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Factors associated with and impact of burnout in nursing and residential home care workers for the elderly

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Abstract. *Background and aim of the work:* Numbers of elderly people worldwide continue to grow. Increasingly these individuals require nursing and residential care to meet their needs. Nursing is an occupation associated with burnout amongst its workforce, associated with increases of emotional exhaustion, depersonalisation and decreases in personal accomplishment. This review of literature provides a more detailed picture of the associations and predictors of burnout within this setting, and also considers the implications this holds for patient care, before providing recommendations for managers of such settings. *Methods:* Literature searches were conducted across a range of academic databases with a series of relevant keywords. *Results:* Examination of search results suggested several factors relating to staff burnout including occupational aspects, types of setting, staff perceptions, coping strategies, education and training and the impact of burnout on care delivery. *Conclusions:* Studies from across the globe suggest that burnout is prevalent amongst staff working in nursing and residential homes caring for elderly people, with implications for the patients, staff and home-care providers. Factors associated with burnout appear to include perceptions of job stress and occupational aspects, as well as the types of coping mechanisms staff employ. Managing grief associated with death of patients at work, as well as staff perceptions of both clients and their illnesses also appear related to burnout as well as the specific type of healthcare setting.

Key words: nursing, residential care, older adults, staff burnout

Introduction

As the numbers of elderly people requiring nursing or residential care increase the wellbeing of nurses and care workers employed in this setting grows in importance. Nursing is inevitably a demanding and stressful job in a complex organizational setting and it has been widely regarded as one of the most stressful occupations, associated with high levels of staff turnover, absenteeism and levels of burnout (1). Burnout can be described as a syndrome of three facets: emotional exhaustion (EE), depersonalisation (DP), and reduced personal accomplishment (PA) (2). Emotional exhaustion occurs when the level of emotional resources becomes depleted such that individuals feel unable to give anymore of themselves emotionally. Depersonalisation describes feelings of cynicism towards clients, whilst reduced personal accomplishment refers to forming a negative evaluation of one's work ability (2). Whilst burnout impacts negatively upon staff members, research has suggested that quality of care is impacted, with levels of patient satisfaction lower in hospitals where nurses experience high levels of burnout (3). Furthermore, burnout in nursing has been associated with poor patient outcomes (e.g., 4). It is reported that nursing and residential homes represent one of the largest and most rapidly growing areas to provide care for the elderly (5), as such a greater knowledge of burnout of staff within these settings is important in terms of stress prevention, health

promotion and indeed patient care. This article aims to review articles examining burnout within workers in nursing and residential care for the elderly, to obtain a more detailed picture of the associations and predictors of burnout within this setting, and to also consider the implications this holds for patient care. Recommendations will be given based on the findings.

Method

Searches were conducted across academic databases Academic Search Complete, MEDLINE with Full Text, and Psychology and Behavioural Sciences Collection. Subject terms (SU) used were 'nursing home' or 'long term care' or 'residential care' or 'nursing homes' AND SU 'elderly' or 'aged' or 'older' or 'elder' or 'geriatric' AND SU 'burnout'. Limiters were placed by publication type to return academic journals only, peer-reviewed journals only and only articles written in English; only publications from the year 2000 to present were included in the analysis, in order to permit an account of the literature of this topic from the last century. This resulted in 30 hits. After removal of duplicate items and those which did not encompass the review criteria (did not consider burnout amongst those working with elderly people in nursing or residential homes) 14 items remained. These are summarised in Table 1.

Results

Research has suggested that nursing care aids working within nursing homes have high levels of job efficacy (a facet of burnout) but also hold a moderate risk for burnout domains of EE and cynicism (6). This would suggest that whilst care home workers place value and importance in the work that they do, they also have a risk for developing a cynical attitude and levels of emotional EE. It is concerning to note that studies have reported how time worked at a nursing home negatively predicts PA, a burnout factor (7). That is, the longer that staff worked at a nursing home, the lower their level of satisfaction and accomplishment around their work.

Occupational aspects

Research surveying Registered Nurses, assistant nurses, and nurse aides has suggested that those who perceive that they have been exposed to violence at work have higher burnout scores than staff who state they have not experienced violence at work (8). Other aspects of the work may also play a role. For example, (9) noted how staff who perceive the care that they give to residents to be person centred are seen to have high levels of PA, whilst those who feel they did not give person centred care have higher levels of EE and DP.

