ASSESSMENT OF NURSES' BURNOUT AND ITS PERCEIVED IMPACT ON PATIENTS' CARE IN A TERTIARY HEALTH INSTITUTION

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OCTOBER, 2025

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IN PARTIAL FULFILLMENT OF THE AWARD OF THE DEGREE OF BACHELOR OF NURSING SCIENCE, FACULTY OF NURSING SCIENCES,

UNIVERSITY OF BENIN, BENIN CITY.

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DECLARATION

This is to declare that this research project titled **ASSESSMENT OF NURSES' BURNOUT AND ITS PERCEIVED IMPACT ON PATIENTS' CARE IN UNIVERSITY OF BENIN TEACHING HOSPITAL** was carried out by **OTIRI OCHUKO** is solely the result of my work except where acknowledged as being derived from other person(s) or resources.

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CERTIFICATION

This is to certify that this project was carried by **OTIRI OCHUKO** with Matriculation number **BMS2001221.** Faculty of Nursing Sciences, under the supervision of **MRS. F. A. ESEBAME**

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Project Supervisor

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Head of Department of
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External Examiner **DATE**

DEDICATION

This research project is dedicated to Almighty God, the source of all wisdom and knowledge. His divine guidance has illuminated my path, and his unwavering support has sustained me throughout this endeavour. May this work serve as a testament to His glory and inspire others to seek His blessings in all their pursuits.

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ABSTRACT

Burnout among nurses is a growing concern in healthcare systems worldwide due to its adverse implications on both professional well-being and quality of patient care. This study aimed to assess the level of burnout among nurses and its perceived impact on patient care at the University of Benin Teaching Hospital (UBTH), Nigeria. A descriptive cross-sectional survey was employed, and a total of 222 registered nurses working across various clinical units were selected using a stratified random sampling technique to ensure equitable representation. Data were collected using a structured, self-administered questionnaire and analyzed using the Statistical Package for the Social Sciences (SPSS) version 26.0. Out of 222 distributed questionnaires, 216 were valid and analyzed, yielding a high response rate of 97.3%. Results revealed that the majority of the respondents were female (81.9%) and within the age group of 30–39 years (33.3%). Most had a Bachelor of Science degree in Nursing (61.1%) and 6–10 years of post-qualification experience (37.0%). The findings indicated a high level of burnout among nurses, with a grand mean score of 3.2 across various burnout indicators. Additionally, the perceived impact of burnout on patient care was notably high, with a grand mean score of 3.3. Notable areas affected by burnout included emotional exhaustion, reduced empathy, communication difficulties, and decreased adherence to patient safety protocols. In conclusion, the study demonstrates that burnout is prevalent among nurses at UBTH and significantly affects the quality of patient care delivered. It underscores the need for organizational and psychological interventions to mitigate burnout and enhance the well-being of nurses. The study recommends implementing supportive workplace policies, adequate staffing, periodic stress management training, and the establishment of mental health support systems to help reduce burnout and improve patient care outcomes.

***Keywords**: Nurses, Burnout, Perceived Impact, Patients, Care*

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Healthcare systems worldwide are currently grappling with the escalating crisis of burnout among healthcare workers, particularly nurses. Burnout is officially recognized by the World Health Organization (WHO) as an occupational phenomenon characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Edú-Valsania et al., 2022). These dimensions manifest as physical and mental fatigue, a cynical attitude toward patients, and feelings of ineffectiveness at work. Nurses are disproportionately affected due to the inherently demanding nature of their profession, which often includes long hours, emotional labor, and critical decision-making under pressure (Amiri et al., 2024). The COVID-19 pandemic has profoundly intensified this burden, pushing healthcare infrastructures to their limits. Nurses, as the backbone of frontline medical response, were especially vulnerable due to high exposure risk, resource scarcity, and emotional trauma associated with patient deaths and staff shortages (Abdulmohdi, 2024). In the context of the pandemic, burnout became not only more widespread but also more complex, involving factors such as social stigma (Patel et al., 2021), moral distress (Alhassan et al., 2025), and workplace isolation. Burnout during this period not only affected nurses' mental health but significantly compromised their clinical performance and quality of patient care.

Research indicates a strong negative correlation between burnout and patient care outcomes. For instance, a comprehensive meta-analysis by Li et al. (2024) involving over 288,000 nurses

found that higher burnout levels were consistently associated with increased nosocomial infections, medication errors, patient falls, and missed care. Furthermore, burnout was associated with lower patient satisfaction and diminished perceived safety climates in hospitals. These findings are corroborated by regional studies across Africa and Asia, emphasizing the global nature of the problem. Locally, studies in Nigeria reveal alarming burnout levels among clinical nurses. Sodimu et al. (2021) reported that over 60% of nurses working in public hospitals in Ogun State experienced moderate to severe burnout, mainly due to staffing shortages and excessive workloads. Similar findings were reported in Ghana, where burnout served as a significant mediator between poor work environments and nurse turnover intentions (Poku et al., 2022). These studies highlight not only the human cost of burnout but also its systemic implications for healthcare delivery in low- and middle-income countries.

In critical care settings such as intensive care units (ICUs), burnout can be particularly severe. Aragão et al. (2021) found a direct link between burnout and compromised attention, lower empathy, and frequent clinical errors among ICU nurses in Brazil. This is consistent with findings from other studies indicating that burnout negatively affects team cohesion, communication, and decision-making speed, all of which are crucial in emergency and high-dependency environments (Ramírez-Elvira et al., 2021). Protective factors against burnout have also been widely studied. Resilience, defined as the ability to recover from stress, is consistently found to buffer the impact of workplace stressors on nurses' mental health (Marrisa & Jacobowitz, 2021). Supportive organizational structures—such as adequate staffing, recognition of employee efforts, peer support, and access to counselling—are critical in mitigating burnout (Cheung et

al., 2020; Çelik & Kılınç, 2022). Interventions such as mindfulness training, schedule flexibility, and improvements in leadership communication have been shown to enhance job satisfaction and reduce turnover intention (Lee & Cha, 2023).

Despite the global attention to nurse burnout, data specific to Nigerian tertiary healthcare institutions remains limited. The University of Benin Teaching Hospital (UBTH), as a major referral and teaching hospital in Nigeria, presents a strategic location for studying this issue. Given its high patient volume, academic responsibilities, and often strained resources, nurses at UBTH may be at heightened risk for burnout. However, the prevalence, contributing factors, and perceived impact of burnout on patient care within this context have not been systematically studied. This study, therefore, seeks to assess the level of burnout among nurses at UBTH and explore how they perceive its impact on the quality and safety of patient care. It aims to provide evidence-based insights that can guide institutional policies, staff welfare programs, and patient safety initiatives.

1.2 Statement of the Problem

The global healthcare system is facing a critical workforce crisis driven in part by occupational burnout, particularly among nurses—the backbone of patient care delivery. Nurse burnout is a multi-dimensional syndrome marked by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach & Jackson, 1981). In hospital settings, especially those that are resource-constrained or under heavy patient load, nurses experience immense psychological and physical stress. Within the University of Benin Teaching Hospital (UBTH), there is growing concern that nurse burnout is compromising both staff wellbeing and

the quality of patient care, yet this issue remains empirically under-investigated. Despite anecdotal reports of fatigue, absenteeism, and emotional distress among nursing staff, no formal assessment has been conducted to determine the prevalence, causes, or consequences of burnout in this institution. Thus, the problem remains both under-recognized and undertreated. Nurses are often the most exposed and emotionally invested group in the healthcare workforce, engaging in prolonged patient interactions, end-of-life care, and medical emergencies. This makes them particularly susceptible to burnout. The COVID-19 pandemic has amplified these stressors, increasing workloads, moral dilemmas, and emotional strain. According to Abdulmohdi (2024), the second wave of the pandemic witnessed a sharp rise in burnout symptoms among nurses, influenced by factors such as organizational support, personal resilience, and social isolation. Burnout has now emerged as not only a personal health risk but also a systemic threat to patient care standards (Çelik & Kılınç, 2022). Within the Nigerian context, overburdened public hospitals, poor nurse-patient ratios, and limited mental health resources exacerbate the problem (Sodimu et al., 2021). UBTH, as a high-volume tertiary hospital, epitomizes these conditions, yet no targeted study has examined the psychological toll on its nursing workforce or how this affects the care patients receive.

International and regional data highlight the magnitude of the burnout crisis. A meta-analysis by Li et al. (2024) involving over 288,000 nurses across 32 countries found that nurse burnout was associated with reduced safety climate, higher rates of adverse events, and diminished patient satisfaction. Closer to home, a study in Nigeria reported burnout rates exceeding 60% among clinical nurses in Ogun State (Sodimu et al., 2021). In Ghana, Poku et al. (2022) linked

poor working conditions to burnout, which in turn predicted nurses' intentions to quit the profession. These findings suggest that burnout is not isolated but pervasive, with potentially catastrophic outcomes for both staff retention and patient outcomes. In UBTH, which serves as both a teaching and referral center, this problem could affect not only the current workforce but also influence how student nurses perceive the profession.

Unchecked burnout carries significant consequences. At the personal level, nurses may suffer from anxiety, depression, insomnia, and even suicidal ideation (Alhassan et al., 2025; Beier et al., 2023). Professionally, burnout leads to reduced work engagement, medical errors, and absenteeism. Studies have shown that emotionally exhausted nurses are more likely to commit medication errors, delay treatment, and disengage from patients emotionally (Kakemam et al., 2021). From a systemic perspective, these lapses jeopardize patient safety, decrease satisfaction levels, and inflate hospital operating costs due to frequent rehiring and staff turnover (Muir et al., 2021). In high-pressure environments like ICUs or emergency departments, the cost of burnout may translate into increased mortality risks and longer hospital stays. Without targeted intervention, UBTH risks falling into a cycle where reduced care quality drives more stress for staff, perpetuating the burnout epidemic.

Despite extensive global literature on burnout, there remains a significant knowledge deficit within tertiary hospitals in sub-Saharan Africa, particularly Nigeria. Most studies focus on general prevalence or isolated units without examining burnout in relation to perceived patient care outcomes (Jun et al., 2021). Furthermore, research often fails to incorporate nurses' voices—how they perceive the link between their emotional states and their capacity to

provide care. At UBTH, there is no existing baseline data on the scale of burnout, its primary contributors, or how it shapes clinical decisions and patient interactions. This lack of data limits the ability of hospital administrators and policymakers to respond appropriately with evidence-based interventions. Additionally, few studies combine validated tools like the Maslach Burnout Inventory (MBI) with contextualized perceptions, which this study aims to address.

This study seeks to fill these critical gaps by conducting a systematic assessment of burnout levels among nurses at UBTH and exploring their perceptions of how burnout affects the quality of patient care. The research will employ a mixed-methods approach using the Maslach Burnout Inventory and structured perception questionnaires to capture both objective data and subjective experiences. By identifying burnout prevalence, root causes, and perceived impacts on patient care, the study will generate practical recommendations for institutional reforms. These may include improved nurse-patient ratios, psychological support systems, stress management workshops, and participatory leadership structures. The ultimate goal is to protect nurse wellbeing, enhance clinical performance, and safeguard patient outcomes—ensuring that UBTH continues to deliver compassionate and competent care in a sustainable work environment.

1.3 Objectives of the study

The general objective of the study is to assess the level of burnout among nurses and its perceived impact on the quality of patient care at the University of Benin Teaching Hospital (UBTH), Benin-City, Edo State.

The specific objectives of this study are:

1. To assess the level of burnout among nurses at the University of Benin Teaching Hospital.
2. To assess perceived impact of burnout on patients' care at the University of Benin Teaching Hospital.
3. To identify the factors contributing to burnout in nurses at the University of Benin Teaching Hospital.

1.4 Research questions

1. What is the level of burnout among nurses at the University of Benin Teaching Hospital?
2. What is the perceived impact of burnout on patients' care at the University of Benin Teaching Hospital?
3. What are the factors contributing to burnout in nurses at the University of Benin Teaching Hospital?

1.5 Hypothesis of the study

1. There is no significant relationship between the level of burnout and its perceived impact on patients' care at the university of Benin teaching hospital.

1.6 Significance of the study

To the Nursing Profession

This study offers critical insights into the psychological and emotional well-being of nurses, highlighting how burnout influences their professional performance and quality of care delivery.

By using validated instruments such as the Maslach Burnout Inventory, the findings will enable nurses to recognize burnout symptoms early and advocate for systemic support. Furthermore, the study contributes to the body of nursing knowledge by contextualizing burnout in a Nigerian tertiary hospital setting, promoting evidence-based practice and continuous professional development. Ultimately, it empowers nurses with data to demand healthier work environments, fair staffing policies, and access to mental health resources—leading to improved job satisfaction and professional identity.

To Healthcare Providers

The study provides empirical evidence on the operational and clinical consequences of burnout, such as reduced efficiency, increased absenteeism, and medical errors. These insights will inform institutional strategies to mitigate nurse burnout through interventions like workload balancing, supportive supervision, staff wellness programs, and participatory leadership. By investing in nurse well-being, healthcare providers can enhance care quality, reduce turnover costs, and improve patient safety metrics. The study also offers a localized assessment that can serve as a model for other tertiary hospitals in Nigeria and beyond.

To the Society at Large

Burnout among nurses affects not only the healthcare system but also the broader society that depends on it. Patients bear the direct consequences of nurse fatigue—through delayed care, errors, and reduced empathy. By addressing burnout, this study indirectly contributes to the protection of patients' rights to safe, timely, and compassionate care. It also promotes public trust in the healthcare system and encourages health-seeking behaviors. In the long term, healthier and more motivated nurses mean better population health outcomes, more resilient health systems, and reduced healthcare costs, benefiting society as a whole.

