INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH AND INNOVATIVE STUDIES
ISSN: 2820-7157
www.ijsrisjournal.com

April 2024 Volume 3 Number 2 36-44

Received Date: February 25, 2024 Accepted Date: March 12, 2024 Published Date: April 17, 2024

Available Online at https://www.ijsrisjournal.com/index.php/ojsfiles/article/view/392

https://doi.org/10.5281/zenodo.15798184

A Scoping Review of Burnout Among Nurses: Causes, Consequences and Interventions

Aeshah Abdu Ahmed Hadadi[1], Fatimah Hassan Al Abbas[2], Afnan Ali Ahmed Almusharraf[3], Layla Hassan Ghanem Alghanem[4]

1. Nursing Technician, ahdadi@moh.gov.sa, Dammam Health Network, Arabie saoudite.
2. Nursing Technician, Fahalabbas@moh.gov.sa, Dammam Health Network, Arabie saoudite.
3. Afnan Ali Ahmed Almusharraf, Nursing Assistant, aaalmusharraf@moh.gov.sa, Central Blood Bank in Dammam, Arabie saoudite.
4. Layla Hassan Ghanem Alghanem, Nursing Technician, Lalgahnem@moh.gov.sa, Dammam Health Network Arabie saoudite.

Abstract

Nurse burnout is an ongoing threatening problem to the healthcare system across the world, particularly after the COVID-19 pandemic. Being defined in terms of exhaustion, deprivation of humanity, and a lower degree of personal accomplishment, nurse burnout does not only impact personal well-being but also risks the life and well-being of patients, the quality of care, and the sustainability of healthcare workforce. The purpose of the proposed scoping review is to synthesize recent academic literature (202024) on multifactorial conditions of nurse burnout, various outcomes of burnout, and the variety of interventions adopted to alleviate the problem of burnout. According to PRISMA-ScR and the framework mentioned by Arksey and OMalley, more than 45 empirical studies, systematic reviews, and meta-analyses were reviewed. Among the most important contributing factors, findings show workload intensity, emotional strain, organizational climate, and the absence of institutional support. The outcomes are reduced job chances, escalated mistakes in clinical experiences, and turnover. There are the following promising interventions to deal with intimate partner violence: mindfulness-based interventions, electronic support tools, resilience training, and organizational reform. Based on this review, nurse burnout is recommended to be dealt with on multi-level, both individual and structural.

Keywords: Burnout in nurses; emotional burnout; resilience; critical workforce; scoping review; an intervention; organizational support; COVID-19; human mind; nursing administration.

1. Introduction

Burnout has become a hot topic in the field of nursing, especially in the face of ever-growing pressure inflicted on nurses in the course of the COVID-19 pandemic. Burnout is an occupational mental disorder originally defined by Maslach and Jackson, and it entails emotional fatigue, depersonalization and loss of a feeling of personal achievement [1]. In nursing, it is represented by the severe expenditure of emotional potential and as a result of losing contact with the patients and the effectiveness in work related tasks [2].

Worldwide statistics indicate that about one third of nurses are experiencing burnout [3]. The latter is not a representation of individual distress only but is also a systemic problem with severe consequences on the delivery of healthcare. Nurse burnout has been associated directly with reduced patients satisfaction, an elevated number of clinical errors, and a rise in turnover rate [4], [5]. In addition, the economic impact of burnout (including absenteeism, staff replacement and loss of productivity) is rather significant and it is a challenge that throws the very survival of healthcare systems around the world in jeopardy [6].

The onset of COVID-19 further contributed to an increase in the burnouts among nurses as it has facilitated new levels of stressors that have never been experienced before. Nurses were expected to work on long shifts in physically and emotionally demanding conditions, with limited supplies of personal protective equipment (PPE) on hand and often away from their families because of the risk of infection [7]. Also, the sight of high patient mortality and making life-and-death decisions according to the limited resources created great emotional pressure on top of moral distress [8]. A few surveys carried out during and after the pandemic have stated a drastic rise in the cases of burnout symptoms in the frontline healthcare workers [9], [10].

Although the problem is serious, there are still some disjointed interventions to alleviate the incidence of burnouts among nurses. Although a number of interventions including resilience training, mindfulness-based stress reduction (MBSR), and peer-support groups have been proposed, a consensus concerning the efficacy of the interventions is lacking [11], [12]. Additionally, most interventions are only inclined towards personal adjustments, not because they do not emphasize the structural and organizational causes of burnout, i.e., work overload, lack of managerial encouragement [13].