A further workplace based element can be noted, namely emotion rule dissonance. A study of nurses, orderlies and nursing aides working within nursing homes or outpatient care organizations provided measures of their levels of emotion rule dissonance (the extent to which their true emotions tallied with those required to be displayed at work) and followed them up at a later date. A high level of emotion rule dissonance (a high level of difference between actual and displayed emotions) was associated with both EE and DP at follow up (10). However, it was also observed that role complexity was an important and protective factor for burnout: Those who had high levels of emotion rule dissonance but had high levels of job complexity were less likely to suffer EE and DP than those colleagues who had a role which was not as complicated.

Types of setting

In an examination of public and private nursing homes in Sweden (11) suggested that there exists similarity in terms of the experiences of the workforce and that variations in the workplace (private or public) holds little difference on these variables. That is, similarities in the factors associated with burnout were largely similar. It was reported that 'Stress of Conscience', (the frequency of stressful situations and extent to which they bother the respondents' conscience), 'having to deaden ones conscience to work in healthcare' and levels of EE and DP were associated in both settings, and levels of burnout were comparable. There were however additional factors associated with burnout within the public organisation with an additional role in burnout found for the perception

Table 1. Studies considering staff burnout within elderly care settings identified in the literature review

Authors	Setting	Staff	Location	Study details
Hunter, Hadjistavropoulos, Thorpe, Lix and Malloy, (2016)	Two large rural long-term residential care facilities	Nurses, nurse assistants, managers, professional staff, recreation staff, dietary staff, and housekeeping) extended beyond nursing staff	Canada	How burnout facets predict extent to which staff report delivering certain aspects of dementia centred residential care
Estabrooks, Squires, Carleton, Cummings and Norton, (2015)	Thirty six Long term care homes	Healthcare aids	Canada	Burnout characteristics of workers, how this differs between type of facility
Narumoto, Nakamura, Kitabayashi, Shibata, Nakamae and Fukui, (2008)	Two nursing homes	Nurses, nursing assistants,	Japan	Personality and coping style influences on burnout
Isaksson, Graneheim, Richter, Eisemann and Åström, (2008)	Three nursing homes	Registered Nurses, assistant nurses, and nurse aides	Sweden	Exposure to violence at work and impact on burnout
Anderson, (2008)	Twelve nursing homes	Certified nursing assistants (CNAs)	USA	Predictors of burnout in relation to different types of grief following resident death
Abrahamson, Anderson, Anderson, Suitor and Pillemer, (2010)	Nursing homes for the elderly	Nursing assistant and nurses	USA	Role of conflict with relatives in burnout
Mandiracioglu and Cam, (2006)	Six nursing homes	Healthcare workers, Office employee Nurse's aides, Social workers, psychologists, Cleaners, Others	Turkey	Associations of burnout e.g. gender, violence, elderly and organisational issues
Åhlin, Ericson-Lidman, Norberg and Strandberg, (2015)	Two residential care units for older people	Registered Nurses and nurse assistants	Sweden	Individual difference variables role in burnout. Differences between types of home
Passalacqua and Harwood, (2012).	A for-profit long-term care facility specialising in memory issues (namely AD and other dementias)	Caregivers	USA	Contribution of dementia communication training intervention on burnout
Hillman, (2006)	Nursing home care unit	Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants	USA	Association of staff perceptions of problematic resident behaviour, staff view of the residents displaying this behaviour and burnout

(continued)

Table 1 ***(continued)*****.** Studies considering staff burnout within elderly care settings identified in the literature review

Authors	Setting	Staff	Location	Study details
Martínez, Suárez-Álvarez, Yanguas, and Muñiz, (2016)	56 residential care homes for the elderly	Care assistants, professionals from a range of disciplines	Spain	Correlations between perceptions of person centred care delivery frequency and burnout
Shinan-Altman, Werner and Cohen, (2016)	Nursing homes and hospitals	Social workers and nurses	Israel	Staff perception of AD and associations with burnout
Kubicek and Korunka, (2015)	Nursing homes and outpatient care organizations	Nurses, orderlies, and nursing aides	Austria	Role of emotion rule dissonance in burnout
Hillman, Skoloda, Angelini and Stricker, (2001)	Nursing home	Registered Nurses, Licensed Practical Nurses and Nursing Assistants	USA	Role of burnout in staff negative perceptions of problematic resident behaviour

of one's conscience as too strict and having a troubled conscience as a result of being unable to achieve one's own standards (11).