1.7 Scope of the study

This study focuses on assessing the level of burnout among registered nurses working at the University of Benin Teaching Hospital (UBTH) in Benin City, Edo State. It explores the perceived impact of burnout on patient care quality, including safety, attention, empathy, and clinical

performance. The study is limited to selected departments such as medical, surgical, ICU, and emergency units.

1.8 Operational definition of terms

Burnout: A state of physical, emotional, and mental exhaustion resulting from prolonged stress and excessive work demands, often characterized by fatigue, reduced efficiency, and feelings of detachment on nurses in university of Benin teaching Hospital.

Nurses: Nurses in this context refer to registered professional nurses working in various units (e.g., medical, surgical, emergency, ICU) of a tertiary healthcare institution in Benin City, Edo State.

Assessment: This refers to the systematic process of collecting data on the level of burnout among nurses using structured questionnaires, interviews, or scales like the MBI.

Perceived Impact: This term refers to the nurses' own views, opinions, and subjective evaluations of how their burnout affects the quality and safety of the care they provide to patients.

Patient Care: The services and interventions provided by healthcare professionals to diagnose, treat, and support a patient's well-being. Patient care in this study includes clinical tasks, emotional support, communication, responsiveness, and general health outcomes delivered to patients by nurses. The impact will be measured based on nurses' self-reports and perceptions of changes in care quality due to burnout.

CHAPTER TWO

LITERATURE REVIEW

This section covers several research on nurse burnout and its impact on patient care in diverse settings, offering light on how nurses care for patients while suffering burnout. It also investigates related literature and works pertinent to the research issue. A detailed assessment of past scholars' academic articles, books, and publications is undertaken on a national and international scale. This review is organized into conceptual, empirical, and theoretical approaches.

2.1 Conceptual Review

2.1.1 Concept of Burnout

According to the World Health Organization (WHO), Burnout is described as a syndrome that arises from prolonged stress at work that has not been effectively managed. It involves three key components:

1) feelings of exhaustion or depletion of energy;

2) an increased mental distance from one's job, or feelings of negativity or cynicism towards work;

and 3) a sense of ineffectiveness and lack of accomplishment.

Burnout is specific to the work environment and should not be used to describe experiences in other areas of life.

According to Jim et al., (2021) Burnout is a serious condition that negatively impacts a nurse's physical and mental health. It is marked by emotional tiredness, depersonalisation, and a decline in personal achievements. It is important l to investigate nurse burnout in the healthcare system as more and more data demonstrates the detrimental effects of burnout on physicians, patients, and firms (Jim et al.,2021).

A state of physical, psychological, emotional, and social exhaustion brought on by poorly managed work-related stress and a lack of social support is known as nurse burnout. The pooled global prevalence of burnout among nurses is 11.2%. Nurse burnout has a substantial impact as it affects not only nurses but also patients and healthcare institutions in a detrimental manner (Miran lee & Chiyoung cha, 2023). Burnout is a major issue that affects nursing professionals globally and has a detrimental effect on patient safety and service quality Kakemam *et al*., (2021).

Burnout is a response to prolonged emotional and interpersonal stress, often triggered by demanding work environments and heavy workloads. Intensive Care Units (ICUs), in particular, are high-pressure settings characterized by advanced medical technology, significant responsibility, rapid patient turnover, and constant stress, all of which contribute to the development of burnout among nurses. ICU nurses frequently experience work-related stress and high levels of burnout, which can lead to various physical and emotional issues such as frequent illness, insomnia, irritability, eating disorders, and depression. These conditions often

result in increased absenteeism, sick leave, and staff turnover. More importantly, burnout can compromise the quality of patient care nurses provide. Several factors contribute to burnout, including individual personality traits, sustained work overload, conflicts with patients, families, or colleagues, lack of support, and a perceived lack of meaning or value in their work. While numerous studies have investigated the prevalence and risk factors of burnout in ICU healthcare workers, fewer have focused on effective interventions or treatment strategies. However, recent research has highlighted the importance of workplace well-being initiatives and coping strategies to reduce burnout symptoms. Practices such as yoga and mindfulness, along with institutional support mechanisms like peer supervision, structured communication, and teamwork, have shown promise in enhancing the well-being of ICU nurses and mitigating the effects of burnout (Friganović et al., 2020). Burnout is increasingly common among professionals in various fields, especially for those who face ongoing environmental stress. Healthcare workers, particularly nurses, are among the most at risk. In nursing, much of the work is centered on direct patient care and collaboration, which fosters strong personal connections and significant emotional investment (Membrive-Jiménez et al., 2022).

Burnout syndrome is a major personal and social issue that primarily stems from work-related factors. Its repercussions affect a range of areas including mental, emotional, physical, professional, and family life, meaning that both the individual suffering from burnout and their immediate surroundings are impacted. For instance, nurses are continually exposed to the hardships of patient illness and life challenges, and they frequently witness the dying process. This constant emotional strain often leads to accumulated stress which, if not effectively

managed, can evolve into chronic occupational stress. Such persistent stress diminishes a nurse's self-esteem, degrades the quality of their work, and impairs their interactions with patients. Furthermore, many female nurses experience burnout due to a lack of adequate appreciation and recognition; low wages add to their sense of frustration and disappointment, and the heavy responsibilities they bear only heighten the risk, ultimately resulting in a complex, multi-dimensional form of burnout (Sodimu et al.,2021).

2.1.2 Nurses and burnout

Burnout among nurses is driven not just by excessive workload but also by a mismatch between job demands and the resources available to meet them. In the workplace, these demands primarily stem from direct interactions with patients and their families, as well as the emotional strain involved in managing these relationships (Ślusarz et al., 2022). Nursing encompasses a diverse group of professionals, with notable variations across different specialties and work environments (Dos Santos et al., 2020; Misiak et al., 2020; Woo et al., 2020). This situation has added to nurses' workload, negatively impacting their health and, in turn, affecting the quality of care they deliver. Longer working hours and irregular schedules, such as rotating shifts, increase their risk of burnout (Vargas-Benítez et al., 2023).

A study was carried out by Borges et al. (2021) the study revealed that a significant percentage of nurses in Portugal, Spain, and Brazil experience moderate to high levels of burnout—42%, 43%, and 42% respectively. Emotional Exhaustion and reduced Personal Achievement were more prominent than Depersonalization among these nurses. Interestingly, while one study reported only 14% of Brazilian nurses showing signs of burnout, a broader cross-cultural

comparison between Portuguese and Brazilian nurses highlighted moderate to high levels in Emotional Exhaustion and Personal Achievement. These variations can be attributed to different work contexts and job expectations. For instance, in Portugal, nurses often spend more time providing direct patient care, which demands both emotional connection and high technical skill. This emotional involvement may contribute to the higher burnout levels found in the Emotional Exhaustion dimension, which one Portuguese study identified in 59% of nurses. In Spain, research with primary care nurses showed an even split, with 50% experiencing high levels of Emotional Exhaustion and the other half at low to medium levels.

Age, shift patterns, and experience were also shown to influence burnout. Older nurses and those working shifts in Spain and Brazil tended to have lower burnout levels, aligning with previous findings that burnout is higher among younger professionals aged 22 to 29, who are often less experienced and more anxious in complex clinical situations. However, some Spanish studies suggest the opposite—burnout increases with longer work experience, particularly after 10 years in the profession. Shift type also played a role; in Brazil, burnout rates were similar among nurses with fixed and rotating shifts. Further analysis revealed that Depersonalization was influenced by factors like age, gender, workplace, job role, and shift schedule, with women showing higher Depersonalization scores. Higher educational attainment, particularly postgraduate training, was associated with greater Personal Achievement. Emotional Exhaustion, on the other hand, was linked to work environments lacking autonomy, support, and control. Nurses working day shifts reported more Emotional Exhaustion and lower Personal Achievement, likely due to increased responsibilities and more frequent interactions with other

healthcare professionals. The nature of the workplace—whether emergency, intensive care, or primary care—also significantly impacted the level of burnout experienced (Borges et al., 2021).

2.1.3. Causes of Nurses burnout

Nurse burnout and excessive workloads are closely linked to an increased risk of medication errors, which can lead to significant patient suffering and even death in many hospitals. These errors not only contribute to poor health outcomes but also impose substantial financial burdens on healthcare facilities due to compensation costs. Although medication errors can be committed by any medical practitioner, the likelihood of errors rises substantially when nurses are overextended and suffering from burnout. This is a critical issue because even one simple mistake can jeopardize both patient and staff safety (Cho et al., 2021).

A study carried out by Karimyar et al. (2022) Census sampling was performed on all 212 nurses working in the hospitals of Jahrom University of Medical Sciences the data collection instrument included two checklists for investigating the causes of burnout syndrome and Cohen's perceived stress scale. to the nurses, the primary factors contributing to burnout were issues within management, social aspects, and professional responsibilities, in that order. Data revealed that 76.41% of nurses experienced moderate stress levels, and a statistically significant link was found between the degree of burnout and stress levels ($p<0.05$).

According to Levins, (2022) Providing patient care is often one of the most fulfilling aspects of nursing, as it allows nurses to build meaningful connections with patients and experience the gratification of aiding in their recovery. However, for those working in critical or end-of-life care settings, the emotional challenges associated with lower recovery rates and higher patient

mortality can contribute to compassion fatigue and elevate the risk of burnout. Additionally, the nurse-to-patient ratio significantly impacts burnout levels. Studies have shown that nurses caring for more than four patients at a time face a 23% increased risk of burnout for each additional patient assigned.

2.1.4. Factors Contributing to Burnout in Nurses

Burnout is categorized into three types based on its possible causes. Personal burnout (CBIpb) stems from individual challenges like sleep disorders, while work-related burnout (CBIwb) results from unfavorable workplace conditions. Patient-related burnout (CBIcb), on the other hand, arises from emotional involvement in patients' issues. Shift work contributes to stress among nurses, negatively affecting their health, well-being, and overall lifestyle. (Durán-Gómez et al., 2021) Although personal factors contribute to burnout, Swamy et al. (2020) argue that the primary cause is an insufficiently supportive work environment.

Burnout in nursing is linked to negative employment features such as a heavy workload, poor staffing levels, lengthy shifts, and a lack of management. The potential repercussions for both workers and patients are serious (Dall'Oral et al., 2020). Excessive workloads, insufficient staffing, conflicting roles, limited autonomy, time constraints, interpersonal conflicts among patients, guardians, and medical staff, and lack of leadership support all contribute to nurse burnout. When nurses experience burnout, they may suffer from physical symptoms like headaches, fatigue, high blood pressure, and musculoskeletal issues, as well as psychological symptoms such as depression, sleep problems, and difficulty concentrating.

According to Maunder et al. (2021) Workplace-related risk factors stem from the culture, environment, and organizational structure within hospital settings. Furthermore, other predators include:

Workload

Burnout is strongly linked to high workloads, which can be measured in various ways, such as time spent on direct patient care, the number of patients per clinician, patient acuity, and turnover rates. While nurse-to-patient ratios are commonly used to assess workload, they often overlook key factors like patient complexity and the availability of support services, which also significantly impact workload. Research among nurses in British Columbia found that higher patient acuity was associated with increased emotional exhaustion, while perceived heavy workload—characterized by working extra hours or missing breaks—was connected to lower job satisfaction. Similar patterns have been found in the United States. Among physicians, burnout also consistently correlates with workload, which has been assessed by factors such as long work hours, night shifts, rigid schedules, and the number of patients or consultations handled. This creates a concerning cycle, where burnout contributes to staff shortages, which in turn lead to heavier workloads and more burnout.

Hours and Shifts

To cope with staffing shortages, nurses are often required to work overtime or extend their shifts, which may temporarily solve coverage issues but lead to long-term problems. Extended

hours negatively affect rest and recovery between shifts, increase stress, and raise the risk of errors, which can compromise patient safety. Studies have shown that long shifts are associated with fatigue and reduced performance, prompting recommendations that nursing shifts should not exceed 12 hours. However, for medical residents, simply shortening shifts hasn't always resulted in better well-being, suggesting the need for more comprehensive scheduling reforms.

Presenteeism

Presenteeism—the act of working while mentally or physically unwell—is another factor that contributes to burnout. A longitudinal study involving hospital nurses found that high job demands and pressures from patients often led nurses to work despite being sick. This pattern not only worsens individual health but also increases the risk of burnout, creating a harmful feedback loop.

Job Insecurity

Uncertainty about job stability, especially during times of organizational change or economic downturns, can elevate burnout risk. This is particularly relevant for healthcare workers employed temporarily during crises such as the COVID-19 pandemic, who may feel insecure about their job future and experience higher stress levels as a result.

Role Characteristics

Burnout is more likely in roles that involve conflicting expectations or lack clarity. Nurses who face role conflict—juggling incompatible duties or unclear responsibilities—are at greater risk. Additionally, positions that lack variety or meaning, or that demand high effort with little reward, are associated with increased emotional exhaustion and job dissatisfaction.

Moral Distress

Moral distress occurs when healthcare workers are unable to act according to their ethical beliefs due to external limitations, such as insufficient resources or policies that conflict with best practices. This is common in high-stakes environments like ICUs, where staff may frequently encounter futile care situations. The experience of moral distress is strongly linked to burnout among nurses, especially when such events are recurrent.

