Perspectives and experiences of registered nurses on the contributory factors to their burnout, a qualitative study

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Abstract

Introduction: Burnout affects millions of nurses physically and psychologically hence increasing their intention to leave the profession.

Aim: This study aimed to explore the perception and experiences which contribute to the burnout of nurses in Tonga.

Method: This qualitative study was conducted amongst registered nurses (RNs) in the Vaiola hospital, the Kingdom of Tonga who were chosen purposively. Twenty-five RNs participated in this study. A semi-structured open-ended interview guide was used to collect data. The interview data was transcribed and analyzed using manual thematic analysis by categorizing the relevant responses that connected to each other, cleaned and the coded data were sorted into themes and sub-themes.

Results: Three major themes identified include work overload factors, lack of reward and recognition and unfair appraisals of staff by the managers. Sub-themes for work overload factors were shortage of staff, physical resources and the number of shifts worked. Sub-themes for lack of reward and recognition were dissatisfaction with the current extrinsic motivators, lack of social recognition and lack of intrinsic recognition. Sub-themes for unfair appraisals of staff by the managers were inequity in workload, dissatisfaction in handling of promotions and nurse's annual performance appraisals and inadequate leadership and management skills. This study highlighted the key factors contributed to burnout among nurses.

Conclusion: The results of this study can help the decision makers improve the nursing workforce job satisfaction in the future. Further research is needed to determine the in-depth effects of burnout on nurses at the maritime hospitals and other healthcare professionals to inform future interventions addressing these issues more effectively.

Keywords: Contributing factors, Burnout, Registered nurses, Job satisfaction, Tonga

Introduction

Burnout has become one of the most pressing occupational challenges across workplaces, particularly in healthcare, where it undermines employee well-being, patient safety, and organizational performance. The concept burnout first appeared in Graham Greene's 1961 novel "A Burnout Case", describing withdrawal from society after losing purpose and passion (Serin & Balkan, 2014). In the 1970s, Herbert Freudenberger, a clinical psychologist, adopted the term to describe the loss of motivation among volunteer staff in New York (Maslach & Leiter, 2016). Christina Maslach later advanced the framework, identifying three dimensions; emotional exhaustion, depersonalization and reduced personal accomplishment and with Jackson, developed the Maslach Burnout Inventory (MBI), which remains the most widely used instrument (Maslach & Jackson, 1981). Burnout is now recognized in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon (WHO, 2019).

Burnout develops when prolonged mismatches exist between employees and their work environment, including excessive workload, lack of autonomy, inadequate pay, poor recognition and unfair processes (Maslach & Leiter, 2016: DallÓra & Saville, 2021). The global nursing workforce has grown from 27.9 million in 2018 to 29.8 million in 2023, yet disparities remain across regions (WHO, 2025). Healthcare systems face mounting pressures from technological change, aging populations and evolving practices, intensifying stress among workers (Raja et al., 2021; Low et al., 2021), while meta-analyses estimate pooled prevalence at 11.23% across 49 countries (Woo et al., 2020). Sub-Saharan Africa demonstrates the highest burnout ratios, with rates ranging from 49% to 100% depending on measurement tools (Owuor et al., 2020). Beyond quantitative prevalence, qualitative studies provide deeper insights into the lived experiences of nurses facing burnout. For instance, a phenomenological study of operating room nurses in China identified excessive workload, insufficient emotional support, career stagnation and strained nurse-physician relationships as key contributors (Li et al., 2025). Similarly, a thematic analysis of nursing residents in Spain revealed heavy demands, inconsistent educational opportunities

and scarce institutional support as drivers of emotional exhaustion, while peer solidarity emerged as a protective factor (Chacon-Docampo et al., 2026). These findings underscore that burnout is shaped not only by measurable stressors but also by subjective perceptions of support, fairness, and professional identity.

Among nurses, burnout has profound consequences including diminished care quality, increased safety risks, reduced job satisfaction and high turnover, all of which impose financial burden on healthcare organizations (Getie et al., 2025). Burnout prevalence varies across regions, with higher rates in high-income and Western countries and among nurses aged 30 years and older. Systematic reviews highlight alarming prevalence rates, with global nursing burnout during COVID-19 reaching 59.5% and emotional exhaustion reported by 36.1% of nurses (Fekih-Romdhane et al., 2025). Recommended interventions include stress management training, adequate rest, healthy lifestyle practices, workplace counselling, staffing improvements, and supportive leadership (Ling et al., 2020; Lopez-Ibort et al., 2021, Boateng et al., 2021)

In the Pacific Islands, limited research exists through studies in Fiji and Vanuatu reveal similar challenges; heavy workloads, unsocial hours, lack of support, and limited career progression, all contributing to burnout (Veitamana et al., 2017; Tamata et al., 2021). Tonga, a monarchy rooted in cultural values of respect, cooperation, and loyalty, faces comparable issues in nursing, including staff shortages, disengagement, and prolonged stress (Rodney et al., 2015; Tonga Tourism Authority, 2018). However, no study has yet examined the contributory factors of burnout among nurses in Tonga.