Public and private nursing homes as well as voluntary ones were compared in Canada and revealed that the majority of burnout facets did not differ by type of home, with comparable levels of EE and efficacy. However those healthcare aids in private facilities reported higher levels of cynicism, and medium size homes had higher levels than small or large homes (6). As such it may not just be the type of nursing home which requires consideration (that is, if it is public, private or voluntary) but also the size of the home and the number of residents it provides care for. Perhaps even, related to the client group themselves. It has been reported that burnout levels are highest amongst those had complaints relating to the elderly, namely considered by the participants as 'the characteristics of the elderly', 'the increase in the expectations of the elderly clients and the decrease in their appreciation', and 'lack of communication with them, the elderly' (12). As such then, perceptions related to older adults and indeed the illnesses from which they frequently suffer may also play a role in burnout.

Staff perceptions

In the study of Shinan-Altman and colleagues (13) it was found that the perception staff have of AD acts may influence levels of staff burnout. Qualitative interviews with staff (social workers and nurses) caring for elderly people with dementia suggested that workers experience EE and DP, in part because of the reductions in ability to communicate in advanced AD, and decreases in PA as a result of these negative feelings, as well as seeing continued deterioration in patients (e.g., failure to recognise previously known others) (13). Others have suggested that staff who have low levels of burnout (assessed here as perceptions of fulfilment and satisfaction with the caring role) were more likely to have positive evaluations of patients and the frequency of problematic behaviour displayed by residents did not influence this (14).

Burnout can also reportedly be associated with staff perceptions of a particular type of illness. For example, Shinan-Altman et al. (13) in their study of nurses and social workers noted that negative connotations of AD correlated with a number of facets of burnout. For example, perceiving AD as caused by psychological attributes (e.g., 'stress or worry') risk factors (e.g., heredity, diet) accident or chance (e.g. 'chance or bad luck') or who held beliefs about a lack of control of the disease (e.g., 'There is very little that can be done to improve AD') had higher levels of EE and DP. Those who held negative emotional illness representations (e.g., 'AD makes me feel angry') had higher EE, DP and lower PA. Further, a direct association was observed between specific cognitive illness

representations (the way in which individuals perceive illness) and different burnout facets: Perceiving AD as attributable to risk factors was negatively associated with EE, whilst believing AD to have a cyclical timeframe was associated with lower levels of PA.

Coping strategies and grief

Within the study of Shinan-Altman and colleagues (13) coping strategies were also relevant: whilst not all coping strategies were associated with burnout, emotion focused coping strategies (focusing on the management of the emotional aspects of the difficult situation) were associated with high EE, DP and lower PA. It was also notable that emotion focused coping strategies were seen to have a linking role between emotional illness representations and all of the burnout facets. Similarly, Narumoto et al. (15) reported that use of emotion-oriented coping predicted EE in nurses and nursing assistants. There was also suggestion that the personality of the individual may be a predictor of burnout. Level of neuroticism (the extent to which an individual responds to events with negative emotions) was seen to positively predict depersonalization in staff. Perhaps most notable however is that the role neuroticism has on burnout is via a specific coping type: Findings suggested that the effects that neuroticism had on DP was a result of emotion-oriented coping, as such, the use of emotional orientated coping enables neuroticism the negative impact on burnout.

Use of coping strategies to manage events within the workplace may not be the only individual difference variable to impact upon burnout. Anderson 7 considered the role of grief within the workplace setting following the death of a resident, and assessed the impact that this has upon certified nursing assistants (CNAs) burnout levels. Anderson (7) uses a distinction between different types of grief. Grief was defined as either Complicated Grief, associated with maladaptive and problematic outcomes as a result of the grief, or as Personal Growth. Personal growth from grief can be defined as associated with gains in levels of tolerance, compassion, forgiveness and hope as well as personal growth (16). Complicated grief as well as race, was seen to predict DP in Anderson's study (7). It was suggested that those who were Caucasian or who had high levels of complicated grief were more likely to experience DP. However, experiencing grief positively had a different impact. PA was seen to be by personal growth from grief, as was religious affiliation and job satisfaction.

