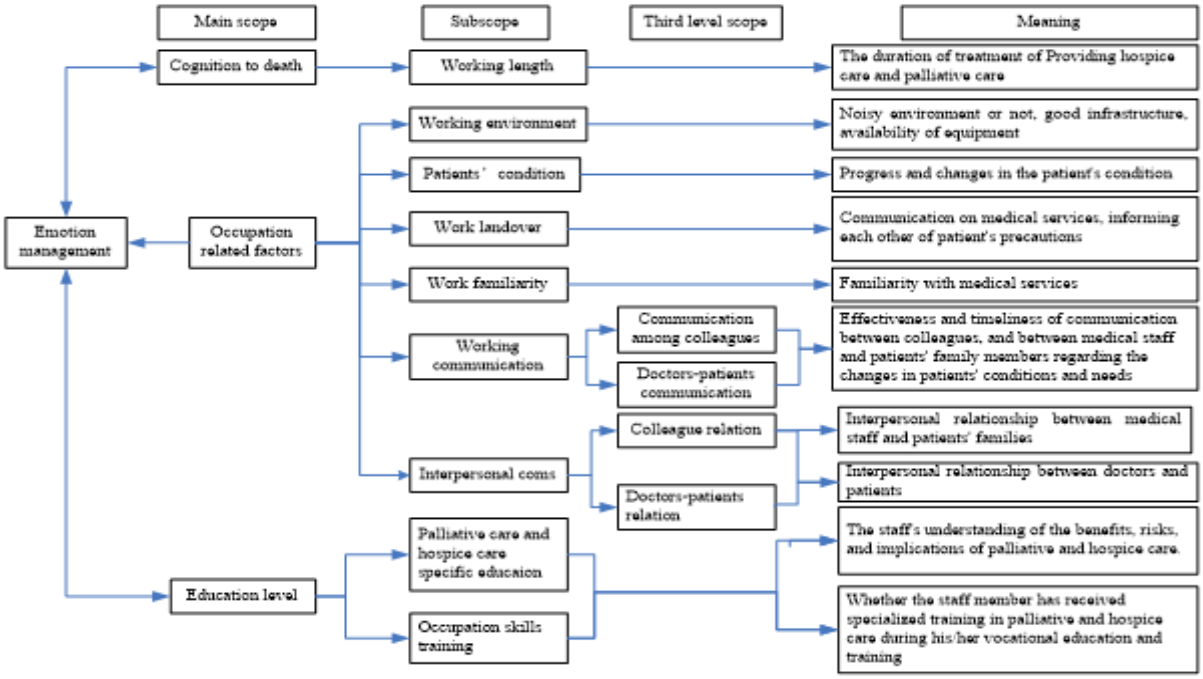

Figure 2: Factor framework for psychological stress among medical staff providing palliative care and hospice care service.

4. Discussion

4.1 Perception of death

For medical staff providing palliative care and hospice care service in the nursing department, working hours have a significant impact on their perceptions of death and psychological stress. First, medical staff who have been engaged in palliative care and hospice care service for a long time are exposed to frequent scenes of patients' life and death, and the continuity in time will allow them to gradually adapt to and understand the inevitability of life and death. Over time, some medical staff may develop more mature and profound concepts about death and recognize the fragility and preciousness of life, thus cherishing every moment more and enhancing their psychological resilience. However, prolonged exposure to the passing away of patients may also put medical staff under tremendous psychological pressure. Extended working hours may lead to fatigue and emotional exhaustion, exacerbating the psychological burden. During end-of-life care, medical staff often develop deep emotional connections with patients, so they may feel intense sadness and despair at losing a patient, and prolonged periods of such psychological burdens may lead to mental health problems. In this study, in most cases, with the increase in working time, medical staff will slowly accept the phenomenon of patient passing away psychologically, change their conception of death, and realize that it is an inevitable event, thus decreasing the probability of negative emotions due to patient passing away.

4.2 Work-related factors

(1) Work environment. Firstly, a comfortable and quiet environment can relieve medical staff's anxiety and fatigue and make them more focused on patients' needs, while a crowded or noisy environment will increase their stress. Secondly, convenience and functionality of facilities are also key factors. Well-equipped medical equipment and a good working layout can improve efficiency and reduce the burden on medical staff. On the contrary, outdated equipment and unreasonable layout may lead to poor work and increase the psychological pressure on the medical staff.