In this regard, a thorough literature review is critical to outline the state of knowledge on burnout in nursing and define evidence-based routes to migration. The questions that are to be addressed through this scoping review are the following:

1.What are leading causes of burnouts in nurses in the recent literature (20202024)?

2.What have been the reported effects of nurse burnout both at personal and institutional level?

3.What interventions so far (individual, organizational or systemic interventions) have shown some potential effectiveness in nurse burnout?

Conducting a synthesis of recent results, the proposed review will contribute to the overall picture of burnout as a multidimensional phenomenon that cannot be addressed independently of the multiple spaces within the nursing practice and policy.

2. Methodology

This scoping review was made by using the methodological framework of Arksey and O Malley [14] and was augmented by Levac et al. [15] with the help of PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) checklist [16]. These frameworks were chosen because of their stringent design and have been universally accepted in the broad and heterogeneous body of literature to a large extent especially in areas that overlap conceptually as in the case of nursing.

2.1 The Search Strategy

Two large and advanced databases PubMed, Scopus, Web of Science, and CINAHL were included in the systematic search strategy. Search strategy The search strategy was based on consultation with a medical librarian so as to be sensitive and specific. Such combos as "nurse burnout," "nursing staff," "COVID-19," "emotional exhaustion," "intervention," "coping strategies," "organizational support," "resilience," and "healthcare workforce" were key terms. Synonyms and related concepts were connected through the serial Boolean operators such as AND, OR. Only peer-reviewed articles in English published between January 1, 2020, and April 30, 2025, were searched, and this was done to find the most up-to-date research results.

One of such a full search string in Scopus was:

nurse burnout OR nursing burnout AND intervention OR resilience OR stress reduction AND COVID-19 OR pandemic AND hospital OR healthcare setting

2.2 Qualification requirements

A study was considered when it satisfied the following criteria: (1) addressed burnout in nurses (rather than all healthcare workers in general), (2) had the form of empirical evidence (quantitative, qualitative, or mixed methods), systematic reviews, or meta-analyses, and (3) discussed the causes, consequences, or interventions of nurse burnout, and (4) was published since 2020 throwing to 2025 in peer-reviewed journals. Articles limited to other professions (e.g. medical doctors, psychologists), opinion papers, letters to the

editor and conferences without full papers, and those that had little methodological description, were excluded.

2.3. Furthermore, selection of the studies to be included in the research.

All the recognized citations were loaded to Rayyan, which is online screening tool that allows us to conduct blind independent screening. The titles and abstracts offered by the search engines were reviewed by two reviewers, and in case of disagreement, the two reviewers discussed and, in case of need, a third reviewer adjudged the disagreement. Screening of full-text was done the same way. The flow diagram in Figure 1 described the search process, revealing that out of 523 identified records, 453 were screened after de-duplication and 77 records had full-text retrieval, with 45 of them fitting the final inclusion criteria.

2.4 The method of extracting data

One form of data extraction was derived and piloted. Information which was retrieved consisted of: (1) author(s), (2) publication year, (3) location and country, (4) objective of the study, (5) method and sample description, (6) important conclusion regarding causes, outcomes, and interventions, and (7) reported indicators of outcomes/effectiveness. Thematic grouping of studies was then determined by the three areas of focus of this review, namely, causes of burnout, consequences of burnout and burnout intervention strategies.

2.5 Synthesis of data

Since the studies were heterogeneous in study design, population, and outcome measures, a narrative synthesis type was implemented. Themes identification was an inductive, iterative process, which involved constant comparison. Findings were arranged into the following major categories: individual-level factors, organizational determinants, and systemic influences as well as the nature and effectiveness of interventions. Some informal appraisal of the quality of the included studies has been done, as would be expected in a scoping review, and the discussion has focussed on high impact studies, reviews, and studies of particularly high quality, including longitudinal studies or randomised controlled trials.

The identified methodology provided a flexible but systematic review of the literature and supported the definition of knowledge gaps, persistent dilemmas, and effective practices in the context of nurse burnout in the modern scenario of the healthcare sector [14]--[16].

3. Reasons of Nurse Burnout

Burnout in nurses has a multifactorial etiology that can be described as a transformation of interactions between individual weaknesses, working conditions, and organizational ineffices. Although the phenomenon is not new to the literature on occupational health, more current studies, especially conducted during and after the COVID-19 pandemic, provided new insight into the traditional and emerging factors of burnout among the nurses [1], [3], [4].