Education and training

One way of increasing staff's knowledge of the role that various aspects of themselves and indeed their work can influence their susceptibility to burnout may lie within education and training. Indeed Shinan-Altman et al. (13) demonstrated that staff who perceived themselves as having a low level of knowledge around AD, (that is the extent of their illness coherence) was associated with EE. As such, providing staff with more training and education around the different illnesses they encounter within their role may act to decrease the likelihood of EE. Indeed, Passalacqua and Harwood (17) provided caregivers with a dementia communication training session based on person centred care. At follow up it was found that the levels of DP displayed by staff towards residents had decreased, demonstrating how adequate training may have a role in reducing facets of burnout. The themes of education and training will be discussed more in depth in the Implications for practice session.

Impact of burnout on care delivery

Hunter, Hadjistavropoulos, Thorpe, Lix, and Malloy, (18) in their work with residents experiencing dementia, noted how elderly care staff who have high levels of PA were more likely to report giving care which focuses on empathy and respect for those with disabilities. EE approached significance in negatively predicting the provision of comfort care and support for relationships of residents, that is, supporting the emotional and physical needs of patients and supporting relationships amongst residents, families and staff.

Discussion

From the findings, it is shown that burnout amongst staff employed in nursing and care homes for the elderly is a significant problem reported across the

globe, with implications for the wellbeing of patients, providers and staff. In the interest of patients, it is important to recognise and to address the high rates of staff burnout in practice settings. Moreover, given that burnout can result in serious health risks for staff and their families, it must also be recognised as a significant occupational health problem warranting the attention of employers, unions, policy makers, and the community of occupational health professionals.

There appear to be a number of factors related to the syndrome, such as perceptions of job stress and types of coping mechanisms employed, to occupational hazards such as grief, the perceptions staff have of the patients that they care for and the illnesses from which they suffer, as well as some variation within type of healthcare setting.

The first issue noted from the articles was the one concerning with what aspects of the role might be associated with facets of burnout amongst nursing care workers. As highlighted in the results, in the study of Isaksson, Graneheim, Richter, Eisemann & Åström, (8), violence is a fact of working life for nurses and care staff, and being exposed to violence at work was seen to be linked with a higher level of burnout. However, this finding is far from consistent, with other researchers studying nursing home workers reporting that levels of violence at work was not associated with burnout (12). Physical violence appears not to be the only consideration; it appears that experiencing conflict with the relatives of patients is seen to lead to an increase in burnout and decrease in job satisfaction. Burnout levels peaked quickly and remained constant regardless of the type of continued interaction with the relatives (19). Roche and colleagues (20) have also seen that perceptions of violence were related to adverse patient outcomes through unstable or negative qualities of the working environment. Moreover, perceptions of violence affect job satisfaction. A quantitative review of the nursing violence literature including a total of 136 articles providing data on 151,347 nurses from 160 samples (21) revealed that around a third of nurses worldwide indicated exposure to physical violence and bullying, about a third reported injury, whilst a quarter experienced sexual harassment, and around two-thirds indicated nonphysical violence. In geriatric facilities the most prevalent was physical violence.

Martínez, Suárez-Álvarez, Yanguas and Muñiz (9) also took into consideration another aspect of the work that may play a role: they noted how staff who perceive the care that they give to residents to be person centred are seen to have high levels of PA, whilst those who feel they did not give person centred care have higher levels of EE and DP. As such it may be suggested that there are aspects within the workplace that may act to prevent the provision of person centred care. Similarly, research with nurses and social workers suggested that high levels of role conflict, role ambiguity and role overload were associated with burnout, specifically increased levels of EE and DP, as well as lower levels of PA (13). Research has also reported burnout levels to be highest amongst those who had organisational issues within the homes in which they worked, such as lack of equipment and personnel, low salaries, workload, administrative mechanisms and bureaucracy (12).