In addition, clean and safe work environments are critical to the provision of palliative care and hospice care service. Dirty environments can pose health risks, causing medical staff to worry about the spread of infections and increasing their psychological burden.

(2) Patient's condition. The progress of the patient's condition will cause a psychological burden to the medical staff. In palliative and hospice intervention, the patient's condition if the rapid deterioration, or the treatment effect is not up to the expectations of the medical staff, the psychological gap will cause a psychological burden on the medical staff, or due to the intervention of medical measures are not timely, medical services do not meet the operating standards caused by the patient's condition changes will also make the medical staff to produce self-responsibility, the guilt of the negative emotions, which will increase the psychological pressure on them.

(3) Handover of work. First, poor information transfer and communication during the handover process may lead to omission or misunderstanding of information, increasing medical staff's anxiety and uncertainty. Second, the time constraints and heavy tasks during the handover may cause medical staff to feel doubly stressed, affecting their ability to concentrate and make decisions, which may lead to incorrect handling and judgment and thus cause psychological stress. In addition, incomplete handovers may lead to difficulties in effectively assuming end-of-life care responsibilities and increased psychological burden for medical staff who are unfamiliar with the new work they are taking over.

(4) Work familiarity. Familiarity with work processes and professional skills can increase the self-confidence of medical staff when facing the situation of patients' dying, reduce uncertainty and lower the sense of nervousness caused by unfamiliarity with the work. It is easier for medical staff who are familiar with their work to cope with the emotions and needs of dying patients and their families, to effectively provide psychological support and comfort, and to reduce their anxiety and fear when facing life-and-death issues. In addition, medical staff who are familiar with their work are more able to rationally arrange nursing measures to alleviate patients' pain and provide more heart-warming care. However, medical staff who lack job familiarity may face greater psychological stress. Lack of familiarity with the condition and treatment options may lead to hesitation and concern in their decision-making, and a less sensitive response to patients' suffering and needs, which in turn exacerbates psychological stress.

(5) Work-related communication. Work-related communication is divided into inter-colleague communication and doctor-patient communication, and the effectiveness of inter-colleague communication directly affects teamwork and collaboration. Good inter-colleague communication can promote information flow, reduce misunderstanding and conflict, and enhance work efficiency. In the process of providing end-of-life care, the communication closeness of the cooperative team can ease the individual psychological pressure of medical staff, share responsibilities and emotions, and thus reduce the burden of healing care tasks. In contrast, doctor-patient communication directly affects the understanding and acceptance of patients and families. In end-of-life care, medical staff need to communicate with patients and their families, express care and respect, and explain treatment programs and prognosis. Poor doctor-patient communication may lead to dissatisfaction and anxiety among patients and their families, and increase the pressure and challenges of medical staff when facing emotional situations.

(6) Interpersonal relationships. For medical staff providing palliative care and hospice care service in the nursing department, interpersonal relationships have a profound effect on their psychological stress. Firstly, close contact with patients and their families, facing the death of the patient and the grief of the family, can easily lead to emotional empathy and psychological burden for medical staff. Secondly, coordinating cooperation between multiple professional

teams and getting along with colleagues of different personalities and work styles may bring about communication barriers and conflicts, increasing psychological pressure.

4.3 Educational background

The study found that palliative and hospice-specific training focuses more on emotional support, ethics, and morals than general vocational training. When receiving this type of training, medical personnel need to have a deeper understanding of the patient's psychology and family situation and learn ways to communicate with terminally ill patients and their families, as well as how to cope with psychological stress and grief. If medical personnel participate in palliative-and-hospice-specific training in addition to acquiring professional skills, this will enable them to gain the ability to alleviate the psychological stress caused by their profession. Additionally, many healthcare professionals have many other work experiences and educational backgrounds before participating in healthcare outside of the nursing department; for example, one nurse practitioner had 12 years of experience in neonatology before participating in the nursing department, and after transferring to a nursing department to practice in palliative and hospice care, she experienced inconsistencies in the demands of her career skills, which created psychological stress for her.

4.5 Research flaws and implications for subsequent research

The proposed framework of psychological stress factors for medical staff providing palliative and hospice care services in the nursing department is only an initial research exploration and needs to be continuously verified, revised, and improved by subsequent studies. The establishment of the framework in this study can provide some reference for relevant departments to alleviate the measures of psychological stress of medical staff providing palliative care and hospice care service.

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