Interpersonal Conflict and Lack of Support

Burnout is often intensified by interpersonal conflict in the workplace. These conflicts can occur between colleagues at similar levels or within hierarchical relationships, such as between nurses and physicians or managers. A lack of support from peers and supervisors also contributes significantly to emotional strain. When healthcare professionals feel isolated or undervalued, their risk of burnout increases substantially.

Violence and Abuse

Violence and abuse in healthcare settings are alarmingly common and strongly associated with burnout. A survey of nurses in British Columbia reported high rates of emotional abuse, threats, physical assaults, and sexual harassment. These experiences are echoed in studies from the U.S. and are particularly prevalent among younger healthcare workers and female physicians, who often face bullying and harassment. Such hostile work environments contribute significantly to psychological distress and burnout.

2.1.5. Impact of Burnout on Patient Care

Tired nurses may also develop behavioural problems like smoking and alcohol consumption, which can impact their health. Nurse burnout could result in staff turnover and pose a burden to healthcare organizations (Mirian Lee Chiyoung Cha,2023).

According to Jun et al., (2021) Nurse burnout is linked to declining safety and quality of care, reduced patient satisfaction, and nurses' commitment and productivity within the organization. In the realm of burnout, emotional fatigue is closely linked to depression and individual traits. Factors like age, being single, limited ICU experience, workload, and long hours impact the likelihood of burnout. This burnout, in turn, leads to a decline in care quality, heightening patient mortality risks due to inadequate performance and errors in healthcare settings (Elvira et al., 2021).

Those under constant strain are more susceptible to anxiety, depression, physical ailments, sleep disturbances, and burnout. Recent studies suggest that continuity of care, as opposed to rotating shifts, is linked to lower levels of burnout and anxiety. (Durán-Gómez et al., 2021)

Patient safety and overall health outcomes are strongly influenced by the quality of nursing care provided in healthcare facilities. Fundamentally, the aim of healthcare is to enhance patients' quality of life and wellbeing, while staff also expect to work in a secure and supportive environment. However, when nurses face excessive workloads and burnout, both patient safety and staff health are compromised. Consequently, healthcare facilities must prioritize delivering high-quality care that not only improves patient health outcomes but also ensures a safe working environment for all staff (Magalhães et al., 2022).

Nurses face considerable burnout as a result of heavy workloads and frequent exposure to ill patients, which increases their risk of contracting work-related infections and other health issues. Burnout prevalence among nurses has been reported to vary widely—from 10% to 70%—underscoring its status as a pervasive problem among healthcare professionals that can ultimately compromise the quality of patient care (Ashipala, 2022).

According to Maunder et al. (2021) Burnout among healthcare professionals and trainees is linked to poorer patient outcomes, lower job satisfaction, and decreased productivity across all disciplines. It significantly impacts the healthcare system by contributing to staff shortages through increased absenteeism, high turnover rates, and a greater likelihood of professionals contemplating leaving their roles. Beyond workplace disruption, burnout is closely associated with mental health challenges such as depression, and in some cases, even suicidal thoughts. Emotional exhaustion—a key component of burnout—has been tied to substance use and poor physical health in physicians, as well as heightened anxiety, low self-esteem, and reduced quality of life in nurses. The consequences extend to patient care, with burnout contributing to

compromised safety, a rise in medical errors, decreased quality of care, and lower patient satisfaction.The widespread burnout among nurses has serious repercussions for their healthcare institutions, manifesting as higher absenteeism, increased staff turnover, a deteriorating work environment, and strained interpersonal relationships. These factors collectively lead to lower quality of care, ultimately affecting the patients. On an individual level, nurses and nurse managers face physical and mental exhaustion, poor concentration, disorganized work habits, more frequent errors, low energy, various physical symptoms, sleep problems, anxiety, and frustration (Membrive-Jiménez et al., 2022).

2.1.6. Coping Mechanisms Adopted by Nurses

Coping is understood as an organizational concept that encompasses a wide range of actions and behaviors individuals use to manage psychological challenges such as stress, anxiety, and burnout. However, categorizing coping strategies is complex, as individuals respond to stress in diverse ways, and there is no fixed set of behaviors universally applied to cope with stress. Coping can generally be classified into three main styles: problem-focused, emotion-focused, and avoidance-focused. Problem-focused coping involves actively addressing the root cause of distress, while emotion-focused coping aims to regulate the emotional impact of the stressor. In contrast, avoidance-focused coping entails efforts to escape or ignore the stressor, often through seeking social support or engaging in distracting activities(Rossi, M. F., Gualano, M. R., Magnavita, N., Moscato, U., Santoro, P. E., & Borrelli, I.,2023).

Strengthening coping mechanisms and reducing stressors are equally vital for improving nurse well-being, job satisfaction, and patient care. coping strategies include peer support, personal

resilience, stress management, reflective practices, and organizational measures like fair shift scheduling and professional development. This highlights the importance of both supportive work environments and personal efforts in building resilience. It also stresses the need for health care system to address nurses's unique stressors.(Austen, 2023)

Two Australian researchers investigated the potential buffering role of humor in managing stress and how job satisfaction influences the link between stress and mood. They emphasized that the nature of the stressful situation often shapes the choice of coping strategies and the way stress is experienced. However, an individual's personal perception and interpretation of the stressor play an even more significant role in determining their response. Notably, seeking support—whether emotional or instrumental—was identified as the most frequently adopted coping strategy (Friganović, A., & Selič, P., 2021).

2.1.7 Strategies to reduce burnout and improve nurses' well-being and patient care.

Work should be a wellspring of joy, fulfillment, and job satisfaction for everyone. When employees feel satisfied, they are more inclined to be motivated and engaged at work, so it becomes essential to consistently support and accompany them throughout their professional journey. Addressing burnout syndrome is crucial because it poses a significant risk to workers' well-being. By understanding and acknowledging its presence, employers are better equipped to make informed decisions that foster a healthy and supportive work environment.

In Nigeria, growing awareness of the stress that leads to job dissatisfaction among registered nurses in hospitals has highlighted significant challenges in recruiting and retaining nursing staff—challenges that are particularly acute in certain states. If nurse leaders in government

hospitals can pinpoint the key factors affecting nurses' satisfaction and actively implement strategies to resolve them, it will likely result in reduced turnover rates and improved recruitment and retention efforts (Sodimu et al.,2021).

To effectively bolster resilience and mitigate burnout among critical care nurses, two primary strategies have emerged: Mindfulness Therapy and Supportive Skills and Training (Olaleye et al., 2022).

A) Mindfulness Therapy

Mindfulness practices have proven to be a potent tool in enhancing resilience among critical care nurses. By fostering early recognition and management of stressors, these practices empower nurses to navigate the daily challenges inherent in high-pressure environments more adeptly. Studies indicate that nurses with heightened mindfulness exhibit greater resilience to burnout-inducing stressors, attributed to their increased awareness and proactive handling of such challenges (Cheung et al., 2020).

Integrating mindfulness into daily routines is vital. For instance, incorporating team meditation sessions within hospital settings has been effective in managing burnout. These sessions provide opportunities for reflection and rejuvenation, helping nurses cope with workplace stressors. Engagement in physical and artistic activities further enhances communication skills, reduces burnout, and supports resilience among critical care nurses. Moreover, mindful practices contribute to the development of strong interpersonal relationships, promotion of teamwork, and identification of resources to address workplace challenges.

B) Supportive Skills and Training:

Approaches to bolster resilience and prevent burnout can be categorized into individual, group, and organizational strategies.

Individual Approach: This involves training nurses in new skills aimed at personal empowerment. Interventions focusing on positive emotional skills include educating nurses on positive reappraisal, recognizing personal strengths, effective decision-making, self-compassion, and compassion towards others. Additionally, addressing physical and psychological challenges through appropriate interventions has been discussed as a means to minimize burnout (Kelly et Al.,2022.

Group Approach: Regular debriefings on unit activities, such as bi-monthly sessions, serve to educate nurses about burnout and resilience. Developing strong interpersonal relationships, fostering teamwork, and improving communication within the team lead to positive interactions and enhanced resilience. Event-triggered counselling sessions also enable nurses to promptly recognize and manage stressors

Organizational Approach: Focusing on the overall health and well-being of nurses is crucial. It's imperative for nurse leaders and organizations to provide necessary support, motivation, and resources to help nurses meet job demands. Ensuring adequate staffing to address nurse-to-patient ratios and offering meaningful recognition, such as awards and expressions of gratitude, serve as positive organizational strategies that support resilience and prevent burnout (Kelly et al., 2021).

Leaders and work environment

Nurse leaders and hospital administrators play a pivotal role in shaping nurses' behaviors and attitudes. Effective leadership is crucial for fostering a positive work environment, as it enhances the meaningfulness of work, empowers staff to engage actively in decision-making, and boosts self-confidence, thereby improving performance and promoting autonomy. Empowerment within the workplace entails acquiring, organizing, and managing resources to align with organizational objectives. Central to this empowerment is providing nurses with easy access to support and resources, which enhances performance and offers opportunities for continuous learning.

2.2 Theoretical review

The **Job Demands-Resources (JD-R) Model** provides a comprehensive and flexible framework for understanding how work environments contribute to employee well-being, motivation, and burnout. Developed by Demerouti and colleagues in 2001, the model categorizes all job characteristics into two primary dimensions: job demands and job resources.

Job demands refer to the physical, psychological, emotional, or organizational aspects of a job that require sustained effort and are therefore associated with certain physiological and psychological costs. In the nursing profession, common job demands include high workloads, emotional involvement with patients, time pressures, shift work, and exposure to suffering and death. While these demands are not inherently negative, they become problematic when they

are excessive, chronic, or mismatched with available coping mechanisms, potentially leading to burnout.

On the other hand, **job resources** encompass the elements of a job that support nurses in meeting professional goals, reduce the negative impact of demands, and promote personal and professional development. Examples of job resources in the nursing context include supportive leadership, adequate staffing levels, teamwork, autonomy, constructive feedback, and access to professional development opportunities. These resources not only help buffer the effects of high demands but also foster work engagement and resilience.

The JD-R model proposes two key psychological pathways. The first is the health impairment process, which posits that excessive job demands lead to energy depletion and, over time, to emotional exhaustion and burnout. This process has direct implications for job performance and patient safety, as exhausted nurses are more likely to make errors, disengage from patients, and experience mental health challenges. The second is the motivational process, which asserts that the presence of sufficient job resources enhances motivation, commitment, and job satisfaction, ultimately leading to improved performance and better patient outcomes.

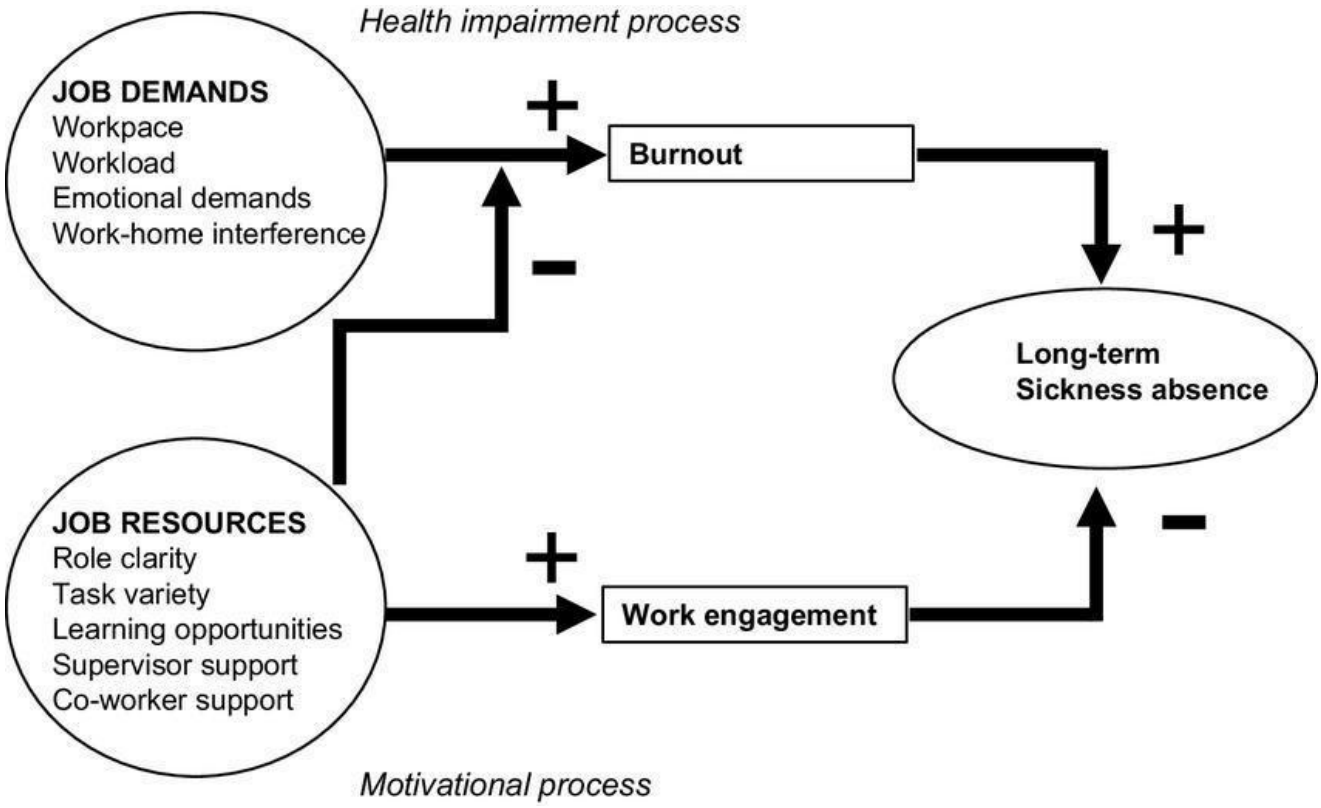

Figure 2.1: Job Demands-Resources (JD-R) Model

2.2.2 Application of the theory to the study

The Job Demands-Resources (JD-R) Model provides a robust theoretical lens through which the study's specific objectives can be explored and interpreted. Each objective of this study aligns with a core component of the JD-R framework, enabling a structured understanding of how burnout develops among nurses and how it may influence patient care within the context of the University of Benin Teaching Hospital.