This study therefore aims to explore the perceptions and experiences of nurses at Vaiola hospital in the Kingdom of Tonga regarding the factors contributing to burnout. Given that burnout is a complex phenomenon shaped by personal, cultural, and organizational realities, a qualitative approach is particularly appropriate. It allows for an in-depth exploration of nurse's lived experiences, capturing how burnout is perceived and felt in the Tongan healthcare setting that quantitative measures alone cannot fully reveal. By situating Tonga within the broader global and regional context, the research

seeks to fill a critical gap and inform strategies to support nurse well-being, retention and healthcare system sustainability.

The research question is: What are the perception and experiences of nurses working in Vaiola hospital in the Kingdom of Tonga about the contributory factors to burnout?

Methods

Study design and setting

This study adopted a phenomenological framework to explore the lived experiences of the Tongan nurses in Vaiola hospital, while employing thematic analysis as the analytic technique. Phenomenology provided the philosophical foundation, guiding the research toward uncovering the essence of nurse's experiences and ensuring that researcher assumptions were bracketed to focus on participant's voices using face to face in-depth interviews (Busetto et al., 2020; Chivanga et al., 2021). The study was conducted at Vaiola hospital, which is the main and only divisional hospital in Tonga playing a role in the provision of medical and healthcare services for a total population of 101,134 (Ministry of Health Tonga, 2020). It is situated on Taufa'ahau Road on the outskirts of the capital city, Nuku'alofa.

Study sample

All registered nurses (RNs) with more than one year work experience in Vaiola hospital were eligible to participate in this study, subject to providing a consent. A total of 270 nurses are currently employed at Vaiola Hospital and they are working at different wards. A purposive sampling was used to recruit the study sample. Purposive sampling is a deliberate process of selecting participants with the relevant information, experiences and specific qualities who are able to answer the research question or the phenomenon of interest (Creswell and Poth 2017). The inclusion criteria were: being a RN, being a midwife, currently work full time, have more than one year work experience in the hospital, and willing to participate. A total of 24 RNs and 1 registered midwife from various Vaiola hospital wards including the Surgical, Obstetric, Paediatric, Emergency, Isolation, Outpatients, Operating Theatre and Matrons

Office participated in this study. The study participants were interviewed using face-to-face in-depth interviews until data saturation was reached.

The exclusion criteria was also set if the nurses worked in health settings other than the designated hospital due to the logistics of not being able to collect data from all health settings for the first author; expatriate or contract nurses, had less than one year work experience in the hospital, and unwilling to consent to the study. These would allow the researchers gather depth of information, perspective and experiences of the nursing staff regarding burnout.

Data collection tool

Data collection included a questionnaire regarding the participants demographic and an interview guide **(Table 1) both** were developed by the first author. The interview guide consists of the semi-structured open-ended questions aimed for participants to express their perspectives and personal experiences in own words (Dawer, 2019). It was drawn from the literature, and in line with the research question and aimed to probe and elicit information from the identified participants.

Interview guide

The first part of the data collection and prior to ask the open-ended questions, a questionnaire was administered. It consisted of a number of questions regarding the participants' demographic such as gender, age, race, marital status, education level, years of employments and the number of shifts worked, job status and work unit.

In the second part of the data collection, the interview guide, consisted of five open ended questions, was administered, to answer the research question. Prior to collection data, the interview guide was reviewed by 2 experts in the relevant field and 5 RNs to ensure they are understandable for the participants and to ensure that are aligned with the research questions and cover necessary requirements.