In the study of (10) a further workplace based element was identified in emotion rule dissonance. Emotion role dissonance refers to the difficult state whereby the self required to be displayed within the workplace is in disconnect from the true feelings one holds. Staff within elderly care settings are required to express a wide variety of emotions during their interactions with patients. They have to switch between keeping a certain emotional distance toward their patients to secure a professional attitude on the one hand, and showing a caring, compassionate attitude on the other. Also, they are faced with situations, such as death, illness, and violence – as it was seen - that trigger emotional reactions, while their professions may require them to inhibit or suppress the emotions that normally occur in reaction to these situations. In the aforementioned investigation was found that high level of emotion rule dissonance was associated with both EE and DP at follow up (10). However, it was also observed that role complexity was an important and protective factor for burnout: Those who had high levels of emotion rule dissonance but had high levels of job complexity were less likely to suffer EE and DP than those colleagues who had a role which was not as complicated. These findings suggest that nurses who feel a discrepancy between the emotions they need to show and their true emotions deplete their energy resources and eventually

become cynical towards their patients and their work. This may be disastrous for their performance: they may no longer achieve the objectives of their work, that is, providing high-quality care to patients.

Considering further role complexity, it was investigated whether the level of complexity in a role varies by workplace, and as such may impact upon staff burnout levels. Åhlin et al. (11) found additional factors associated with burnout within the public organisation with an additional role in burnout found for the perception of one's conscience as too strict and having a troubled conscience as a result of being unable to achieve one's own standards. This may suggest that there is some aspect particular to a specific type of nursing home environment which adversely influences staff in terms of their ability to achieve their own standards of care and the impact upon their conscience. The standards staff place upon themselves can be linked to staff perceptions, which are also seen to link to burnout in other ways. The results of a study by Shinan-Altman et al. (13) suggested that the perception staff have of Alzheimer's disease (AD) influence levels of stuff burnout. Alzheimer's disease (AD) represents one of the most common neurodegenerative diseases and is the most common dementia amongst the elderly (22). Hence, it is very frequent for nurses to deal with these patients in geriatric facilities. In the aforementioned study, qualitative interviews with staff (social workers and nurses) caring for elderly people with dementia suggested that workers experience EE and DP, in part because of the reductions in ability to communicate in advanced AD, and decreases in PA as a result of these negative feelings, as well as seeing continued deterioration in patients (e.g., failure to recognise previously known others) (13). Indeed research suggested that burnout seems to have a vital role in the extent to which certain resident problem behaviours (described as 'annoying or attention seeking behaviours' e.g. complaining or whining) were associated with a negative perception of the resident by staff. When the level of burnout was statistically removed certain annoying or attention seeking problem behaviours were no longer associated with a negative perception of the resident (23). Further, in another study taken into consideration in this review, Hillman et al. (14) have suggested that staff who have low levels of burnout were more likely to have positive evaluations of patients and the frequency of problematic behaviour displayed by residents did not influence this. This suggests that burnout is an important factor in both how annoying behaviours are perceived to be, and that in those with low levels of burnout more positive perceptions of residents are observed regardless of the frequency of problematic behaviours.

Among other recurring themes, grief and coping seems to be also relevant. Grief is, at its essence, a form of stress. Coping is the process of responding to stress or, more specifically, the thoughts and actions that individuals use to manage the external and internal demands of stressful situations. This process is complex and coping with grief is influenced by a great number of intrinsic and extrinsic factors. Shinan-Altman et al. (13) found that emotion focused coping strategies, in particular, were associated with high EE, DP and lower PA. Also, Narumoto et al. (15) reported that use of emotion-oriented coping predicted EE in nurses and nursing assistants. The other individual difference variable that was found to have an impact upon burnout is, as we said, grief. Anderson (7) considered the role of grief within the workplace setting following the death of a resident, and assessed the impact that this has upon certified nursing assistants (CNAs) burnout levels. In this study, grief was defined as either Complicated Grief, associated with maladaptive and problematic outcomes as a result of the grief, or as Personal Growth. Personal growth from grief can be defined as associated with gains in levels of tolerance, compassion, forgiveness and hope as well as personal growth (16). Results from these studies suggest that the types of grief elicited in the individual from patient deaths at work can adversely or positively impact upon an individual's level of burnout. It is nonetheless true that relationships with residents are one of the primary reasons why nursing home staff remain on the job (24). Yet despite the intimacy of the relationships between staff and residents, many institutions continue to view these relationships as primarily functional in nature and fail to acknowledge the depth of the grief that results when residents die (25). In addition, care in nursing homes also tends to focus on prolonging life and death is often a viewed as a taboo subject. Residents who are close to death are isolated from other