The first objective, which seeks to assess the perceived impact of burnout on patients' care, corresponds directly to the health impairment pathway of the JD-R model. According to this pathway, when job demands are chronically high and resources are inadequate, nurses

experience emotional exhaustion and reduced personal accomplishment. These psychological consequences can impair clinical performance, lower attentiveness, and reduce the quality of interpersonal interactions with patients. By investigating nurses' perceptions, the study aims to capture how burnout manifests in real-time caregiving scenarios, such as through diminished empathy, delayed responses, or increased medical errors—all of which are predicted by the JD-R framework under conditions of imbalance.

The second objective, which involves assessing the level of burnout among nurses, addresses the core outcome variable in the JD-R model: burnout itself. This objective is central to operationalizing the model in the study. Through the use of validated instruments like the Maslach Burnout Inventory, the study will quantify the presence and intensity of burnout symptoms—emotional exhaustion, depersonalization, and reduced professional efficacy—as they are experienced by nurses. This assessment will help to confirm the extent to which the JD-R model's health impairment mechanism is active within this particular healthcare setting.

The third objective—to identify the factors contributing to burnout in nurses—engages both dimensions of the JD-R model: job demands and job resources. This part of the study will examine organizational and environmental variables such as workload, staffing levels, shift patterns, leadership quality, peer support, and access to professional development. These variables will be analyzed to determine which demands exert the most pressure on nurses and which resources, if lacking, fail to protect them from burnout. By mapping these contributing factors onto the JD-R model, the study will provide a diagnostic perspective that can inform targeted interventions to restore balance and mitigate burnout.

2.3 Empirical Review

To assess the level of burnout among nurses.

In a Nigerian context, Sodimu et al. (2021) conducted a descriptive cross-sectional study to determine the prevalence, knowledge, and prevention strategies related to burnout among clinical nurses. The research was carried out at the State Hospital in Ijaye, Abeokuta, using stratified sampling to recruit 100 nurses. Data were collected using a structured, closed-ended questionnaire, and analyzed using descriptive statistics. The results revealed that 99% of respondents identified long working hours as a key contributor to burnout, while 96% cited patient and family demands as stressors. Notably, a high percentage of nurses acknowledged the importance of burnout prevention strategies such as establishing social support (94%) and goal setting (99%). These findings indicate that while burnout is prevalent, nurses are also aware of personal strategies to mitigate it. The authors emphasized the need for institutional reforms to improve nurse job satisfaction, patient safety, and healthcare quality.

A broader perspective was provided by Ramírez-Elvira et al. (2021) through a systematic review and meta-analysis of burnout in intensive care unit (ICU) nurses. Drawing from 15 studies (with four included in the meta-analysis) and a total sample of 1,986 nurses, the study found that burnout was highly prevalent in ICU settings. Specifically, emotional exhaustion affected 31%, depersonalization 18%, and low personal accomplishment 46% of the sampled population. The review also identified strong associations between burnout and individual psychological variables such as depression and personality traits. Furthermore, younger age, single marital

status, less ICU experience, and high workloads were significant risk factors for burnout. The authors concluded that both sociodemographic and occupational variables contribute to burnout, with serious implications for care quality and patient safety.

Expanding the scope further, Zhang et al. (2022) conducted a large-scale national survey involving 8,971 psychiatric nurses from 41 tertiary psychiatric hospitals in China to examine burnout prevalence and gender-specific factors during the COVID-19 pandemic. Using the Maslach Burnout Inventory-Human Services Survey and the DASS-21, the study found that 27.3% of respondents experienced burnout, with higher rates in male nurses (32.24%) compared to female nurses (25.97%). Burnout was strongly associated with mental health symptoms such as depression, anxiety, and stress. Work-related factors including longer hours, frequent night shifts, and the perceived negative impact of COVID-19 were common across genders. However, gender-specific associations were also noted: in males, burnout correlated significantly with night shift frequency, while in females, it was associated with marital status, mid-level professional titles, and administrative roles. The authors emphasized the need for targeted interventions that consider gender differences in burnout risk and experience.

In a study conducted by Beier et al. (2023), the researchers examined the relationship between nurse age, coping mechanisms, and burnout levels during the peak of the COVID-19 pandemic. The study was carried out among 376 nurses in Texas, using a cross-sectional survey design. Participants were recruited via a professional nursing association and through snowball sampling. The research was framed within lifespan development theories, positing that older and more experienced nurses would engage in more positive coping strategies—such as

seeking emotional support—and fewer maladaptive strategies like substance use. It was also hypothesized that age would be negatively associated with emotional exhaustion and depersonalization and positively associated with personal accomplishment, the three core dimensions of burnout.

The findings largely confirmed these expectations. Older nurses were more likely to use positive coping strategies and reported higher levels of personal accomplishment, while age and experience were negatively associated with depersonalization and the use of negative coping mechanisms. However, contrary to expectations, age did not significantly predict emotional exhaustion. Further analysis through mediation modeling suggested that coping strategies partially mediated the relationship between age and burnout, indicating that how nurses cope plays a critical role in the age-burnout dynamic. The study concluded that age and experience offer a protective effect against certain dimensions of burnout, particularly through healthier coping strategies. These findings offer a valuable extension of lifespan development theory to high-stress healthcare environments and underscore the importance of coping interventions tailored by age group to reduce burnout among clinical nurses.

To assess perceived impact of burnout on patients' care.

In a study conducted by Kakemam et al. (2021) in Iran, the researchers investigated the relationship between nurse burnout and its association with perceived patient care quality and the occurrence of adverse events (AEs) during the COVID-19 pandemic. Using a cross-sectional online survey design, the study recruited 1,004 nurses through a convenience sampling

technique. Data were collected using the Maslach Burnout Inventory (MBI) alongside self-reported measures of patient care quality and adverse event occurrence. The results revealed that 31.5% of nurses experienced high levels of burnout, and a significant proportion reported poor patient care and increased incidence of AEs, ranging from 26.1% to 71.7%. A positive correlation was identified between emotional exhaustion and depersonalization and poor care quality, whereas personal accomplishment was negatively associated with these outcomes. Notably, higher depersonalization scores were linked to an increased risk of all reported AEs, while higher personal accomplishment reduced the likelihood of medication errors and patient-related verbal abuse. The study concluded that higher levels of burnout correlate with increased adverse outcomes in patient care. The authors recommended implementing psychosocial interventions, such as web-based mental health support and self-care strategies, to reduce burnout and enhance care quality in public hospitals.

Similarly, a systematic review conducted by Jun et al. (2021) critically examined the associations between nurse burnout and various patient and organizational outcomes in hospital settings. The authors followed the PRISMA guidelines and included 20 primary studies retrieved from databases such as PubMed, CINAHL, PsychInfo, Scopus, and Embase. The review included studies that considered burnout as an independent variable and evaluated outcomes related to patient safety, care quality, and organizational metrics. The findings consistently demonstrated that burnout was inversely related to patient safety, quality of care, organizational commitment, nurse productivity, and patient satisfaction. The review emphasized that nurse burnout should not be treated merely as an individual issue but as a collective and organizational phenomenon.

It concluded that addressing systemic contributors to burnout—such as staffing, leadership, and institutional culture—is essential for improving both nurse well-being and healthcare delivery outcomes.

A systematic review and meta-analysis conducted by Lee et al. (2024) assessed the effectiveness of various interventions aimed at reducing burnout among clinical nurses. The study synthesized data from 30 intervention studies published between 2011 and 2020, with 24 studies included in the meta-analysis. The researchers explored multiple databases, including seven English-language and two Korean-language sources. The most frequently implemented intervention was face-to-face mindfulness group training. The findings demonstrated that burnout, when measured as a single construct using tools such as the Professional Quality of Life Scale (ProQoL) and the Maslach Burnout Inventory (MBI), was significantly reduced through these interventions. Specifically, emotional exhaustion and depersonalization—the two key dimensions of burnout—showed notable improvement across interventions (SMD = -0.752 and -0.822, respectively; $p < 0.01$). However, there was no significant improvement in personal accomplishment, indicating that this aspect of burnout may require different or longer-term strategies. The study concluded that structured interventions, especially those focused on mindfulness and group support, are effective in mitigating burnout symptoms, although they may be limited in addressing the full spectrum of burnout.

In another empirical study, Soósová (2021) conducted a cross-sectional analysis to examine the relationship between nurse burnout, patient safety climate, and the occurrence of adverse events. A total of 117 nurses participated, completing the Copenhagen Burnout Inventory and

the Hospital Survey on Patient Safety Culture. The study employed Pearson correlation and linear regression to analyze associations between burnout and safety-related variables. The results indicated that higher burnout levels were significantly associated with a lower patient safety grade, increased frequency of adverse events, and higher medication error rates. Moreover, positive perceptions of patient safety were linked to strong teamwork within units and a non-punitive approach to error management. Conversely, adverse events were more frequent in environments where management support and supervisory engagement were lacking. The study concluded that improving the organizational safety climate, including enhancing teamwork, communication, and leadership support, is critical for reducing nurse burnout and improving overall patient safety outcomes.

In a cross-sectional study conducted by Montgomery et al. (2022), the researchers examined the relationship between nurse burnout, work environment, and perceived patient safety grades in acute care hospitals. The study surveyed 928 nurses across various hospitals in Alabama, using an electronic questionnaire that included the Copenhagen Burnout Inventory and measures of the nursing work environment. Using multilevel ordinal mixed-effects modeling, with nurses nested within hospitals, the study found that higher levels of burnout across all dimensions—personal, work-related, and client-related—were significantly associated with lower patient safety grades (odds ratios ranging from 0.63 to 0.78, $p < .05$). Conversely, positive perceptions of the nursing work environment were strongly associated with higher safety ratings (odds ratios ranging from 4.35 to 4.89, $p < .001$). The authors concluded that healthcare organizations can improve patient safety outcomes by addressing burnout at a

systemic level and investing in work environment improvements, such as leadership support, teamwork, and staffing adequacy. This study emphasizes the organizational responsibility in mitigating burnout and its downstream effects on care quality and patient safety

To identify the factors contributing to burnout in nurses.

In a large-scale systematic review and meta-analysis, Amiri et al. (2024) investigated occupational risk factors associated with burnout syndrome among healthcare professionals globally. The study synthesized findings from 109 primary studies identified through a comprehensive literature search in August 2023. Using a random-effects meta-analytic model, the authors assessed 13 occupational risk variables. The findings revealed that all examined risk factors had a statistically significant positive association with burnout. Key risk factors included workplace bullying, with odds ratios (ORs) ranging from 4.05 to 15.01 ($p < 0.001$), as well as low job satisfaction (OR = 5.05) and high job stress (OR = 4.21). Protective elements, such as supportive work environments, adequate staffing, and individual resilience, were identified as moderating factors. The study emphasized that burnout is not merely an individual vulnerability but a result of cumulative systemic stressors that require institutional policy responses.

In a related study, Alfuqaha et al. (2021) explored psychological and existential contributors to burnout among nurses. Using a descriptive design, the study included a convenience sample of 181 nurses who were assessed using three psychometric instruments: an existential vacuum scale, locus of control scale, and a burnout inventory. The results indicated that 93.9% of the nurses experienced moderate levels of burnout, and 40.3% reported a severe existential

vacuum. The majority of participants demonstrated an external locus of control, and both existential vacuum and external locus of control were identified as significant predictors of burnout. The study concluded that existential distress and a perceived lack of personal control over workplace outcomes exacerbate burnout risks. The authors recommended implementing psychological prevention programs, advocacy training, and organizational interventions to reduce emotional exhaustion and foster resilience.

Complementing these findings, Rossi et al. (2023) conducted a systematic review to examine the relationship between burnout and coping strategies during the COVID-19 pandemic. Adhering to PRISMA guidelines, the authors screened over 3,400 articles and included 15 studies, the majority of which focused on healthcare workers and used the Maslach Burnout Inventory and the Brief-COPE as primary instruments. The review found that task-oriented and adaptive coping styles were consistently protective against burnout, whereas avoidance-oriented coping was a predictive risk factor. The findings on emotion-oriented coping were mixed—some studies indicated it was protective, while others found it contributed to burnout, with gender emerging as a moderating factor (i.e., women were more likely to rely on emotional coping). The authors concluded that training in adaptive coping strategies could be a crucial component of workplace interventions to prevent and manage burnout in high-risk professions such as nursing.

In a mixed-methods study, Austen (2023) explored the diverse occupational stressors faced by nurses in the UK and the coping mechanisms they adopt in response. The study combined quantitative data analysis with qualitative interviews, providing a comprehensive view of how

nurses manage stress arising from high patient loads, long shifts, emotional demands, and shifting professional responsibilities. Findings indicated that these stressors negatively affect nurses' physical and psychological well-being, yet nurses demonstrated a wide range of adaptive coping strategies. These included both problem-focused techniques (e.g., time management, seeking support) and emotion-focused approaches (e.g., resilience-building, reflective practice, stress management training). Organizational support, such as fair shift scheduling and access to professional development, also emerged as key protective factors. Austen emphasized the interactive and reciprocal nature of stress and coping, concluding that both individual-level resilience training and institutional reforms are needed to build a more sustainable nursing workforce and enhance patient care outcomes.