Study procedures

Following the ethics approval, the first author informed the hospital matron via e-mail about the intended study. Advertising fliers were sent out to the nurses through using of the flyers that were posted on the ward's noticeboard, seeking study participants, about two weeks prior to conducting the interviews. All participants who were interested to be part of the study were verified to ensure that they meet the inclusion criteria and those who falls in the exclusion criteria were informed that they cannot participate via telephone and e-mail. Each package contains participant information sheet in English, outlining the purpose of the study, procedure and nature of the study, interview procedure, and approximate duration of the interview, confidentiality and storage of data, the study participant's right to participate, and the right to withdraw at any time, and informed consent. Those who met the study criteria and agreeing to participate were asked to sign a written consent form in English prior to the interview. An arrangement was made about the date, time and venue of the interview. Participants were asked about their preferred language to do interview before the interview. Those who preferred to speak in local language were interviewed by the principal researcher in Tongan otherwise the English language was chosen for the interviews. Each interview lasted between 30 to 45 minutes. All interviews were audio recorded for transcription later while unstructured note were taken as well. Data collection was from August to October 2020.

Data management and analysis

Data were analysed using the manual thematic analysis, guided by a deductive approach informed by Maslach's Burnout Theory Framework (Braun and Clarke, 2006). Thematic analysis is one of the qualitative research methods for identifying, analysing, organizing, describing and reporting themes found within a data set. A cross translation using the forward translation was applied for translating those interviews in Tongan to English. All the interviews were transcribed by the first author and were checked by the second and third authors as well as a bilingual translator to ensure the most accurate translation from the original language. Following a review of transcriptions for corrections, they were anonymised. Transcribed results were later transferred to the Microsoft Word 2016. The first author read and re-read the interview transcripts as well as her own initial fieldnotes constructed during the

data collection. The fieldnotes enriched the data during the familiarisation process. The participants' key words and quotes alongside the fieldnotes were developed into a number of codes. It was followed by categorizing the codes and how they connected with each other, cleaned and manually analysed using deductive approach to reflect the lived experiences described by the participants. This means the coded data were sorted into sub-themes and themes based on the similar categories (Braun and Clarke, 2006). Throughout the analysis, the researcher (first author) wrote notes to keep track of the thoughts and reflections as they went along. These notes showed how decisions were made during coding and theme building. Other authors also helped the first author set aside own opinions so that she could stay focused on what the participants really saying.

As explained earlier, the fieldnotes are the observational notes of the first author when collecting data that were initially constructed. Some fieldnotes and raw materials have developed into codes then informed sub-themes or themes. However, depends on context and participants interview transcripts some were excluded. The fieldnotes were messy and occasionally repetitive demonstrating their link with different or similar observations. Whilst many fieldnotes developed or incorporated into the codes/sub-themes, but some did not. For instance, some fieldnotes repeatedly showing in the first author's groupings are poor leadership & management skills, working long hours, short staff, lack of motivation, yet as highlighted by Braun and Clarke, some fieldnotes and event initial codes might not appear in the final themes (Braun and Clarke, 2021).

Study trustworthiness

Trustworthiness of the study is to ensure the quality is thoroughly examined for accuracy and exactness (Merriam Webster, 2020). Lincoln and Guba's evaluative criteria were adopted to help in evaluating the trustworthiness of this study included transferability, credibility, dependability and confirmability (Morse 2015; Forero, et al., 2018). Credibility was enhanced firstly through the interview guide created by the first author and the contribution of other team members. More credible ways were the prolonged engagement with each participant during the data collection. The semi-structured interviews, allowed some flexibility during interviews such as probing that enhanced the confidence in the results through

demonstrating perspective of the participants that are true, believable and credible. Discussion of data and interpretation of findings with the supervisors help to ensures that themes truly reflect the participant's perspectives. Dependability is to ensure the findings of this qualitative inquiry are repeatable if the inquiry occurred within the same cohort of participants (Forero et al 2018; Forero et al., 2015) through the data analysis process, the fieldnotes, developed codes, subthemes and themes. In this study the rich description of the study methods, interview guide (see table 3), data collection process, coding process which was internally assessed by other research team for inter-coders' reliability. Confirmability was to extend the confidence that the results would be confirmed or corroborated by other researchers (Forero et al 2018). This was achieved through the first author's weekly journals such as notes and documents anything that would be beneficial during the research process. She maintained self-awareness of her role as the data collector engaging with the participants, combined with the weekly researcher's meetings. Triangulation enhanced confirmability which includes detailed methodological process, as well as the interview guide data and rich contextual and detailed interviews, contribution of other study team and theoretical inputs. Transferability was to extend the degree to which the results can be generalized or transferred to other contexts or settings (Forero et al., 2018). Transferability was achieved by using the purposive sampling method to include the most appropriate participants with relevant life experiences who could contribute to answering the interview questions. Special care was given to the data collection and data analysis such as ensuring a quiet venue and sufficient time for conducting the interviews which is convenient to all the participants, the interview guides were checked by again by first author prior to conducting the interviews. The audiotaped data were meticulously transcribed by the first author who made every to document all aspects of operational and theoretical data analysis, making sense of the transcribed data, creating codes and themes and collectively discussing with other team members who contributed to creation of themes and data saturation.