3.1 Overworking and Shortage of Staffs

Among those causes of nurse burnout that are the most consistent and have the best empirical support is high workload, which not only implies the patient volume that a nurse attends to, but also the level of complexity and acuity of the patient population [17]. Through a systematic review article by Garccia et al. [18], a nurse-to-patient ratio has been revealed to be a statistically significant predictor of emotional exhaustion and depersonalization. The expectation to care about more patients than it is possible clinically results in role overload among nurses, morphine distress, and the inability to deliver care that would be safe and of quality.

This burden is compounded by shortage of staff. Because of the long-term underinvestment into nursing education and retention, numerous healthcare systems are operating under severely unsafe staffing levels. In a meta-analysis conducted by DallOra et al. [19], it is revealed that inadequate staffing was considered to be correlated not only with elevated burnout scores, but even with elevated death rates of patients and reduced satisfaction levels. This is a serious failure or flaw in the architecture of the workforce planning since the phenomenon is cyclic: that is, the burnout causes the attrition, which, in turn, increases the staffing ratios and resulting burnouts.

3.2 Emotional Requirements and COVID-19 Trauma

Another noticeable cause of burnout is the psychological burden of working with ill patients, especially in the case of the COVID-19 pandemic. Often the only company that dying patients got was the nurses who even had to provide end- of -life care at the same time being afraid to die themselves or fearing about the safety of their families [9], [20]. Italian, Chinese, and United States researchers document that emotional effects are similar with symptoms of secondary traumatic stress, compassion fatigue, and moral injury [21], [22].

Also, regular death exposure, moral and ethical issues, and the absence of an appropriate psychological support combined to produce an environment of unprocessed grief and an accumulation of emotional burnout patterns [7], [8]. According to a longitudinal research by Labrague [23], the burnout rates in nurses serving in COVID-19 units raised tremendously after six months of the surge, in contrast to burnout rates in nurses serving in non-COVID-19 units. The results of this study highlight the long-term effects of the pandemic on the mental health area, remaining significant even when the direct demands during the crisis have declined.

3.3 They have No Autonomy and Managerial Support

Organizational climate is central in determining the experience of burnout in the nurses. Organization structures and practices with strict hierarchies, ineffective communication, and autocratic leadership tends to ignore or abate emerging manifestations of burnout [24]. The lack of significant input in the decision-making processes, insufficient autonomy in clinical decisions, and inability to have their input acknowledged, all have the combined effect of incurring a sense of futility and professional disappointments.

In its turn, transformational leadership has been linked to reduced burnout rates, high rates of job satisfaction and better patient outcomes [25]. In one of study examining the relationship between managerial support and participation in evidence-based care, Boamah et al. [26] showed that the odds of the emotional exhaustion were significantly lower in nurses with high levels of managerial support as well as the odds of these nurses taking part in evidence-based care were higher. Nevertheless, these are not treated equally in the healthcare systems, and the burnout prevalence is starkly uneven.

3.4 Violence and Discrimination at Workplace

Psychosocial hazards like workplace bullying, verbal abuse, and racial or gender discrimination are also included among the psychosocial hazards to burnout that have grown to possess a considerable amount of literature [27]. In particular, those nurses who work in emergency departments or psychiatric locations report the prevalence of verbal aggression, as well as physical assault by patients or family members. It is not just physical safety that is jeopardized in such cases but mental health and faith in the machine of institutional protection mechanisms as well [28].

Additionally, minority nurses can be overburdened even more, as they might deal with the problems of unconscious bias, microaggression, and underrepresentation in managerial positions. These aspects develop a feeling of professional invisibility and emotional susceptibility, which aggravates exposure to burnout [29].

3.5 Low Pay and poor Career Advancement

Lastly, underpaying the work of nurses is a common feature of burnout studies. In most of the countries, nurses confirm that they are tired of their overworking and underpaying, and there are rare chances of their promotion or recognition [30]. Career-development transparent pathways, wage stagnation, and increased responsibilities have contributed to unsatisfaction with the job and unhappy turnover (especially among younger nurses) [31].

Overall, the causes of nurse burnout can be believed to lie deep in the systemic, organizational, and interpersonal processes. Safe to say that the individual resilience and coping strategies are likely to act as a moderating factor, the tendency is still overwhelmingly on the side of structural determinants as system-wide drivers of the problem excessive workload, lack of support, emotional trauma and institutional neglect [18]-[31].