Similarly, Cheung et al. (2020) focused on burnout prevention in critical care nurses through the lens of positive psychology. The study introduced a Positive Emotion Skills Intervention, designed to counteract burnout not merely by reducing negative emotional states but by actively enhancing positive emotions. This intervention, previously successful in other high-stress populations, was adapted for critical care nurses. It involved teaching empirically-supported techniques such as gratitude, mindfulness, and optimism. While the article was descriptive in nature, it reviewed the evidence supporting positive emotion as a unique and powerful buffer against stress and burnout. The authors advocated for dual-level interventions—targeting both individual nurses (via skills training) and healthcare organizations (via structural supports)—to promote long-term well-being and resilience in intensive care units.

2.4 Summary of Literature Review

This literature review explores the pervasive issue of burnout among nurses and its significant implications for patient care. Burnout, characterized by emotional exhaustion, depersonalization, and diminished personal accomplishment, not only affects nurses' mental health but also leads to decreased job satisfaction and increased turnover rates. The review highlights key factors contributing to burnout, including high workload, emotional demand, lack of support, and insufficient resources. Research consistently shows that nurse burnout negatively impacts patient outcomes, resulting in lower quality of care, increased medical errors, and higher patient mortality rates. Furthermore, the review discusses the cycle of burnout and its broader implications for healthcare systems, emphasizing the importance of addressing this issue to improve both nurse well-being and patient safety.

Strategies for mitigating burnout are also considered, such as the implementation of support systems, enhanced communication, and fostering a positive work environment. Ultimately, addressing nurse burnout is essential not only for the health and retention of nursing staff but also for enhancing the overall quality of patient care.

CHAPTER THREE

METHODOLOGY

This chapter outlines the research methodology adopted for the study on assessment of nurses burnout and its perceived impact on patients' care in University of Benin Teaching Hospital

The methodology is designed to achieve the specific objectives of the study, ensuring reliability and validity of findings.

3.1 Research Design

The study employed a descriptive cross-sectional design to assess the nurses burnout and its perceived impact on patients' care in University of Benin Teaching Hospital. This design is suitable for capturing data at a single point in time, providing a snapshot of current practices and perceptions.

3.2 Research setting

The research was conducted at the clinical areas; University of Benin Teaching Hospital. It is located geographically in Ugbowo community between the boundaries of Egor and Ovia Local Government Area of Edo State. It is situated along Benin-Lagos express way. It shares boundary with Federal Government Girls College Road, it was founded in 1973, it is also made up of various wards and department. University of Benin Teaching Hospital is a tertiary health institution setup for the purpose of rendering health services to the general public and also, training of nurses, midwives, medical doctors, and other health professionals.

3.3 Target Population

The target population comprised registered nurses working in various clinical areas at the University of Benin Teaching Hospital (UBTH), Benin City, Edo State. These clinical areas included a diverse range of inpatient wards such as the Renal Unit, Male Medical Ward (A1), Female Medical Ward (A3), Maternity Wards (M1 and M2), A2 Ward, Ophthalmic Ward, Male Surgical Ward (B4), Children Surgical Ward, B2 Ward, Female Gynaecological Ward (A4), Neurological Ward, Female Orthopaedic Ward, Male Orthopaedic Ward, Emergency Ward, Labour Ward, Children's Emergency Room (CHER), Paediatric Ward, Paediatric Extension Ward,

Special Care Baby Unit (SCBU), C2 Ward, Special Intensive Unit (SIU), Main Theatre, Accident and Emergency Unit, Intensive Care Unit (ICU), and Burns and Plastic Ward.

These nurses are actively engaged in direct patient care, clinical decision-making, and routine documentation of health information. As frontline healthcare providers, they are central to the process of healthcare data collection, entry, validation, and utilization within the hospital's Health Management Information System (HMIS) and other electronic health data platforms.

Table 3.1 number of nurse in various units/wards in University of Benin Teaching Hospital.

IN PATIENT WARDS	NUMBER OF NURSING
Renal units	18
Male medical ward(A1)	22
Female medical ward(A3)	21
Maternity ward 1(M1)	19
Maternity ward 2(M2)	21
A2	18
Ophthalmic ward	19
Make surgical ward(B4)	21
Children surgical ward	17
B2	21
Female gynecological ward(A4)	15
Neurological ward	29
Female Orthopedic ward	21
Male Orthopedic ward	18
Emergency ward	18
Labour ward	26
Children's Emergency ward (CHER)	21
Pediatric ward	19
Pediatric extension	19
Special care baby unit	26
C2	19
SIU	6
Main theater	22
Accident and Emergency unit	14
Intensive care unit	21
Burns and plastic	20

Total	511

Source, Unit/Ward Roster, March 2025

3.4 Sample Size

The sample size was determined using statistical methods to ensure adequate representation of the nursing population at UBTH.

The sample size was calculated as indicated below:

Using Taro Yamane's Formula

$$n = \frac{N}{1+N(e)^2}$$

Where

N= Population under study

E= Constant 0.05%) margin error

$$n = \frac{511}{1+511(0.05)}$$

$$n = \frac{511}{1+511(0.0025)}$$

$$n = \frac{511}{1+1.3}$$

$$n = \frac{511}{2.3}$$

n= 222

Therefore, the sample size is 222

3.5 Sampling Technique

A stratified random sampling method was employed. Nurses were grouped based on their units/ward, and participants were randomly selected from each stratum to ensure diversity.

Units/Wards	Determination of sample size in each level	Sample size per level
Renal units	18/511x222	8
Male medical ward(A1)	22/511x222	10
Female medical ward(A3)	21/511x222	9
Maternity ward 1(M1)	19/511x222	8
Maternity ward 2(M2)	21/511x222	9
A2	18/511x222	8
Ophthalmic ward	19/511x222	8
Make surgical ward(B4)	21/511x222	9
Children surgical ward	17/511x222	7
B2	21/511x222	9
Female gynecological ward(A4)	15/511x222	7
Neurological ward	29/511x222	13
Female Orthopedic ward	21/511x222	9
Male Orthopedic ward	18/511x222	8
Emergency ward	18/511x222	8
Labour ward	26/511x222	11
Children's Emergency ward (CHER)	21/511x222	9
Pediatric ward	19/511x222	8
Pediatric extension	19/511x222	8
Special care baby unit	26/511x222	11
C2	19/511x222	8
SIU	6/511x222	3
Main theater	22/511x222	10
Accident and Emergency unit	14/511x222	6
Intensive care unit	21/511x222	9
Burns and plastic	20/511x222	9
Total	511	

3.6 Instrument for data collection

A structured questionnaire was developed for data collection. The questionnaire contained three sections:

Section A: Demographic Information - Age, gender, years of experience, and department.

Section B: To assess the level of burnout among nurses at the University of Benin Teaching Hospital.

Section C: To assess perceived impact of burnout on patients' care at the University of Benin Teaching Hospital.

Section D: To identify the factors contributing to burnout in nurses at the University of Benin Teaching Hospital

3.7 Validity of the Instrument

The instrument was tested for validity using face and content validity method which ensure that the instrument supplied answers to the research questions in the study. They will be scrutinized by the project supervisor and corrections will be effected before administering the instrument to respondents.

3.8 Reliability of Instrument

This refers to the consistency of a measure according to Nwachukwu, 2015. To ensure the reliability of the instrument, the reliability of instrument was determined through test re-test method. 10% of the sampled population which is 22 will be administer the questionnaire. The population comprised nurses working in clinical areas in Edo Specialist Hospital, Benin City

which are outside the sample population. If correlation coefficient of 0.8 is obtained. Which will be satisfactory enough to establish that the instrument is reliable for the study.

3.9 Method of data collection

The questionnaire was administered to the research participants on a daily basis after a careful explanation of the topic, and the questionnaire was retrieved on the spot. This process will continue until the desired sample size is obtained.

3.10 Method of Data Analysis

Data collected was analyzed using Statistical Package for Social Sciences (SPSS) version 29.0. The gathered data was organized, analyzed, and described using simple frequency tables and percentages, as well as pie charts and bar charts to provide meaning to the research findings. Brief descriptions of the findings will be included in the tables to offer a clearer picture of the outcomes and detailed interpretations for easier understanding.

3.11 Ethical consideration

Ethical approval was obtained from the Health Research Committee, University of Benin Teaching Hospital, Benin City. Permission will be obtained from the various ward managers before proceeding with the research. Before data collection begins, participants will receive detailed explanations about the research's purpose, content, and implications. They will be assured of confidentiality, ensuring the protection of their personal and private information. Throughout the research, ethical guidelines will be strictly adhered to, including the following considerations:

Confidentiality: Respondents' information was treated confidentially, with no request for names or addresses in the questionnaire. Participants will understand that their responses are

confidential and solely used for research purposes. No personal identifiers will be used in any document or questionnaire to maintain anonymity.

Voluntary Participation: Participants was informed of their right to voluntary participation without facing penalties or bias. They can choose to withdraw or decline to provide information at any point if they feel uncomfortable or unsure.

Avoidance of Plagiarism: Proper citation of all authors used in the study was ensured, both within the content and in the reference page.

CHAPTER FOUR

RESULTS

This chapter deals with the representation of data collected regarding the assessment of nurse's burnout and its perceived impact on patients' care in University of Benin Teaching Hospital. A total of 222 questionnaires were distributed to registered nurses working in various clinical areas at the University of Benin Teaching Hospital, 216 were properly filled and valid for data analysis, giving a response rate of 97.3%.

Table 4.1: Socio-demographic characteristics of respondents

Variable	Frequency (n = 216)	Percent (%)
Sex		
Male	39	19.1
Female	177	81.9
Age		
Less than 30 years	68	31.5
30-39 years	72	33.3
40-49 years	41	19.0
50-59 years	28	13.0
60 years & above	7	3.2
Marital status		
Single	31	14.4
Married	172	79.6
Divorced	10	4.6
Widowed	3	1.4
Highest educational qualification		
Diploma	45	20.8
BSc	132	61.1
MSc	33	15.3
PhD	6	2.8
Ethnicity		
Bini	106	49.1
Esan	38	17.6
Hausa	16	7.4
Igbo	27	12.5
Yoruba	23	10.7

Others	6	2.8

Table 4.1 Cont'd

Variable	Frequency (n = 216)	Percent (%)
Religion		
Christianity	174	80.6
Muslim	38	17.6
Others	4	1.8
Length of post-qualification nursing experience		
Less than 1 year	11	5.1
1–5 years	66	30.6
6-10 years	80	37.0
11-15 years	40	18.5
16 years and above	19	8.8
Length of experience on current hospital unit		
Less than 1 year	13	6.0
1–5 years	72	33.3
6-10 years	91	42.1
11-15 years	34	15.7
16 years and above	6	2.8
Rank (position of the nurse)		
Nursing Officer	103	47.7
Senior Nursing Officer	59	27.3
Principal Nursing Officer	29	13.4
Assistant Chief Nursing Officer	14	6.5
Chief Nursing Officer	10	4.6
Others	1	0.5
Shifts		
Only morning shift	45	20.8
12-hours shifts	76	35.2
8-hours shifts	87	40.3
Others	8	3.7

Table 4.1 provides a snapshot of the socio-demographic characteristics of 216 respondents. The majority of respondents were female (81.9%), with the largest age groups being 30-39 years (33.3%) and less than 30 years (31.5%). A significant portion was married (79.6%), and most held a Bachelor of Science (BSc) degree (61.1%). Ethnically, the largest group was Bini (49.1%), followed by Esan (17.6%) and Igbo (12.5%). Christianity was the dominant religion (80.6%), and the majority of respondents had 6-10 years of post-qualification experience (37%) as well as experience of 6-10 years in their current hospital unit (42.1%). Most nurses were Nursing Officers (47.7%), with a diverse shift schedule: 40.3% worked 8-hour shifts, 35.2% worked 12-hour shifts, and 20.8% worked only morning shifts.

Answering Research Questions

Research Question 1: What is the level of burnout among nurses at the University of Benin Teaching Hospital?

Table 4.3: Level of burnout among nurses

Statement	Always	Sometimes	Rarely	Never	Mean	Remark
I feel emotionally drained after a day's work.	98 (45.4)	93 (43.0)	22 (10.2)	3 (1.4)	3.3	High
I feel tired even before starting my shift.	105 (48.6)	87 (40.3)	20 (9.3)	4 (1.9)	3.4	High
I feel indifferent or detached when caring for patients.	60 (27.8)	103 (47.7)	42 (19.4)	11 (5.1)	3	High
I feel I am no longer making a meaningful difference in my work.	68 (31.5)	112 (51.9)	28 (13.0)	8 (3.7)	3.1	High
I have trouble sleeping or relaxing due to work-related stress.	82 (38.0)	95 (44.0)	31 (14.4)	8 (3.7)	3.2	High
I find it difficult to concentrate during my shift.	65 (30.1)	100 (46.3)	45 (20.8)	6 (2.8)	3.1	High
I feel unappreciated or unsupported in my work environment.	56 (25.9)	108 (50.0)	43 (19.9)	9 (4.2)	3	High
I feel overwhelmed by the number of tasks I must complete.	90 (41.7)	99 (45.8)	19 (8.8)	8 (3.7)	3.3	High
I feel emotionally numb or distant from my work.	57 (26.4)	105 (48.6)	42 (19.4)	12 (5.6)	3	High
I consider quitting my nursing job due to stress or emotional exhaustion.	50 (23.1)	92 (42.6)	58 (26.9)	16 (7.4)	2.9	High
			Grand Mean		**3.1**	**High**

Mean Cut-off = 2.5

Table 4.3 shows the level of burnout among nurses, with the highest mean score of 3.4 recorded for the statement "I feel tired even before starting my shift," followed by "I feel emotionally drained after a day's work" with a mean of 3.3. Other statements such as "I feel overwhelmed by the number of tasks I must complete," "I feel emotionally numb or distant from my work," and "I have trouble sleeping or relaxing due to work-related stress" each had a mean of 3.3. The statements "I feel indifferent or detached when caring for patients," "I feel I am no longer making a meaningful difference in my work," and "I find it difficult to concentrate during my shift" had a mean of 3.1. The lowest mean, 2.9, was observed for "I consider quitting my nursing job due to stress or emotional exhaustion." The overall grand mean of 3.1 suggests a high level of burnout among nurses.