Ethical consideration

Ethical approval for this study was obtained from Fiji National University (FNU) College Health Research Ethics Committee (CHREC) with ID- 268.20. Permission was obtained from the study facility, Vaiola hospital Health Research Ethics Committee prior to the commencement of the interviews. Each participant was given an information sheet stating the purpose and methods of the study, the voluntary nature of the study, the right to withdraw from the study at any time without penalty. Nurses who had agree to participate were given the written consent form, has his/her copy for future references, ensures that their identities were anonymous, participant's data and any other information were kept confidential and protected.

Results

Demographic characteristics of respondents

As Table 2 shows, 80% of respondents were between 26-35 years, 84% were females, 60% of them were single, 64% were living with other adult and children while 28% were living with other adult and no children and only 8% were living alone. The majority held a Diploma in Nursing followed by a bachelor's in nursing.

Table 2: Respondents' demographic characteristics (n=25)

Personal information	Frequency (n)	Percentage (%)
Age Group		
20-25	2	8
26-35	20	80
≥36++	3	12
Gender		
Male	4	16
Female	21	84
Marital Status		
Single	15	60
Married	10	40
Living Situation		
Live alone	2	8
Live with other adult (s), no children	7	28
Live with other adult (s), and children	16	64
Level of Education		
Certificate in Nursing	1	4

Certificate in Midwifery	1	4
Diploma in Nursing	11	44
Bachelor in Nursing	10	40
Post Graduate Diploma in Child Health	1	4
Masters in Nursing	1	4

The descriptive data in Table 3 demonstrates that 92% of the respondents' job title were (RN) while 4% were registered midwife, and 4% were sister nurses who are female nurses with high grade. While 44% of the nurses were day shift worker, 48% worked in night shifts that might refers to higher demands for working at night. Among the respondents, most of them worked in Surgical (12%), Obstetric (12%), Paediatric (12%, Emergency (12%), Outpatient (12%) while Medical, Theatre, Isolation were 8% each and the remaining 4% worked in the Antenatal Unit. A total of 44% had 7 to 11 years of job experience and only 4% had more than 17 years of experience. 80% of the respondents did not have any intention of leaving the profession while 20% had an intention to leave in the next 12 months.

Table 3: Participant's job characteristics (n=25).

Variable	Frequency (n)	Percentage (%)
Job title		
Registered Nurse (RN)	23	92
Registered Midwife (MW)	1	4
Sister Nurses (SN)	1	4
Working Shift		
Day	11	44
Night	12	48
Day and Night	2	8
Area of Hospital mostly work at		
Medical	2	8
Surgical	3	12
Obstetric	3	12
Paediatric	3	12
Psychiatric	3	12
Emergency	3	12
Outpatient	3	12
Antenatal	1	4
Theatre	2	8
Isolation	2	8
Years of Experience		

1 to 6 years	3	12
7 to 11 years	11	44
12 to 16 years	10	40
≥ 17++	1	4
Intention to Leave		
Yes	5	20
No	20	80

Table 4 demonstrated all codes, sub-themes and three main themes identified including; work-overload factors, lack of reward and recognition, and unfair appraisals of staff by the managers with each three sub-themes as demonstrated in Table 4 below. In this section, respondents are presented with a pseudonyms and brief demographic details.

Table 4: Codes, subthemes and themes

Themes	Sub-themes	Codes
Work overload factors	• Shortage of staff	• sick or absent staff and Double responsibility • Inspection and busy workload
	• Physical resources shortage	• Poor stock of physical resources • Lack of sanitary resources and risk to staff • Poor patient quality care & safety • Dealing with patient's demands • Physical exhaustion • Social media poor publicity and emotional exhaustion
	• Number of shifts worked	• Work overload • Double shifts/frequent shifts • Working long hours • patient quality care • Lack of work life balance