residents and, upon death, residents' bodies are often removed through back entrances in order to conceal this element of long-term care from residents and staff (26). Staff who are not at work when deaths occur may return to work the next day to find rooms empty or occupied by new residents. The failure to acknowledge the relationships between nursing staff and residents and the denial of death in nursing homes may preclude nurses from effectively moving through the grief process.

The last theme identified was the impact of burnout on care delivery. The study of Hunter and colleagues (18) illustrates that elderly care staff who have high levels of PA were more likely to report giving care which focuses on empathy and respect for those with disabilities. EE approached significance in negatively predicting the provision of comfort care and support for relationships of residents, that is, supporting the emotional and physical needs of patients and supporting relationships amongst residents, families and staff. This may mean that, whilst burnout can have a profound impact upon the staff that experience it, it also impacts the quality of care given to the patients with whom they work. Moreover, this might mean that staff who are experiencing the negative aspects of burnout e.g. EE are less likely to provide specific aspects of care to their residents, but conversely that the positive effects of PA, a feeling of pride within one's role can act to increase the likelihood of providing care which is emphatic and respectful. This also may suggest that some aspects of burnout are more influential on care provision than others.

Conclusions and implications for practice

The concept of burnout is not new to nurses and researchers. However, despite the large amount of studies conducted in an attempt to investigate and predict the related factors of burnout, no conclusive data could be drawn. This is might be due to the fact that the health care system is in constant change. The factors that relate to burnout will present different relative significance with the changes. Despite this, the related factors to burnout could generally be classified as both organisational and personal related. Therefore, to inform best practice, burnout intervention programmes should be multidimensional consisting of work-related as well as personal directed approaches.

Evidence-based strategies must be implemented aimed at reducing the likelihood of nurse burnout. Based on the findings of this review a number of care management recommendations are made. First it is suggested that nurse managers and administrators in care homes for older adults should carefully examine the working conditions of their nurses. More specifically they should look to understand the sources of stress from the perception of the workforce and be proactive in ways of tackling it in collaboration with their staff. This should also include an analysis of the complexity of the role workers are asked to do. Complexity of work appears to be a protective factor against burnout, so managers should work with staff to ensure that their role includes adequate levels of challenge.

Moreover, findings from this literature review indicate that providing staff with more training and education around the different illnesses they encounter within their role may act to decrease the likelihood of EE. Hence, nurse burnout might be reduced by ensuring their staff have a good level of knowledge around common diseases amongst older people. Specifically education and training of staff should extend to consider in more depth the process and origins of disease processes often associated with their elderly client groups (such as dementia). Increasing an understanding of the condition may assist in decreasing burnout risk. Staff should also receive training in the types of coping mechanisms which are most adaptive for their caring role and guidance and support in their application, as some types of coping act to encourage burnout, whilst others may offer a preventative role. Perceived coping efficacy, the belief that one can respond well and perform successfully in the face of adversity and stress is a central element of the stress and coping perspective. It is generally regarded as a resource factor for individuals, one which mitigates the impact of stress (e.g., 27).

The challenges of grief should also be considered by managers, perhaps by allocating time to reflective learning sessions, to examine the different types of grief, and how grief can be channelled more productively. Studies analysed in this review (i.e., 7) have un-

derlined that failure to acknowledge the relationships between nursing staff and residents and the denial of death in nursing homes may preclude nurses from effectively moving through the grief process. Indeed, studies of nurses and long-term care staff indicate that many providers – often half or more – report at least one grief-related symptom in response to the death of a patient (e.g., 28). Common symptoms included sadness, feeling upset when thinking about the patient, and feeling numb. A smaller number of health care staff, up to about ten per cent, reported that they experienced more intense emotional and physical responses (e.g., 29). The possible consequences of providers' repeated exposures to loss and the deaths of patients also include burnout and occupational distress (e.g., 30).