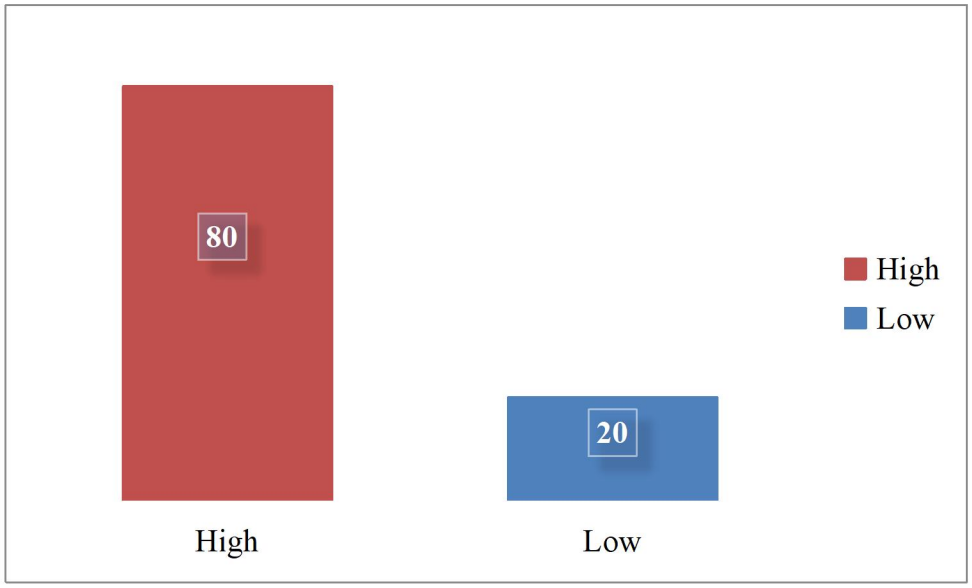

Figure 4.2: Bar chart showing level of burnout among nurses

Figure 4.2 shows that 173 nurses (80%) reported a high level of burnout, while 43 nurses (20%) reported a low level of burnout.

Research Question 2: What is the perceived impact of burnout on patients' care at the University of Benin Teaching Hospital?

Table 4.2: Perceived impact of burnout on patients' care

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
I find it difficult to provide high-quality care when I feel emotionally exhausted.	112 (51.9)	85 (39.4)	15 (7.0)	4 (1.9)	3.4	High
Burnout affects my ability to communicate effectively with patients.	101 (46.8)	95 (44.0)	15 (7.0)	5 (2.3)	3.4	High
When I feel depersonalized, I tend to be less empathetic toward patients.	90 (41.7)	100 (46.3)	20 (9.3)	6 (2.8)	3.3	High
Due to fatigue, I sometimes delay attending to patients' needs.	85 (39.4)	110 (50.9)	15 (7.0)	6 (2.8)	3.3	High
My feelings of burnout contribute to making more mistakes in patient care.	98 (45.4)	95 (44.0)	18 (8.3)	5 (2.3)	3.3	High
Burnout has negatively affected my patient care performance over time.	110 (50.9)	90 (41.7)	12 (5.6)	4 (1.9)	3.4	High
When I feel overwhelmed, I am less attentive to patient safety protocols.	105 (48.6)	85 (39.4)	18 (8.3)	8 (3.7)	3.3	High
I am less motivated to go above and beyond for patients when I feel emotionally drained.	113 (52.3)	90 (41.7)	10 (4.6)	3 (1.4)	3.4	High
Patients may notice a decline in the quality of care I provide when I am burnt out.	94 (43.5)	96 (44.4)	20 (9.3)	6 (2.8)	3.3	High
Burnout has made it harder for me to build trusting relationships with my patients.	80 (37.0)	99 (45.8)	30 (13.9)	7 (3.2)	3.2	High
				Grand Mean	**3.3**	**High**

Mean Cut-off = 2.5

Table 4.2 shows the perceived impact of burnout on patient care, with all statements indicating a high perceived impact as reflected in the mean scores. The statement "I am less motivated to go above and beyond for patients when I feel emotionally drained" had the highest mean of 3.4, followed by "I find it difficult to provide high-quality care when I feel emotionally exhausted," "Burnout has negatively affected my patient care performance over time," and "Burnout affects my ability to communicate effectively with patients," each also having a mean of 3.4. Other statements such as "When I feel depersonalized, I tend to be less empathetic toward patients," "Due to fatigue, I sometimes delay attending to patients' needs," "My feelings of burnout contribute to making more mistakes in patient care," and "When I feel overwhelmed, I am less attentive to patient safety protocols" had a mean of 3.3. The statement "Burnout has made it harder for me to build trusting relationships with my patients" had the lowest mean of 3.2. The overall grand mean of 3.3 further emphasizes the high impact burnout has on patient care.

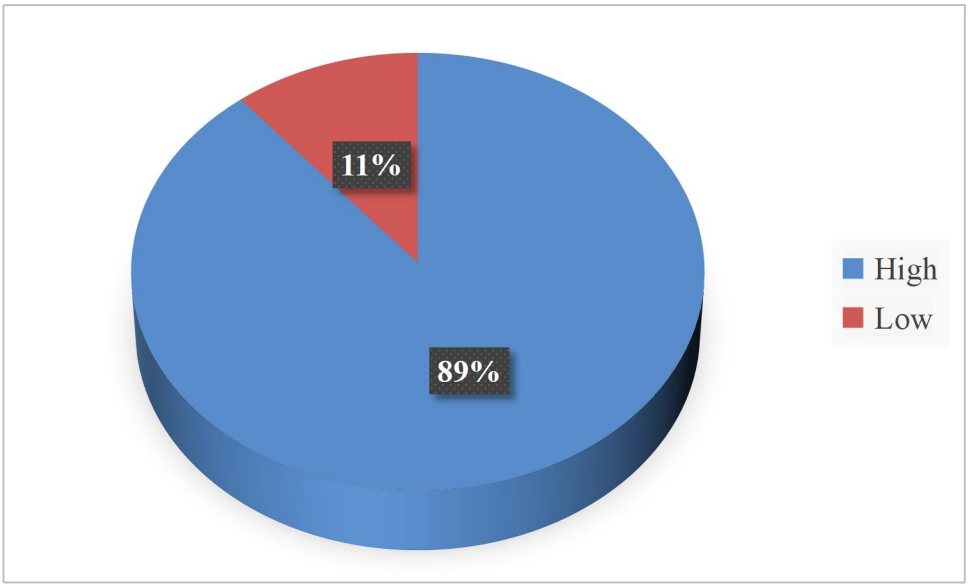

Figure 4.1: Pie chart showing perceived impact of burnout on patients' care

Figure 4.1 shows that 193 respondents (89%) perceived a high impact of burnout on patient care, while 23 respondents (11%) perceived a low impact.

Research Question 3: What are the factors contributing to burnout in nurses at the University of Benin Teaching Hospital?

Table 4.4: Factors contributing to burnout in nurses

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
The workload I am assigned is often too much to handle within my shift.	98 (45.4)	84 (38.9)	28 (13.0)	6 (2.8)	3.3	High
Inadequate staffing contributes to my feeling of burnout.	108 (50.0)	88 (40.7)	16 (7.4)	4 (1.9)	3.4	High
I often feel that I receive insufficient support from hospital management.	85 (39.4)	102 (47.2)	22 (10.2)	7 (3.2)	3.2	High
Frequent night shifts or rotating schedules increase my stress levels.	95 (43.9)	87 (40.3)	24 (11.1)	10 (4.6)	3.2	High
The emotional demands of caring for critically ill or dying patients contribute to my burnout.	112 (51.9)	85 (39.4)	14 (6.5)	5 (2.3)	3.4	High
Lack of recognition or appreciation from supervisors contributes to my work-related stress.	90 (41.7)	105 (48.6)	14 (6.5)	7 (3.2)	3.3	High
I do not have enough time during my shift to complete all assigned tasks properly.	98 (45.4)	85 (39.4)	26 (12.0)	7 (3.2)	3.3	High
Poor communication among healthcare staff adds to my work stress.	105 (48.6)	92 (42.6)	15 (6.9)	4 (1.9)	3.4	High
I feel that my job gives me little or no control over how I perform my duties.	89 (41.2)	96 (44.4)	23 (10.6)	8 (3.7)	3.2	High
I lack opportunities for professional growth or career development in this hospital.	84 (38.9)	89 (41.2)	28 (13.0)	15 (6.9)	3.1	High
			Grand Mean		**3.3**	**High**

Mean Cut-off = 2.5

Table 4.4 shows the factors contributing to burnout in nurses, with the highest mean score of 3.4 observed for the statements "Inadequate staffing contributes to my feeling of burnout," "The emotional demands of caring for critically ill or dying patients contribute to my burnout," and "Poor communication among healthcare staff adds to my work stress." Other statements such as "The workload I am assigned is often too much to handle within my shift," "Lack of recognition or appreciation from supervisors contributes to my work-related stress," and "I do not have enough time during my shift to complete all assigned tasks properly" each had a mean of 3.3. The statements "I often feel that I receive insufficient support from hospital management," "Frequent night shifts or rotating schedules increase my stress levels," "I feel that my job gives me little or no control over how I perform my duties," and "I lack opportunities for professional growth or career development in this hospital" had a mean of 3.2. The overall grand mean of 3.3 indicates a high level of burnout among nurses due to these contributing factors.

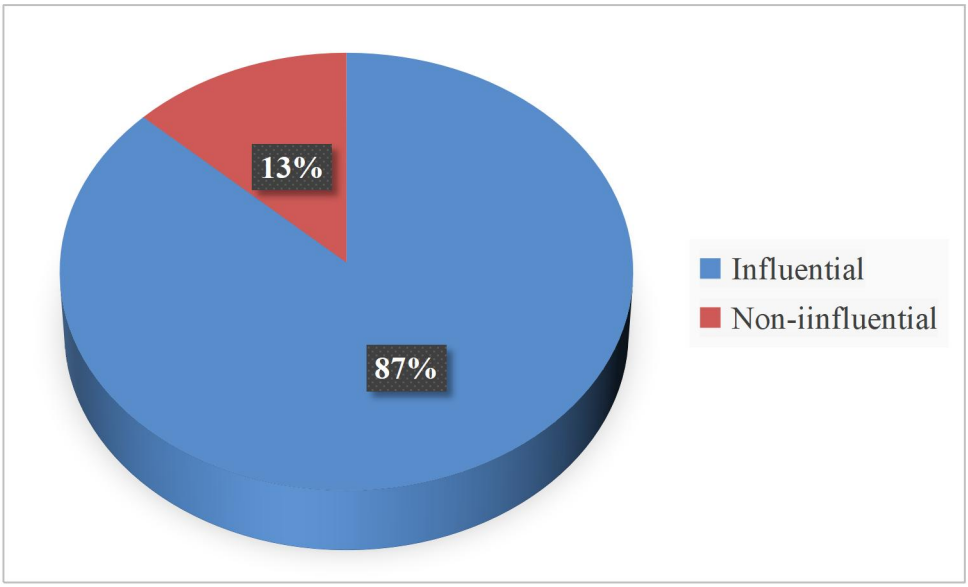

Figure 4.3: Pie chart showing perceived impact of burnout on patients' care

Figure 4.3 shows that 188 respondents (87%) perceived burnout as influential on patient care, while 28 respondents (13%) viewed it as non-influential.

Hypothesis Testing

There is no significant relationship between the level of burnout and its perceived impact on patients' care at the university of Benin teaching hospital.

Table 4.5: Relationship between the level of burnout and its perceived impact on patients' care

perceived impact	Level of burnout		Test Statistics (χ^2)	df	P value	Decision
	High	**Low**				
High	173(80.1)	43(19.9)	7.153502	1	0.007482	Rejected
Low	193(83.4)	23(16.6)				

Table 4.5 presents the relationship between the level of burnout among healthcare providers and its perceived impact on patient care. The chi-square test revealed a statistically significant association ($\chi^2 = 7.15$, $p = 0.007$), leading to the rejection of the null hypothesis. Among respondents who perceived a high impact of burnout on patient care, 80.1% experienced high levels of burnout, while only 19.9% reported low burnout. Conversely, among those who perceived a low impact, 83.4% had high burnout and 16.6% low burnout. These findings indicate that perceptions of burnout's effect on patient care are significantly associated with the level of burnout experienced.

CHAPTER FIVE

DISCUSSION AND FINDINGS

This chapter discusses the major findings of the research compared with the literature reviewed, the implication for nursing, summary, conclusion, Recommendations and Suggestions for further Studies.