Lack of reward and recognition	• Dissatisfaction with current extrinsic motivators	• Lack of financial reward • Off days not money
	• Lack of social recognition	• Lack of recognitions by managers • Demotivated • Undervalued • Patients and staff gender differences and communication issues
	• Lack of intrinsic recognition	• Barriers to furthering studies • Barriers to promotion • Prioritising seniors and lack of equality
Unfair appraisals of staff by the managers	• Inequity in workload	• Unfair workload • generational differences and low ethical values • co-worker laziness • valuing younger staff with higher digital literacy • poor relationship among staff • senior vs junior staff
	• Dissatisfaction in evaluation procedure	• biased appraisal • favouritism • task allocations/patients allocation • hard work and unfair appraisal
	• Inadequate leadership and management skills	• lack of unit managers leadership skills • expectation of leaders as the source of inspiration and motivation • seeking help • availability of counsellors to deal with feeling of grief

		• Good relationship, poor relationship • expectation of leaders as knowledgeable and skilful

Theme 1: Work overload factors

Work overload was the most obvious area of work-life discussed due to job demands exceeding human limits. Nurses reported that they have to do much in too little time with only a few resources. Analysis of data showed the following factors that contributed to work overload namely shortage of staff, physical resources shortage and number of shifts worked.

Shortage of staff

Increased workload coupled with fewer nurses working in the hospital caused nurse's physical exhaustion leading to job dissatisfaction and powerlessness to provide optimum care for patients was the reason expressed by all 25 respondents.

Mele (a 31-year-old female, RN) expressed the results of shortage of staff on her well-being:

> "You know….there are times that my sister in charge is away for a personal reason hence I am the one doing her job description such as solving some administrative issues and the funny part is that I don't get any credit for it…ahem…I feel demotivated and tired too"

Likewise, Ána (a 27 year old female RN) added that:

> "When other staff are sick or absent from work, our job description is doubled such as going to pharmacy to collect medications and other administrative chores…doing extra work makes me feel physically and mentally exhausted"

Furthermore, Semisi (a 36-year-old male RN), voiced increase absenteeism is a growing management concern:

> "When there is a specialised team coming from overseas, most of the nurses at my workplace take their leave during this time (smile) because they knew that it's going to be a busy period. This is not because they don't like the work but because they are tired of having shortage of human resources to assist them during this busy period"

Physical resources shortage

All the respondents (25) confirmed that instrument unavailability has been a challenge for a long time now. Shortage of equipment was affecting the patient care negatively and the nurses psychologically. Lina (a 25-year-old female, RN), described that lack of physical resources was throughout the hospital wards and contributed to putting her at risk on becoming infected:

> "There are times that we don't have antiseptic solutions to wash our hands between patients and most of the time, there are no paper towels to dry our hands after hand washing….it makes me feel angry, frustrated and doesn't want to come to work because there is a possibility for me to spread infections"

Siosi (a 31-year oldfemale, RN), echoed her frustration:

> "When there is a full ward, it's a chaos. We haven't been able to meet the patient's needs especially the picky patients. When we improvised in the ward, some picky patients mocked us, and we found out later that they posted our pictures on social media informing the public about the status of the hospital. It hurt us emotionally"

Number of shifts worked

The study revealed six respondents stressed their experiences on the impact of working long shifts that were up to 12hours with less days off and a more call backs.

Sana (a 40 year old female, RN) expressed the reasons for long shifts and its impact on the nurses as well as the patients:

> "Most of the time we spent long shift hours of work such as doing double shift due to not enough staff in the ward. If we don't double the shift, sometimes the unit manager only give us one day off per week or doing call back. It is so tiring and causes a lot of stress to most of us who work long hour's results in affecting the quality care provided to patient"

Similarly, Mele (a 31-year-old female, RN) expressed frustration on the impact of doing long shifts on her family:

> "When I am doing a double shift, I don't have much quality time to spend with my family hence creating disagreements with my husband because of the work-life imbalance".

Theme 2: Lack of reward and recognition

All respondents commented on the lack of recognition from the leaders and they strongly acknowledged the value of recognition from peers, patients, and management. Analysis of data showed the following

factors that contributed to work overload namely "dissatisfaction with the current extrinsic motivators", "lack of social recognition" and "lack of intrinsic recognition".