From a practice perspective, several avenues that facilities can take to help to enfranchise the grief of nurses may be identified. Nursing homes typically do not have facility-based memorial services to mark the death of residents, nor are there commonly any other forms of remembrance (e.g., pictures, wall plaques) for deceased residents (25). As suggested by Anderson and Gaugler (24), facilities may choose to initiate something as simple as a memorial board where the staff can read death announcements and brief statements about the lives of recently deceased residents. Other facilities may elect to hold brief memorial services on the unit in which the death has occurred which not only acknowledges the loss, but also allows for validation and mutual support. Through such simple and cost effective measures, facilities may be able to accentuate the positive aspects of grief and add to the well-being of their front line staff, and more importantly, encourage personal growth.

Nurses and care staff will continue to be confronted with physical and emotional suffering, illness, and death, sometimes also dealing with aggression form patients' relatives – as said before. Because it was seen (i.e., 10) that emotional dissonance coincides with burnout and reduces in-role performance, it seems important for management to consider ways to reduce the impact of emotional dissonance. Again, further training in managing their emotions could be necessary. Company training with regard to emotion work generally focuses on teaching employees skills to regulate the emotions of recipients. However, include training on how to deal with their own emotions in a healthy manner may be also beneficial. Employees might be taught how to respond to the emotional demands of their work while staying true to their own feelings. In addition, the organizational rules regarding emotional display of frontline employees and the style of supervision may need revision. Allowing employees to express their true emotions may seem undesirable for recipients, but the current research suggests that in the long run this approach may be positive for both clients and organizations (31). It is without doubt that providing safe and high quality care in a context of nurse burnout and severe nursing shortages is very challenging. Developing, testing, and implementing intervention programs to reduce burnout may produce a variety of beneficial effects, including keeping nurses in clinical positions, and maintaining or raising quality of care.

References

1. Jamal M, Baba VV. Shiftwork and department-type related to job stress, work attitudes and behavioral intentions: A study of nurses. Journal of organizational behavior 1992; 13(5): 449-64.
2. Maslach C. Burnout: A multidimensional perspective. In WB Schaufeli, C Maslach, T Marek (eds), Professional burnout: recent developments in theory and research 1993 (pp.19-32). Washington DC: Taylor and Francis. Maslach C, Jackson SE, Leiter MP. 1996. Maslach Burnout Inventory (3rd ed). Palo Alto, California: Consulting Psychologists Press Inc.
3. McHugh MD, Kutney-Lee A, Cimiotti JP, Sloane DM, Aiken LH. Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. Health Affairs 2011; 30(2): 202-10.
4. Nayeri ND, Negarandeh R, Vaismoradi M, Ahmadi F, Faghihzadeh S. Burnout and productivity among Iranian nurses. Nursing & health sciences 2009; 11(3): 263-70.
5. Ford S. (2018). New guidance promotes role of nurses working in care homes Nursing times available at: https://www.nursingtimes.net/news/community/new-guidance-promotes-role-of-nurses-working-in-care-homes/7022980.article
6. Estabrooks CA, Squires JE, Carleton HL, Cummings GG, Norton PG. Who is looking after Mom and Dad? Unregulated workers in Canadian long-term care homes. Canadian Journal on Aging/La Revue canadienne du vieillissement 2015; 34(1): 47-59.
7. Anderson KA. Grief experiences of CNAs: relationships with burnout and turnover. Journal of Gerontological Nursing 2008; 34(1): 42-49.