5.1. Discussion of major Findings

The study assessed nurses burnout and its perceived impact on patients' care in University of Benin Teaching Hospital. The socio-demographic profile of respondents in this study reveals important patterns that both align with and differ from previous research on nurse burnout. The gender distribution showed a predominance of female nurses (81.9%) compared to male nurses (19.1%), which is consistent with typical nursing workforce demographics but offers an interesting contrast to Zhang et al.'s (2022) findings where male nurses showed higher burnout rates (32.24%) compared to female nurses (25.97%). Age distribution revealed that the majority of respondents (64.8%) were under 40 years old, with 31.5% being less than 30 years and 33.3% between 30-39 years. This younger workforce composition aligns with Beier et al.'s (2023) findings regarding age as a significant factor in burnout vulnerability, where younger nurses were found to be more susceptible to burnout symptoms. The relatively small proportion of nurses aged 50 and above (16.2%) might have implications for mentorship and experience-based resilience within the workforce. Regarding marital status, the high percentage of married nurses (79.6%) contrasts with Ramírez-Elvira et al.'s (2021) identification of single marital status as a risk factor for burnout. This demographic characteristic might serve as a protective factor through social support mechanisms, though further investigation would be needed to confirm

this relationship in the current context. Educational qualifications showed that most nurses (61.1%) held BSc degrees, with smaller proportions having diplomas (20.8%), MSc (15.3%), and PhD (2.8%). This educational profile suggests a well-qualified workforce, though Montgomery et al.'s (2022) research indicates that education level alone may not protect against burnout without supportive organizational structures. Experience levels revealed that the majority of nurses (67.6%) had 1-10 years of post-qualification experience, with 37% having 6-10 years of experience. This aligns with studies suggesting that mid-career nurses face particular burnout challenges, as noted in Sodimu et al.'s (2021) Nigerian study. The distribution of unit-specific experience showed similar patterns, with 75.4% having 1-10 years of experience in their current units. The rank distribution showed a pyramid structure with 47.7% at the Nursing Officer level and decreasing percentages through senior ranks. This hierarchy pattern might influence burnout through workload distribution and decision-making authority, as suggested by Amiri et al.'s (2024) findings on organizational risk factors. Shift patterns revealed that most nurses worked either 8-hour (40.3%) or 12-hour shifts (35.2%), with only 20.8% working exclusively morning shifts. This variation in work schedules corresponds with findings from multiple studies, including Kakemam et al. (2021), highlighting the impact of shift work on burnout levels. The ethnic and religious composition of the sample reflects the local context, with Bini (49.1%) being the predominant ethnic group and Christianity (80.6%) the main religion. While these factors weren't specifically addressed in the referenced studies, they may influence social support systems and coping mechanisms, as suggested by Rossi et al.'s (2023) work on cultural aspects of burnout resilience. Understanding these demographic characteristics is crucial for developing targeted interventions, as suggested by Jun et al.'s (2021) emphasis on

contextualizing burnout prevention strategies. The predominance of younger, well-educated nurses with moderate experience levels suggests a need for interventions that address both career development and work-life balance concerns while considering the specific challenges faced by different demographic groups within the nursing workforce.

Level of burnout among nurses

The current study reveals a concerning prevalence of burnout among nurses, with 80% of respondents reporting high levels of burnout. This finding indicates a substantially higher burnout rate compared to previous studies, notably exceeding the 31.5% reported by Kakemam et al. (2021) and the 27.3% found in Zhang et al.'s (2022) large-scale study of psychiatric nurses. However, it aligns more closely with Alfuqaha et al.'s (2021) findings, which reported 93.9% of nurses experiencing moderate levels of burnout. The detailed analysis of burnout manifestations reveals that emotional exhaustion is particularly prevalent, with 88.4% of nurses reporting feeling emotionally drained after work (45.4% always, 43% sometimes). Similarly, 88.9% reported feeling tired before even starting their shifts, suggesting a chronic state of fatigue that aligns with the findings from Beier et al.'s (2023) study on nurse exhaustion patterns. Depersonalization symptoms were evident, with 75.5% of nurses reporting feelings of indifference or detachment when caring for patients. This finding corresponds with Ramírez-Elvira et al.'s (2021) meta-analysis, though their study found lower rates of depersonalization (18%) among ICU nurses. The current study also found that 83.4% of nurses feel overwhelmed by their tasks, and 75% experience emotional numbness or distance from their work, indicating a significant impact on professional engagement. Sleep disturbances and stress-related issues

were prominent, with 82% of nurses reporting trouble sleeping or relaxing due to work-related stress. This finding adds to the growing body of evidence about the physiological impacts of burnout, as documented in Zhang et al.'s (2022) research on mental health symptoms among nurses during the COVID-19 pandemic. The study revealed concerning trends in professional fulfillment and job satisfaction, with 83.4% of nurses feeling they are no longer making a meaningful difference in their work. Additionally, 75.9% reported feeling unappreciated or unsupported in their work environment, echoing Amiri et al.'s (2024) findings about the importance of supportive work environments in preventing burnout. Perhaps most alarmingly, 65.7% of nurses have considered quitting their nursing job due to stress or emotional exhaustion. This finding suggests that burnout not only affects current performance but also threatens workforce stability, supporting Montgomery et al.'s (2022) emphasis on the need for systemic interventions to improve work environments. The consistently high mean scores across all dimensions (ranging from 2.9 to 3.4, with a grand mean of 3.1) indicate that burnout manifestations are both severe and multifaceted. These findings align with Sodimu et al.'s (2021) Nigerian study, which emphasized the prevalence of burnout among clinical nurses and the importance of both personal and institutional strategies for its prevention. The higher burnout rates found in this study compared to some international studies might reflect local contextual factors, including resource constraints and workload issues specific to the Nigerian healthcare system. This suggests that while burnout is a global phenomenon in nursing, its prevalence and severity may be influenced by local healthcare system characteristics and resources, as suggested by Jun et al.'s (2021) systematic review of burnout in hospital settings.

Perceived impact of burnout on patients' care

The findings from the current study demonstrate a significant perceived impact of burnout on patient care, with 89% of respondents reporting a high impact. This striking proportion aligns with but exceeds the concerns highlighted in Kakemam et al.'s (2021) research, which documented substantial correlations between burnout and diminished care quality. When examining specific aspects of care delivery, the current study reveals that emotional exhaustion significantly impairs nurses' ability to provide high-quality care, with 91.3% of respondents acknowledging this impact. This finding reinforces Jun et al.'s (2021) systematic review conclusions about the inverse relationship between burnout and care quality, while providing more precise quantification of this relationship in the clinical setting. The study also uncovered profound effects on nurse-patient interactions, with 90.8% of nurses reporting that burnout compromises their ability to communicate effectively with patients, while 88% acknowledged experiencing reduced empathy due to depersonalization. These findings build upon Soósová's (2021) work by offering deeper insights into how burnout affects the interpersonal dimensions of nursing care. Patient safety emerged as another critical concern, with 89.4% of nurses indicating that burnout contributes to increased mistakes, and 88% reporting decreased attention to safety protocols when overwhelmed. These results complement Montgomery et al.'s (2022) research linking burnout to lower patient safety grades, while providing specific examples of how burnout manifests in safety-related behaviors. The study revealed concerning patterns in care delivery timing and motivation, with 90.3% of nurses reporting delays in attending to patient needs due to fatigue, and 94% indicating reduced motivation to exceed

basic care requirements. Furthermore, 82.8% of nurses reported difficulty building trusting relationships with patients, highlighting burnout's impact on the fundamental nurse-patient relationship. Across all dimensions measured, the consistently high mean scores (ranging from 3.2 to 3.4, with a grand mean of 3.3) indicate that burnout's impact on patient care is both pervasive and substantial. This comprehensive impact supports Lee et al.'s (2024) findings while offering more detailed insights into specific areas affected. The consistency in responses across different aspects of care quality suggests that burnout's impact is not isolated to particular care dimensions but affects the entire spectrum of nursing care delivery. This holistic impact reinforces Jun et al.'s (2021) assertion that burnout should be addressed as a collective and organizational phenomenon rather than solely an individual issue. These findings underscore the critical need for organizational interventions to address burnout, as its effects clearly extend beyond individual nurse well-being to significantly impact the quality and safety of patient care. The high percentage of nurses reporting burnout's negative effects on various aspects of care delivery suggests that addressing this issue is crucial for maintaining healthcare quality standards and ensuring optimal patient outcomes.

Factors contributing to burnout in nurses

The study identified significant factors contributing to nurse burnout, with 87% of respondents acknowledging these factors as influential on patient care. This finding closely aligns with Amiri et al.'s (2024) meta-analysis of occupational risk factors in healthcare settings. Workload emerged as a primary contributor to burnout, with 84.3% of nurses reporting their assigned workload as excessive for their shifts. This finding is particularly resonant with Sodimu et al.'s

(2021) Nigerian study, where 99% of nurses identified long working hours as a key burnout factor. The current study also revealed that 90.7% of nurses cited inadequate staffing as a significant contributor to burnout, supporting Montgomery et al.'s (2022) findings regarding the critical relationship between staffing adequacy and burnout levels. The emotional toll of nursing work was prominently highlighted, with 91.3% of respondents indicating that caring for critically ill or dying patients contributes to their burnout. This finding extends Alfuqaha et al.'s (2021) work on existential aspects of burnout, demonstrating how the emotional demands of patient care can lead to psychological strain. Organizational factors played a substantial role, with 86.6% of nurses reporting insufficient support from hospital management. Additionally, 90.3% cited poor staff communication as a stressor, and 85.6% reported feeling a lack of control over their duties. These findings align with Amiri et al.'s (2024) identification of workplace environmental factors as significant burnout predictors, where supportive work environments emerged as crucial moderating factors. Schedule-related stressors were significant, with 84.2% of nurses indicating that frequent night shifts or rotating schedules increase their stress levels. This corresponds with Zhang et al.'s (2022) findings about the impact of shift patterns on burnout, particularly their observation of higher burnout rates among nurses working frequent night shifts. Professional development concerns were evident, with 80.1% of nurses reporting limited opportunities for career growth. This finding adds to Rossi et al.'s (2023) understanding of how institutional factors contribute to burnout, suggesting that career stagnation may be an important consideration in burnout prevention strategies. The issue of recognition and appreciation emerged strongly, with 90.3% of nurses identifying lack of recognition from supervisors as a contributor to work-related stress. This

aligns with Austen's (2023) mixed-methods study findings about the importance of organizational support in preventing burnout. Task completion pressure was also significant, with 84.8% of nurses reporting insufficient time to properly complete assigned tasks. This temporal constraint, combined with high workload and inadequate staffing, creates a perfect storm for burnout development, as noted in Cheung et al.'s (2020) analysis of critical care nursing environments. The consistently high mean scores across all factors (ranging from 3.1 to 3.4, with a grand mean of 3.3) indicate that burnout in this setting is driven by multiple, interrelated factors. This multifactorial nature of burnout supports Jun et al.'s (2021) conclusion that burnout should be addressed as a systemic issue rather than an individual problem. These findings suggest that addressing burnout requires a comprehensive approach targeting both organizational structures and individual support mechanisms. The high prevalence of both structural and emotional factors contributing to burnout indicates the need for interventions at multiple levels, as suggested by recent systematic reviews and meta-analyses in the field.

5.2 Implication to nurses

The findings of this study have significant implications for nurses, both at the individual and organizational levels. The high prevalence of burnout among nurses at the University of Benin Teaching Hospital—reported by 80% of respondents—signals a serious threat not only to the well-being of nursing professionals but also to the quality of care delivered to patients. This level of emotional exhaustion, depersonalization, and reduced sense of personal accomplishment suggests that many nurses are working under sustained stress that exceeds their coping capacities.

At the individual level, the implications are profound. Emotional and physical fatigue, sleep disturbances, and feelings of detachment from patients may impair nurses' ability to maintain empathy, communicate effectively, and stay attentive to safety protocols. The psychological toll, including feelings of professional inadequacy and a diminished sense of purpose, may result in decreased job satisfaction and increased intention to leave the profession, as evidenced by the 65.7% of nurses who reported considering quitting due to stress. These outcomes threaten the sustainability of the nursing workforce, especially in a healthcare environment already strained by staffing shortages and high patient loads.

Organizationally, the implications point to the urgent need for systemic reforms. The study highlights how work conditions—such as shift patterns, hierarchical structures, and limited support—contribute significantly to burnout. Therefore, addressing burnout cannot be seen as an individual responsibility alone but must involve institutional changes. This includes implementing supportive supervision, ensuring adequate staffing, offering mental health support, and fostering a workplace culture that values and appreciates nurses' contributions.

5.3 Summary

This chapter has presented a detailed discussion of the key findings of the study on burnout among nurses at the University of Benin Teaching Hospital. The results revealed a high prevalence of burnout, with 80% of nurses reporting symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment. Several factors were identified as contributing to this condition, including long working hours, inadequate staffing, lack of support, poor work-life balance, and limited opportunities for professional growth.

The discussion further emphasized that burnout not only affects the physical and emotional well-being of nurses but also undermines the quality of patient care and increases the risk of errors, absenteeism, and turnover. Younger nurses and those in junior positions appeared to be more susceptible, indicating a need for targeted interventions. In addition, the lack of institutional support and the pressure from organizational demands were seen as major stressors that must be addressed to improve workplace conditions.