Dissatisfaction with the current extrinsic motivators

Laisa (a 35-year-old female, RN) indicated how different nursing units handled recognition and reward:

> "It would be nice if management would appreciate us the grass-root level a little bit more. Our financial status at home is very much needed but when I'm asking to do a double shift, it makes me happy because the extra money from my double shift will help support my family but it's very sad for me since sometimes our overtime are not paid in a form of money only days"

Lack of social recognition

Semisi (36-year-old male, RN) voiced the feeling he felt:

> "I feel that my unit manager does not value me at our workplace. No matter how good my performance will turn out but she doesn't like me. I don't know why and it makes me feel demotivated. She never praised me. I only wish she can just tap my back and say "thank you"

Sione (a 34 years old male, RN) described his uncomfortable relationship with the patients, being a male nurse: by patient

> "As a male nurse working at the women's ward, there was one night shift that only I and another male nurse were working. By the time we were about to check the mother's lactation, we kept pushing each other's outside the patient's room who's going to do the talking. The multipara mothers are alright with us but the young mothers are the ~~one~~ ones that I find it a challenge. It's hard for them to accept us male nurses to do any nursing care for them including taking their vital signs"

Lack of intrinsic recognition

This sub-theme refers to the lack of recognition including lack of recognition of achievement, responsibility, and career advancement. All the respondents studied in the same nursing institution in Tonga. A significant number of respondents felt that their superiors do not support and facilitate their career advancement.

Mele (a 31-year-old female, RN) commented on the lack of recognition from supervisors in terms of achievement of her degree studies:

> "You know our unit manager and also our supervisors should support us in terms of facilitating our career advancement. However, during our online studies, we can feel that there is a barrier between us and them because of furthering our studies. They look

> at us and saying that we are still young. We have to wait in line for senior nurses first and then our turn. I feel demotivated listening at this kind of comments".

Theme 3: unfair appraisals of staff by the managers

Analysis of data showed the following factors that contributed to work overload namely inequity in workload, dissatisfaction in evaluation procedure and poor leadership and management skills.

Inequity in workload

Laisa (a 35-year-old female, RN) commented on the difference in work ethic between generational cohorts:

> "Sometimes I do not like looking at the younger nurses sitting around the computer scrolling and scrolling unnecessary things. They do not want to work as much as they have to. I hate when I see the nurses especially the younger ones spending their time on the computer and their mobile phones than in their patient's rooms. The saddest part for me is when there is some entitlement is given to them"

Seini (a 29-year-old female, RN) on the other hand stated her view among some of the senior nurses in her work unit:

> "For me, I get along well with the younger nurses except some of the senior nurses even our unit manager. Our unit manager used to tell the younger nurses to do her job and it makes me lose hope in trusting her. Some of the senior nurses, I don't have good relationship with them because I don't like seeing them relax and enjoying their women's talk during working hours"

Dissatisfaction in evaluation procedure

Semisi (36-year-old male, RN) expressed his feeling lack of interest and discouragement toward his unit manager in the area of evaluation:

> "I worked very hard together with some of my other nurses however, my unit manager doesn't like me. She never praised any good work from me. When they conducted our performance appraisal. We are rated two (2) while some are rated three (3) out of five (5). If there is an opportunity for a promotion or even overtime, I am the last person in our ward that she will pick. This kind of unhealthy environment discouraged me and caused us body aches since we work very hard under pressure… (sighed)!"

Likewise, Lona (29 years old female, RN) commented on how unhappy she was in the way performance appraisals were conducted:

> "You know I am not happy with the way our annual performance appraisal is conducted and I do not like and trust that recognition strategy. I work very hard under pressure

> where there is high absenteeism but the rating that I got from the unit manager is low. This makes me feel sad and motivated to work under this kind of leadership"

Inadequate leadership and management skills

Throughout the interviews, over 50% of the respondents echoed a lack of leadership and management skills among unit managers and supervisors.

Losa (a 29 years old female, RN) echoed the same struggles between some of the unit managers and herself:

> "I thought that leaders are the source of inspiration and motivation for the employees however I find it not aligning well with some of our nurse managers. I have some personal issues that somehow, I needed to share my struggles with them but I no longer trust them. If only we have a counsellor specialised for us nurses so that I can share my burden with her. I feel sorry at some of our nurses since our nurse leaders should take into consideration our mental health too"

Semisi (a 36-year-old male, RN) stressed the importance for every unit manager having some form of qualification:

> "…in this hospital, a nurse leader should obtain a degree in order to help ease the burden that we nurses felt. The knowledge that they received from their studies will help change the old culture into a more transformation leadership….one of the reasons that we don't have good relationship here with some of our supervisors is that they are still using the autocratic and transactional leadership…."