4. Nurse Burnout Results

Not only does burnout among the nurses jeopardize personal health but it also entails long-term consequences regarding patient well-being, quality of healthcare, and organizational soundness. The effects are at numerous levels; individual, professional, clinical and economic and this means burnout is a matter of severe concern to any health system in the world.

4.1 Lack of Patient Safety and Care Quality

The last but certainly the most threatening impact of nurse burnout is the direct link to the situation of low patient safety. It has been established several times that the clinically depressed nurses had greater likelihood of committing clinical errors, misreading the condition of a patient or prescribing the wrong doses of medications [32]. Another broad cross-sectional study that examined more than 30,000 nurses in 12 countries found that higher scores of nurse burnout was strongly linked to the high patient fall rates, the nosocomial infection rate, and the mortality rate [33].

In addition, exercising lessened attention detail and slackened reaction time and low vigilance are reported interventions of burnout among nurses [34]. Such lapses occur not because of negligence but as the necessary consequence of mental fatigue and emotional exhaustion. Burnout may have disastrous outcomes in such an environment as intensive care units (ICUs) or emergency departments, where the ability to make decisions quickly is essential.

4.2 Reduced Satisfaction of Patients and Treatment Relationship

Burnout undermines the therapy relationship between the nurse and patient, which is the foundation of the non-confrontational and kind treatment. Nurses who are emotionally drained are likely to be detached, irritable or less vocal to the patients thus creating an impact on the process of patient perception of care [35]. The facilities with a greater rate of nurse burnout have been reported to have lower satisfaction levels because the patients usually feel that there is no empathy, warmth, or responsiveness [36].

This loss of trust and bonding is just particularly damaging in long-term care and palliative environments, where the emotional presence of the nurse appears to be nearly as essential as the levels of clinical intervention. The lack of rapport may interfere with patient compliance, slow down the healing process and lead to readmission in the hospital [37].

4.3 Higher turnover, workforce turnover 4.3 A higher turnover workforce

The other negative effect of burnout is that it causes high turnover rates among the nursing staff. Burnout has been reported to be a key indicator of the intention to quit the profession, although certain studies show that approximately 40 percent of nurses with burnout actively pursue a non-clinical job [38]. Such turnover also worsens the problem of staffing shortages, which in turn compounds the number of work hours and burnout potential on its already-long resumes, it is also a self-sustaining loop.

It costs more than 40,000 dollars to cover the loss of a precisely one registered nurse; including the time of hiring and training a new employee and missing work [39]. On the system level, high turnover rates interrupt the continuity of care, reduce the team cohesion, and impose additional pressure on healthcare budgets.

4.4 Physical and psychological Health Outcomes

On the subjective level, burnout results in variances of negative health effects. Burnout in nurses is more associated with the occurrence of depressive, anxiety symptoms, sleep disorders, GI discomforts, and even substance abuse [40]. In other instances, exposure to chronic stress associated with burn out has been attributed to expressions of cardiovascular disease and immune disruption [41].

Moreover, burnout interferes with coping skills and resiliency, which exposes the nurses to the increased risk of developing post-traumatic stress disorder (PTSD), especially when they are consistently subjected to exposure to patient decease or workplace violence [42]. These health conditions do not only decrease quality of life of nurses but also lead to additional absenteeism and early retirement.

4.5 Financial and Organizational performance

Nurse burnout at the organizational level lowers efficiency, raises absenteeism, decreases the level of engagement and morale. The nurses who are burned-out He or she is less willing to engage in quality improvement, evidence-based practice, and/or continuing professional education [43]. This institutional apathy impairs institutional innovation and freezes the implementation of new clinical practices.

The monetary cost of burnout is overwhelming in the amount of cumulative impact. Lost days, low productivity, legal issues of clinical negligence and hiring temporary workers cost healthcare institutions a lot. One of the latest studies approximated the number of losses of the U.S. healthcare system (because of burnout) at nearly 4.6 billion dollars per year [44].

To sum up, nurse burnout has far-reaching, systematic and multidimensional implications. They do not just impact on the individual but patients, institutions and the society in general. Burnout, consequently, concerns not only a subject of occupational well-being but a strategic variable in healthcare systems across the world [33]--[44].

5. Interventions

The most effective response to the issue of burnout among nurses is comprehensive and of many levels. Literature-based interventions can be categorized into three general categories individual-level interventions, in which the stressors to be addressed are at the level of the individual, organizational-level interventions, whose target structures are organizational, and system-level interventions, whose impact on solutions can be seen as long-term structural change. Most of the interventions portend potentials but their application varies depending on contextual issues as well as implementation fidelity and long-term sustainability.