The implications for nursing practice are substantial. Nurses require more supportive work environments, better mental health resources, and policies that recognize and mitigate the risk of burnout. Institutions must prioritize the well-being of their nursing workforce to ensure optimal care delivery and professional sustainability.

5.4 Conclusion

This study concludes that burnout is a significant and widespread issue among nurses at the University of Benin Teaching Hospital, with profound implications for both healthcare providers and patient outcomes. The high levels of emotional exhaustion, depersonalization, and reduced job satisfaction reported by the majority of respondents reflect the demanding nature of the nursing profession and the challenges inherent in the hospital's working environment.

The findings clearly demonstrate that burnout is not only a personal health concern for nurses but also a systemic problem that affects the overall quality, safety, and efficiency of patient

care. Contributing factors such as excessive workload, long shifts, insufficient staffing, lack of organizational support, and limited career development opportunities must be addressed urgently.

Efforts to mitigate burnout should focus on improving working conditions, promoting mental health and well-being, ensuring adequate staffing, and fostering a supportive and respectful workplace culture. Addressing these challenges will not only enhance nurses' professional satisfaction and retention but also improve the standard of care delivered to patients. Ultimately, combating burnout requires a collaborative effort involving individual resilience, peer support, institutional reform, and policy-level interventions.

5.5 Limitations of study

Despite the valuable insights provided by this study on nurse burnout and its impact on patient care at the University of Benin Teaching Hospital, several limitations must be acknowledged. First, the study relied heavily on self-reported data, which may be subject to response bias, such as social desirability or underreporting of negative experiences. This could affect the accuracy of the results, especially in a sensitive area like emotional exhaustion or job dissatisfaction.

Second, the cross-sectional design of the study limits the ability to establish causality between burnout and its perceived effects on patient care. Longitudinal studies would be better suited to examine how burnout develops over time and how it specifically impacts nursing performance and patient outcomes.

5.6 Recommendations:

Based on the findings of this study, several key recommendations are proposed to help address nurse burnout and its impact on patient care at the University of Benin Teaching Hospital and similar healthcare settings:

- Hospital management should prioritize creating a supportive and psychologically safe environment for nurses. This includes fostering open communication, reducing hierarchical barriers, and recognizing nurses' contributions to boost morale and reduce feelings of underappreciation.
- Adequate staffing levels and balanced workload distribution are essential to reducing burnout. Management should evaluate nurse-to-patient ratios regularly to prevent excessive fatigue and ensure equitable shift scheduling, particularly for high-intensity units.
- Regular mental health support, such as counseling services, stress management workshops, and wellness programs, should be made accessible to all nurses. Encouraging self-care and offering confidential psychological support can mitigate emotional exhaustion and depersonalization.
- Career growth opportunities, continuous education, and mentorship programs can help mid-career nurses stay motivated and engaged. More experienced nurses should be encouraged to mentor younger colleagues, fostering professional development and resilience.

- Allowing some level of flexibility in shift schedules could help nurses better manage work-life balance. Consideration for family responsibilities and personal well-being in rostering can reduce long-term stress and job dissatisfaction.
- Periodic surveys and assessments should be conducted to monitor burnout levels among staff. This proactive approach will help management identify trends and intervene early before issues escalate.
- Institutions should develop and enforce policies that address workplace stressors, such as excessive overtime, lack of support, and unfair promotion practices. Ensuring transparency and fairness in administrative decisions can build trust and reduce systemic causes of burnout.

5.7 Suggestion for Further study

While this study has provided valuable insights into the impact of burnout on nurses' performance and patient care at the University of Benin Teaching Hospital, further research is recommended to expand the understanding and address remaining gaps:

1. Future research should adopt longitudinal designs to assess the long-term effects of burnout on nurses' physical and mental health, as well as on patient outcomes over time. This approach would provide deeper insight into causal relationships and burnout progression.
2. It is recommended that similar studies be conducted in other tertiary hospitals, both public and private, across different regions in Nigeria. Comparative analysis will help

determine if the findings from UBTH are consistent or vary based on institutional policies, resources, and regional differences.

3. Future studies could extend the investigation to other healthcare workers such as doctors, laboratory scientists, and support staff to understand how burnout affects the entire healthcare team and how inter-professional stress dynamics influence hospital performance.

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APPENDICES

APPENDIX I: QUESTIONAIRE

FACULTY OF NURSING SCIENCES,

UNIVERSITY OF BENIN, BENIN CITY, EDO STATE

Dear Respondent,

QUESTIONNAIRE

I am Otiri Ochuko; a 500L student in the above name institution. I am carrying out a research study on the topic: **"Assessment of Nurses' Burnout and Its Perceived Impact on Patients' Care in University of Benin Teaching Hospital".** Kindly assist me by indicating your opinion where necessary.

This study is strictly for academic purpose and you are hereby assured that all information supplied will be treated in a strictly confidential manner.

Thank you.

Yours faithfully,

_____

Otiri Ochuko.

Researcher

SECTION A: DEMOGRAPHIC DATA

Instruction; please tick where appropriate

1. Sex: (a) Male [ ] (b) Female [ ]
2. Age: (a) Less than 30 years [ ] (b) 30-39 years [ ] (c) 40-49 years [ ] (d) 50-59 years [ ] (e) 60 years & above [ ]
3. Marital status: (a) Single [ ] (b) Married [ ] (c) Divorced [ ] (d) Widowed [ ]
4. Highest educational qualification in Nursing: (a) Diploma [ ] (b) Bsc [ ] (c) Msc [ ] (d) Phd [ ]
5. Ethnicity: (a) Bini [ ] (b) Esan [ ] (c) Hausa [ ] (d) Igbo [ ] (e) Yoruba [ ] (f) Others (specify) _____
6. Religion: (a) Christian [ ] (b) Muslim [ ] (c) Others (specify) _____
7. Length of post-qualification nursing experience: (a) Less than 1 year [ ] (b) 1–5 years [ ] (c) 6-10 years [ ] (d) 11-15 years [ ] (e) 16 years and above
8. Length of experience on current hospital unit: (a) Less than 1 year [ ] (b) 1–5 years [ ] (c) 6-10 years [ ] (d) 11-15 years [ ] (e) 16 years and above
9. Rank (position of the nurse): (a) Nursing Officer [ ] (b) Senior Nursing Officer [ ] (c) Principal nursing officer [ ] (d) Assistant Chief Nursing Officer [ ] (e) Chief Nursing Officer [ ] (f) Others _____
10. Shifts: (a) Only morning shift [ ] (b) 12-hours shifts [ ] (c) 8-hours shifts [ ] (d) Others _____
11. Unit: Please specify_____

Section B: To assess the level of burnout among nurses at the University of Benin Teaching Hospital.

Please indicate how often you engage in the following practices: (Always, Sometimes, Rarely, Never)

S/N	Statement	Always	Sometimes	Rarely	Never
1	I feel emotionally drained after a day's work.				
2	I feel tired even before starting my shift.				
3	I feel indifferent or detached when caring for patients.				
4	I feel I am no longer making a meaningful difference in my work.				
5	I have trouble sleeping or relaxing due to work-related stress.				
6	I find it difficult to concentrate during my shift.				
7	I feel unappreciated or unsupported in my work environment.				
8	I feel overwhelmed by the number of tasks I must complete.				
9	I feel emotionally numb or distant from my work.				
10	I consider quitting my nursing job due to stress or emotional exhaustion.				

Section C: To assess perceived impact of burnout on patients' care at the University of Benin Teaching Hospital.

Please indicate your level of agreement with the following statements: (Strongly Agree, Agree, Disagree, Strongly Disagree)

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1	I find it difficult to provide high-quality care when I feel emotionally exhausted.				
2	Burnout affects my ability to communicate effectively with patients.				
3	When I feel depersonalized, I tend to be less empathetic toward patients.				
4	Due to fatigue, I sometimes delay attending to patients' needs.				
5	My feelings of burnout contribute to making more mistakes in patient care.				
6	Burnout has negatively affected my patient care performance over time.				
7	When I feel overwhelmed, I am less attentive to patient safety protocols.				
8	I am less motivated to go above and beyond for patients when I feel emotionally drained.				
9	Patients may notice a decline in the quality of care I provide when I am burnt out.				
10	Burnout has made it harder for me to build trusting relationships with my patients.				

Section D: To identify the factors contributing to burnout in nurses at the University of Benin Teaching Hospital

Please indicate your level of agreement with the following statements: (Strongly Agree, Agree, Disagree, Strongly Disagree)

S/N	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
1	The workload I am assigned is often too much to handle within my shift.				
2	Inadequate staffing contributes to my feeling of burnout.				
3	I often feel that I receive insufficient support from hospital management.				
4	Frequent night shifts or rotating schedules increase my stress levels.				
5	The emotional demands of caring for critically ill or dying patients contribute to my burnout.				
6	Lack of recognition or appreciation from supervisors contributes to my work-related stress.				
7	I do not have enough time during my shift to complete all assigned tasks properly.				
8	Poor communication among healthcare staff adds to my work stress.				
9	I feel that my job gives me little or no control over how I perform my duties.				
10	I lack opportunities for professional growth or career development in this hospital.				

APPENDIX II

RELIABILITY OF INSTRUMENT

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	No. of Items
0.8	0.70	30

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I find it difficult to provide high-quality care when I feel emotionally exhausted.	53.4931	15.077	-.047	.701
Burnout affects my ability to communicate effectively with patients.	54.1111	15.302	.204	.210
When I feel depersonalized, I tend to be less empathetic toward patients.	53.4167	15.126	-.061	.185
Due to fatigue, I sometimes delay attending to patients' needs.	87.3188	27.590	-.123	.099
My feelings of burnout contribute to making more mistakes in patient care.	87.4813	26.138	.053	.092
Burnout has negatively affected my patient care performance over time.	53.4931	15.077	-.047	.565
When I feel overwhelmed, I am less attentive to patient safety protocols.	53.2986	14.141	.055	.196
I am less motivated to go above and beyond for patients when I feel emotionally drained.				
Patients may notice a decline in the quality of care I provide when I am burnt out.	87.3188	27.590	-.123	.099
Burnout has made it harder for me to build trusting relationships with my patients.	87.4813	26.138	.053	.092
I feel emotionally drained after a day's work.	53.4931	15.077	-.047	.165
I feel tired even before starting my shift.	87.2313	27.034	-.044	.078
I feel indifferent or detached when caring for patients.	87.3188	27.590	-.123	.099
I feel I am no longer making a meaningful difference in my work.	87.3188	27.590	-.123	.099
I have trouble sleeping or relaxing due to work-related stress.	87.4813	26.138	.053	.092
I find it difficult to concentrate during my shift.	53.4931	15.077	-.047	.165
I feel unappreciated or unsupported in my	87.4500	25.582	.125	.071

work environment.				
I feel overwhelmed by the number of tasks I must complete.	87.3188	27.590	-.123	.099
I feel emotionally numb or distant from my work.	87.4813	26.138	.053	.092
I consider quitting my nursing job due to stress or emotional exhaustion.	87.3188	27.590	-.123	.099
The workload I am assigned is often too much to handle within my shift.	87.4813	26.138	.053	.092
Inadequate staffing contributes to my feeling of burnout.				
I often feel that I receive insufficient support from hospital management.	87.3188	27.590	-.123	.099
Frequent night shifts or rotating schedules increase my stress levels.	87.4813	26.138	.053	.092
The emotional demands of caring for critically ill or dying patients contribute to my burnout.				
Lack of recognition or appreciation from supervisors contributes to my work-related stress.	87.6438	27.325	-.076	.081
I do not have enough time during my shift to complete all assigned tasks properly.	87.5938	26.658	.058	.077
Poor communication among healthcare staff adds to my work stress.	87.3188	27.590	-.123	.099
I feel that my job gives me little or no control over how I perform my duties.	87.4813	26.138	.053	.092
I lack opportunities for professional growth or career development in this hospital.	86.2813	26.719	-.064	.095

Comment: The reliability analysis using Cronbach's Alpha, yielding a result of 0.71, for the overall scale. Additionally, the Cronbach's Alpha of 0.52 when the items are standardized. These values suggest a good level of internal consistency among the items in this scale.

APPENDIX III

ETHICAL LETTER

HEALTH RESEARCH ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

P.M.B. 1111 BENIN CITY NIGERIA Telephone: 052-600418 Website: ubth.org

CHIEF MEDICAL DIRECTOR
Prof. Darlington E. Obaseki
E-mail: dariobaseki@gmail.com

DIRECTOR OF ADMINISTRATION
Jim Uwadie, Esq

CHAIRMAN
Prof. (Mrs.) Antoinette N. Ofili

HREC OFFICE:
Committee email: ubthresearchethics@gmail.com
Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL.VII/2025/75

PROPOSAL TITLE: "ASSESSMENT OF NURSES BURNOUT AND ITS PERCEIVED IMPACT ON PATIENTS' CARE IN UNIVERSITY OF BENIN TEACHING HOSPITAL"

PRINCIPAL INVESTIGATOR(S): OTIRI OCHUKO

DEPARTMENT/INSTITUTION: DEPARTMENT OF NURSING SCIENCE, SCHOOL OF BASIC MEDICAL SCIENCES UNIVERSITY OF BENIN, BENIN CITY, EDO STATE

DATE CONSIDERED: APRIL 25TH, 2025

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 25/4/2025 TO 24/4/2026. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI **SIGNATURE & DATE:** 25/4/2025

SUPERVISOR (S): MRS E.A. ESEBAME

DECLARATION BY INVESTIGATOR(S):
PROTOCOL NUMBER (please quote in all enquiries)
Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual re-port to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification

Signature & Date.....