Kato (a 28 years old female, RN) on the other hand outlined the good relationship she shared with her unit manager:

> "My unit manager is like a mother to me at work. We talk a lot during tea break and she helps lift our self-esteem. Our short comings and wrong doings are reported for the sake of the patient and the Ministry and I like it. It is better this way then leaving work with feeling guilty".

In summary findings suggest that a number of factors regarding work overloads and poor management skills lack due to lack of recognition and inspiring staff contribute to Tonga, Vaiola Hospital nurses' burnout. A major factor, staff shortage led to physical exhaustion and job dissatisfaction and inability to provide optimum patient care. Shortage of medical supplies such as antiseptics and paper towels also are the cause for concern due to direct impact on patient risk safety and increasing risk of spreading infectious diseases. Ample evidence in this study highlights the inability of management team and their poor management and leadership skills in creating a culture of rewards and aspiration of the

nursing workforce in this hospital. As far as the account of participants demonstrate lack of rewards and recognition and lack of job promotion opportunities and unfair appraisals of nurses felt demoralising and demotivating staff due to the failure of managers praising nurses for providing patient care. Discrimination, unequal workload and generational gap were also highlighted by some who believed that the younger age staff who are more digitally skilled spend some time on their mobile while the older age nurses engaged in more time providing patient care but receive less recognition.

Discussion

To our knowledge this study is the first that aims to explore the perception and experiences of nurses on the factors contributing to burnout among nurses in the workplace; Vaiola Hospital in the Kingdom of Tonga. The findings of this study are consistent with other studies highlighting various challenges experienced by nurses and affecting their nursing care (Dubaleet al., 2019; Zhang et al., 2021; Adhikari, 2021; Kabunga, 2021).

Three major challenges highlighted by all participants are work overload, lack of reward and recognition and unfair appraisals of staff by the managers.

Work overload was seen as the first contributing factor whereby they have expressed that work overload caused by the shortage of nurses, physical resource shortage and the number of shifts worked. This is consistent with other studies reporting the mismatch in workload in various aspect of job for instance mismatch of job demands and human limits, the expectation of quality work with the available time or the complexity of the task with the current resources that eventually create major negative impact on the nurse's performance and the patients' quality of care due to job dissatisfaction (Vidotti et al., 2018; Wang et al., 2019; Dall'Ora et al., 2020; Shah et al., 2021).

Findings of the qualitative interviews from this study reveal that nurses experience frustration due to dealing with chaos during overcrowded ward because of nursing shortages which all lead to increase in the likelihood of developing infection and their current job description were being doubled. This is consistent with the experience of nurses in South Korea with a result highlighted that poor patient-to-

nurse ratios were linked to very high rates of wrong medication administration (95%), pressure ulcers and patient falls. When ratios improved, these rates dropped significantly (45%, 39%, and 32% respectively) (Cho et al., 2016). Similarly, research in China found that inadequate staffing contributed to burnout among nurses and reduced quality of life (Wang, et al., 2019). It is worth noting that both studies highlight that adequate staffing and positive work environments are essential for patient safety and the nurse's well-being. Tonga is a small country and the provision of adequate levels of basic equipment remains an ongoing challenge. Participants of this study also noted risk for infections due to shortages of antiseptic solutions and paper towels, which increased the chance of transmission between patients. This issue is common in developing countries where healthcare systems already faced significant pressure (Cho et al., 2016). Their argument indeed supports the findings of a longitudinal study of nurses in The Netherland, and how the quality of leadership, developmental opportunities, and social support from supervisors and colleagues could potentially enhance the meaning of work (Van der Heijden et al., 2011). Increased stress was linked to higher burnout while finding meaning in work minimized it. Burnout increased the rate of turnover intentions drawing an attention the need for healthcare managers to safeguard the sustainability of the workforce. High job demands with limited resources often led to frustration and burnout (Ahmed et al., 2020). Reviews using the Maslach Burnout Inventory showed predictors such as heavy workload, low control, poor support and inadequate rewards. Long shifts, especially 12 hours or more were associated with burnout, poor work-life balance and drop in retention due to dissatisfaction with irregular hours (Rajan, 2017)