5.1 Interventions at Individual Level

One of the most examined individual level strategies involve mindfulness-based interventions. Emotional exhaustion and perceived stress found to be reduced with significant effects among nurses in the case of Mindfulness-Based Stress Reduction (MBSR) programs, which mostly include meditation, breathing exercises, and training in cognitive awareness [45]. A feasibility study on the outcomes of the 8-week MBSR program in a randomized controlled trial of 85 hospital nurses revealed a 30 percent decline on burnout symptoms of these nurses compared to controls [46].

On the same note, cognitive-behavioral treatment, which focuses on dysfunctional thinking and developing control over emotions, have also produced favorable results. Such programs are usually aimed at promoting self-efficacy, redefining clinical stressors, and sustainable coping styles [47]. According to a meta-analysis by Burton et al. [48], the sleep quality, anxiety, and job satisfaction of nurses that experienced a brief cognitive-behavioral training were improved.

Digital tools have become popular, as well, particularly during the COVID-19 pandemic, when face-to-face training was minimal. Smartphone-based mobile apps and virtual environments providing guided mindfulness, journaling, and peer-to-peer support have had feasibility and medium efficacy on pilot studies [49], [50]. Nevertheless, issues like low engagement and digital fatigue should be solved in the subsequent implementations.

5.2 Interventions at Organizational Level

The problem of burnout cannot be dealt with properly as long as there are organizational frameworks that produce it. The best organizational interventions include the alteration of nurse-to-patient ratio. Based on research, staffing at accurate levels had been shown to increase patient outcomes inherent with a decreasing burnout level [19], [33]. Such repayment in countries that reduce nurse turnover through legislative

mandate, and increase job satisfaction, includes California, where there are minimal ratios of nursing staffing [51].

Another determining factor is the leadership style. Nurse burnout has been reported to be fewer in transformational leadership, which involves encouragement, inspiration, and motivating efforts of leaders, as well as appreciating and listening to them [25], [26]. Emotional intelligence and conflict resolution training programs of nurse managers were found promising to develop psychologically safe work environments [52].

Furthermore, work flexibility, professional growing opportunities, and awards are organizational processes that reduce burnout. Nurses working in institutions which provide an opportunity to influence their shifts schedule and provide some time off to train report lower staff turnover and emotional burnout [53].

Peer-support programs, including Schwartz Rounds or so-called well-being champions, have been discovered as effective platforms to share their emotions and feelings and become a community. Such relatively low cost interventions have been observed to increase morale and decrease isolation in high stress units amongst nurses [54].

5.3 Interventions on the System Level

The most understudied but most influential area is the one of systemic change. The introduction of national health policies focusing on nurse well-being, making investments in education pipelines, and support of safe staffing benchmarks standardization is crucial to sustainability in the long perspective. The WHO report (State of the Worlds Nursing 2020) gives the example where to counteract the burnout, countries should introduce strategic frameworks consisted of retention incentives, career advancement opportunities, and workforce planning [55].

In some countries there are burnout surveillance programs, compulsory screening of mental health or publicly funded resilience programs. Though empirical tests remain modest, preliminary evidence confirms that well-being integration in the licensure, accreditation, and quality assurance systems increase institutional accountability [56].

In addition, bundling of occupational health services in hospitals, interpretation in the form of mental health setting, stress management, and early interventional pathways have not only become a facet of better healthcare systems but also a mark of a progressive care system [57]. Together with workload control based on data, these services are the transition towards proactive burnout prevention.

Overall, the policies that are aimed at the reduction of nurse burnout should be multilevel and suit the workforce demands. The resilience-building programs among individuals are effective, but they are not enough. The sustainable impact particularly relies on system-wide alignment, leadership involvement and political commitment to acquire investment at the level of nursing workforce [45]-[57].

6. Discussion

The results of this scoping review further emphasize the multidimensionality of the phenomenon of nurse burnout based on multilevel factors (individual, organizational, and systemic). Despite the broad scope of the suggested and applied interventions, after the review, it becomes evident that there is a lack of continuing problem-solving as far as effectiveness, scalability, and operability in the healthcare systems are concerned.

6.1 Causal Interdependence The reaction to consequences is dependent on the causes.

Causes and consequences of nurse burnout are not linked linearly but have a cyclical and mutually beneficial relationship. As an example, understaffing is one of the factors contributing to the emotional exhaustion, which, subsequently, will contribute to low-quality care, medical errors, and turnover, which in turn will aggravate the problem of staffing shortages [33], [38]. This is a self-crystallizing cycle that shows why preventive measures focusing on structural determinants and not just on treatment of the symptoms are urgently required.