8. Isaksson U, Graneheim UH, Richter J, Eisemann M, Åström S. Exposure to violence in relation to personality traits, coping abilities, and burnout among caregivers in nursing homes: a case–control study. Scandinavian journal of caring sciences 2008; 22(4): 551-9.
9. Martínez T, Suárez-Álvarez J, Yanguas J, Muñiz J. Spanish validation of the person-centered care assessment tool (P-CAT). Aging & mental health 2016; 20(5): 550-8.
10. Kubicek B, Korunka C. Does job complexity mitigate the negative effect of emotion-rule dissonance on employee burnout? Work & Stress 2015; 29(4): 379-400.
11. Åhlin J, Ericson-Lidman E, Norberg A, Strandberg G. A comparison of assessments and relationships of stress of conscience, perceptions of conscience, burnout and social support between healthcare personnel working at two different organizations for care of older people. Scandinavian journal of caring sciences 2015; 29(2): 277-87.
12. Mandiracioglu A, Cam O. Violence exposure and burn-out among Turkish nursing home staff. Occupational Medicine 2006; 56(7): 501-3.
13. Shinan-Altman S, Werner P, Cohen M. The connection between illness representations of Alzheimer's disease and burnout among social workers and nurses in nursing homes and hospitals: a mixed-methods investigation. Aging & mental health 2016; 20(4): 352-61.
14. Hillman J, Skoloda T E, Angelini F, Stricker G. The moderating effect of aggressive problem behaviors in the generation of more positive attitudes toward nursing home residents. Aging & mental health 2001; 5(3): 282-8.
15. Narumoto J, Nakamura K, Kitabayashi Y, Shibata K, Nakamae T, Fukui K. Relationships among burnout, coping style and personality: study of Japanese professional caregivers for elderly. Psychiatry and clinical neurosciences 2008; 62(2): 174-6.
16. Prigerson HG, Maciejewski PK, Reynolds III CF, Bierhals AJ, Newsom JT, Fasiczka A, et al. Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. Psychiatry Research 1995; 59: 65-79.
17. Passalacqua SA, Harwood J. VIPS communication skills training for paraprofessional dementia caregivers: an intervention to increase person-centered dementia care. Clinical Gerontologist 2012; 35(5): 425-45.
18. Hunter PV, Hadjistavropoulos T, Thorpe L, Lix LM, Malloy DC. The influence of individual and organizational factors on person-centred dementia care. Aging & mental health 2016; 20(7): 700-8.
19. Abrahamson K, Anderson JG, Anderson MM, Suitor JJ, Pillemer K. The cumulative influence of conflict on nursing home staff: A computer simulation approach. Research in gerontological nursing 2010; 3(1): 39-48.
20. Roche M, Diers D, Duffield C, Catling-Paull C. Violence toward nurses, the work environment, and patient outcomes. Journal of Nursing Scholarship 2010; 42(1): 13-22.
21. Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. International Journal of Nursing Studies 2014; 51(1): 72-84.
22. Kumar A, Singh A. A review on Alzheimer's disease pathophysiology and its management: an update. Pharmacological Reports 2015; 67(2): 195-203.
23. Hillman JL. The overlooked role of deficit or non-productive behaviors in traditional assessment of long-term care residents. Clinical gerontologist 2006; 29(3): 19-37.
24. Anderson KA, Gaugler JE. The grief experiences of certified nursing assistants: personal growth and complicated grief. OMEGA-Journal of Death and Dying 2007; 54(4): 301-18.
25. Moss SZ, Moss MS. Nursing home staff reactions to resident deaths. In KJ Doka (Ed), Disenfranchised grief: New directions, challenges, and strategies for practice. Champaign, IL: Research Press, 2002: 197-216.
26. Katz J. Dealing with death. In JS Katz, S Peace (Eds.), End of life in care homes: A palliative care approach. Oxford, UK: Oxford University Press, 2003: 75-86.
27. Bandura A. Editorial. American Journal of Health Promotion 1997; 12(1): 8-10.
28. Rickerson EM, Somers C, Allen CM, Lewis B, Strumpf N, Casarett DJ. How well are we caring for caregivers? Prevalence of grief-related symptoms and need for bereavement support among long-term care staff. Journal of Pain and Symptom Management 2005; 30: 227-33.
29. Redinbaugh EM, Schuerger JM, Weiss LL, Brufsky A, Arnold R. Health care professionals' grief: A model based on occupational style and coping. Psycho-oncology 2001; 10: 187-98.
30. Redinbaugh E, Sullivan A, Lock S, Gadmer N, Lakoma M, Mitchell A, Seltzer D, Woldford J, Arnold R. Doctors' emotional reactions to recent death of a patient: Cross sectional study of hospital doctors. British Medical Journal 2003; 327: 1-6.
31. Bakker AB, Heuven E. Emotional dissonance, burnout, and in-role performance among nurses and police officers. International Journal of Stress Management 2006; 13(4): 423.

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