Lack of reward and recognition is the second contributing factor where they spoke of their dissatisfaction with the current extrinsic motivators, lack of social and intrinsic recognition. They mostly felt demotivated, stressed, and angry due to poor pay and mismatch between the job rewards and the cost-of-living expenses. This is in line with a study conducted and proposed the need to improve the work from human resource management in the healthcare sector (Zamanzadeh et al., 2020)[41] Nurses compellingly spoke of excessive job demands, absence of rewards, and lack of job promotion that led them feeling detached and exhausted. Majority of the study participants expressed their dissatisfaction

related to the lack of monetary incentives, inability of the hospital leaders in establishing good relationship and appreciating the nurses' services showing through positive interaction with the nurses for instance with a tap on their shoulder, offering a smiling face, being more approachable, and facilitating ownership and enable active participation by listening to their ideas and including them in decision making. While findings of this study suggest that some study participants find it challenging to seek support and approval about their career path and progression from managers and leaders. Some are confused and some do have an idea what they are going to do but it's hard for them to share with their superior due to a lot of personal reasons. These findings identified that continuing education courses and professional development programs are all valuable to the nurses' engagement. The provision of rewards is an effort to increase job satisfaction, commitment and is expected to improve nurse's performances (Putra et al., 2021; Ge et al., 2021). A wealth of studies suggests that support from supervisors is essential in developing a positive relationship and establishing transformational leadership and job satisfaction among staff nurse (Anderson et al., 2021; Kaewpan et al., 2019). Healthcare managers should support healthcare workers and realize the potential of their work and maintain their morale through various rewards and incentive. To get the best from employees, the workplace culture and intrinsic reward system must take into consideration a balanced effort and reward and provide training opportunities for career development (Ge et al., 2021).

Unfair appraisals of staff by the managers are another contributing factor as the study participants expressed inequity in workload, dissatisfaction in handling of promotions and nurses' annual performance appraisals and inadequate leadership and management skills resulting in feeling of discouragement, lack of interest, sadness, demotivation, and anger. Some were dissatisfied due to the bias in offering promotions while others found unfair rating in appraisal performance and evaluation. It has been suggested that there is a significant positive relationship between transformational leadership and job satisfaction among qualified staff nurses (Anderson et al., 2021). This might be related to working environment such as productive atmosphere, open and honest communication, growth opportunities, and positive thinking that subsequently impact on the patient's quality of care by nursing

staff (Alrobai et al 2020). whilst in this study, 50% of the study participants voiced the lack of leadership and management skills among nurse managers and their superiors. They believe that good leaders and managers should be a good role model and a source of inspiration for the follower in every aspect of their life by starting from being approachable. Nurses are demotivated to attend to work that is related to the poor leadership including lack of approachability inability to maintain confidentiality and distrust between staff and managers. Participants demand the need for a change in work culture towards a collaborative approach to uphold good governance. A study in Philippine found that positive leadership and low toxic environment among nurse leaders and managers are strongly associated with years of work experience and ability to cope with the leadership demands (Labrague et al., 2020). Leader empowering behaviour (LEBs) and motivating strategies helped to minimize nurse's level of burnout among Jordan nurses (Mudallal et al., 2017). The results strongly emphasized the significant influence of LEBs because it signalled that nurse's feelings of empowerment will minimize their feeling of burnout and how crucial the role of the leader in the workplace.

Limitations

While this study provided an in depth understanding of experiences of nurses' burnout in Vaiola Hospital in Tonga, the results are nor generalizable to other Tonga hospitals since it not only focused on participants in Vaiola Hospital, but it only gave voice to the nurses. It would be helpful if other healthcare professionals i.e. doctors, pharmacists, radiographers, lab staff etc were included.

Conclusions

Three major factors identified in this study were work overload factors, lack of reward & recognition, and unfair appraisals of staff by the managers experienced by the nurses in Vaiola Hospital, the Kingdom of Tonga. It is viewed that there is a need to improve the area of leadership and management in the workplace such as the capacity to empower, motivate, and boost other's energy to commit in putting their efforts into achieving organizational goals. When nurses are dissatisfied with the communication, work environment they are more likely to be engaged and leave the profession. Future

studies could explore multiple hospitals and compare the results. A multi-case study could also be used to compare the views of nurses in Vaiola Hospitals and the major hospitals from other major islands. Also, to conduct a quantitative study to supplement these qualitative findings.

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Table 1: Interview guide

When you hear about this word “burnout”, what does it mean to you?
From your experience, what are some of the factors that contribute to burnout among nurses here in Vaiola Hospital?
How do you describe or what are some of the consequences of prolong burnout among nurses here in Vaiola Hospital?
Would you be able to discuss with me about your relationship with your unit manager, co-workers and your patients?
What can be done to prevent burnout among nurses (some coping strategies)?