Besides, the psychological pressure that nurses endure, particularly in the context of the COVID-19 pandemic, demonstrated the relevance of trauma-informed organizational policies. The pandemic was used a stress test on healthcare systems, and identified long-term weaknesses in healthcare such as failure to invest in workforce well-being, neglecting mental health infrastructure, and barriers to flexibility through their bureaucratic cultures [9], [20].

6.2 Shortcomings of Personal-Application Interventions

Despite modest successes of behavior-based interventions on the individual level, including mindfulness, cognitive-behavior, and digital self-care platform, their inability is present. Such strategies are likely to shift the blame of burnout to the individual such that it is only emotional resilience that can aid in the disproportional allocation of resources to the dysfunction [45], [46], [48]. This can be counter-productive and such a framing may encourage guilt amongst nurses that cannot bounce back even though they have been given these tools.

Moreover, there are numerous interventions with a short term of follow-up and not longitudinal. As Turner et al. [58] mention, the individual interventions effects tend to wear off without the changes in the working environment to go parallel. It is not clear how long these measures can be used or applied to other cultural and clinical situations.

6.3 Implementing Barriers and Organizational Resistance

At the organizational level, interventions are quite promising yet in most instances, they are resisted by the institutional leadership particularly where they involve reallocation of resources or rearrangement of structures. Indicatively, reducing the nurse to patient ratios or enhancing wage levels can be seen as a costly venture even though the research has revealed a long-term saving that will be realised due to improved retention and reduced number of errors [33], [51].

Within most health care systems, the issue of mitigating burnout is not integrated into strategic priorities. Burnout is also seen as a soft issue, the peripheral aspect of main clinical outcomes. This understanding challenges any attempt to institutionalize well-being programs, or frequency audits of staff well-being or integrating psychological online casino canada safety into initiatives that improve the quality [43].

Also, the nursing workforce is seldom heterogeneous in culture as interventions rarely consider this factor. The literature does not include adequate representations of studies on low- and middle-income countries (LMICs), which decreases the possibility of generalizing the study conclusions and using interventions in different environments [56].

6.4 Integrated, multi- level strategic necessity

Regarding the evidence introduced, it can be reported that burnout should be solved with complex, multilevel interventions that would integrate both the individual-level support and structural changes. According to recent implementation science studies, programs most effective in promoting mental health are contextualized in organizational culture, coincide with leadership ambitions, and are constantly modified by taking into consideration what is said at the frontlines [57], [59].

Such integrated models can be wellness task forces; a dashboard of areas of burnout; and participatory leadership models in which nurses can co-design solutions. Such models do not only improve program relevance, but also lead to ownership and accountability of staff [52], [54].

To be explored in future studies, bundled interventions need to be considered as these are programs that combine staffing, leadership, mental health, and career development. There is a need to conduct longitudinal, multi-site studies, using different populations to determine scalability, cost-effectiveness, and cultural applicability of these interventions.

To sum it up, it is not a secret that nurse burnout is an issue that has been documented, yet the answers to the problem are disorganized and far not enough. It is time to change the paradigm: so that the healthcare systems can safeguard their core workforce, it is time to shift the paradigm of reactivity of coping measures toward proactivity of structural changes [45].

Conclusion

This scoping review makes it clear that burnout in the nursing profession is neither a personal illness but a systematic shortcoming of the modern healthcare system. Burnout causes, which include overworking, emotional trauma, and unavailability of institutional support and violence, are complex and compounding. The implications are also far-reaching in that they not only affect the mental and physical wellbeing of nurses but also patient safety, clinical quality and health care expenditures.

Although ranged interventions are designed in a large number, most of them are divided, underfunded, or they are not incorporated well into institutional practices. Mindfulness and resilience training means are not enough to cope with the mental burden since they offer only a temporary solution. More sustainable solutions that would be more involved are organizational and system-level reforms: enhancing staffing levels, transformational leadership, incorporation of well-being into policies, and so on but they demand political action and investment.

Finally, the issue of nurse burnout not only needs to be treated as such but it also requires us to have a paradigm shift in the way we care, regard and organize the nursing profession. It demands an ethical decision towards a dignified workplace, a strategy to plan workforce, and a cultural place where the well-being of the nurses is not a luxurious addition to quality care, but a precondition. Without it, the health of the nurses and the systems they are supporting will continue being under threat.

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