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# Nursing Burnout: A challenge facing health administrators: An updated review

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***Abstract*---Background:** Nursing burnout is a widespread issue within healthcare systems, affecting nurses' well-being, job performance, and patient care. Burnout in nurses is primarily linked to work-related stressors and organizational factors such as workload, job control, and interpersonal relationships. Despite numerous studies investigating burnout, a comprehensive understanding of its contributing factors and effects remains elusive. This updated review aims to synthesize research on the determinants and consequences of nursing burnout. **Aim:** This review examines the key factors associated with nursing burnout, such as workload, job control, reward, and community, and explores the impact of burnout on nursing performance, patient outcomes, and organizational

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effectiveness. The review also evaluates the validity of existing burnout models in healthcare settings. **Methods:** A systematic review of the literature was conducted, focusing on studies published since 2010 that investigated burnout among nurses. The review identified studies using various burnout measures, including the Maslach Burnout Inventory (MBI), and categorized findings based on the six dimensions of work life proposed by Maslach (workload, control, reward, community, fairness, and values). Factors beyond the MBI framework, such as shift work, staffing levels, and job support, were also considered. **Results:** The findings confirm that workload, staffing levels, and insufficient job control are the primary contributors to burnout among nurses. Studies consistently showed that high workload and low staffing ratios lead to emotional exhaustion and depersonalization. Additionally, poor job control, lack of reward, and value conflicts exacerbate burnout. The review also identified the protective role of job support, positive workplace relationships, and schedule flexibility. **Conclusion:** Nursing burnout is a multifaceted issue influenced by organizational and individual factors. To mitigate burnout, healthcare administrators must focus on improving staffing levels, enhancing job control, and fostering a supportive work environment. Comprehensive interventions addressing both structural and psychological aspects of nursing work can reduce burnout and improve job satisfaction, performance, and patient care outcomes.

***Keywords*---**Nursing burnout, healthcare, workload, staffing, job control, Maslach Burnout Inventory, emotional exhaustion, depersonalization.

## Introduction

Over the past several decades, there has been an increasing scholarly and policy-oriented focus on the ways in which characteristics of work organization influence various outcomes in nursing. Numerous studies and reviews have explored the relationships between work organization variables and outcomes such as care quality, patient safety, absenteeism, turnover, and job dissatisfaction [1,2,3,4]. Burnout is frequently identified as a key 'outcome' in workforce research aimed at understanding the impact of contextual factors and 'inputs' on outcomes within healthcare environments. However, the specific nature of burnout—its definition, contributing factors, and the broader consequences it may have for individuals, organizations, or patients—is not always clearly addressed in these studies. The concept of burnout was first introduced by Freudenberger in 1974, when he observed a loss of motivation and a reduction in commitment among volunteers at a mental health clinic [5]. It was Maslach who later developed the Maslach Burnout Inventory (MBI), a scale that has become the most widely utilized tool internationally for measuring burnout [6]. According to Maslach's conceptual framework, burnout is a response to excessive workplace stress, characterized by feelings of emotional depletion and a lack of emotional resources—termed Emotional Exhaustion; a negative, detached attitude towards others, and a loss of idealism—referred to as Depersonalization; and a diminished sense of competence

and performance at work—known as reduced Personal Accomplishment [7]. Maslach theorized that burnout is a state resulting from a prolonged mismatch between an individual and at least one of six key dimensions of work [7,8,9]. These dimensions include:

- **Workload**: Excessive workload and demands that prevent adequate recovery.
- **Control**: Insufficient autonomy over the resources necessary to accomplish tasks.
- **Reward**: The absence of appropriate recognition or compensation for the work performed, including financial, social, or intrinsic rewards (such as the personal satisfaction derived from completing a task).
- **Community**: A lack of positive interpersonal relationships with colleagues and supervisors, which diminishes social support and fosters frustration.
- **Fairness**: Perceptions of inequity in the workplace, particularly with regard to workload and compensation.
- **Values**: Feeling constrained by the job from acting in accordance with one's personal values or experiencing conflict with the organization's values.

Maslach posited that these six work characteristics contribute to burnout, which, in turn, leads to deterioration in both employee health and job performance [7]. Subsequent models of burnout diverge from Maslach's in one of two keyways: either they do not exclusively view burnout as a work-related phenomenon, or they conceptualize burnout as a process rather than a fixed state [10]. The job demands-resources model [11] builds on the notion of burnout as a result of a work-based mismatch but proposes two distinct pathways through which burnout develops: excessive job demands that lead to exhaustion, and insufficient job resources that foster disengagement. This model, along with Maslach and Schaufeli's work, situates burnout as the negative extreme of a continuum of employee well-being, with 'work engagement' positioned at the positive end [12].

Among those who treat burnout as a process, Cherniss employed a longitudinal approach to explore the development of burnout in early career human services workers. He framed burnout as a progressive process, marked by negative shifts in attitudes and behaviors toward clients over time, often driven by the workers' disillusionment with the ideals that initially motivated them to pursue the profession [13]. Gustavsson and colleagues applied this model to examine longitudinal data on early-career nurses and discovered that exhaustion is the initial phase of burnout, which progresses further only if nurses exhibit dysfunctional coping mechanisms such as cynicism and disengagement [14]. Shirom and colleagues posited that burnout arises when individuals deplete their resources due to prolonged exposure to emotionally demanding circumstances, both in work and personal life, indicating that burnout is not solely an occupational syndrome [15, 16]. This review seeks to identify research that has investigated the theorized relationships with burnout, aiming to clarify what is currently known (and unknown) about the factors associated with burnout in nursing. Additionally, it will assess the extent to which studies have been informed by, or have supported or contradicted existing burnout theories [17-21].

**Measures of Burnout**

The majority of studies utilized the Maslach Burnout Inventory (MBI) Scale (n = 81), which includes three subscales corresponding to the theoretical framework of burnout: Emotional Exhaustion, Depersonalization, and reduced Personal Accomplishment. However, fewer than half (47%, n = 39) of the studies employed and reported results based on all three subscales. In contrast, twenty-three studies used only the Emotional Exhaustion subscale, while eleven incorporated both the Emotional Exhaustion and Depersonalization subscales. Additionally, in nine studies, the three MBI subscales were aggregated to produce a composite burnout score, despite Maslach and colleagues advising against this method of analysis [22]. Five studies adopted the Copenhagen Burnout Inventory (CBI) [23], which comprises three distinct dimensions of burnout: personal, work-related, and client-related burnout. Two studies employed the Malach-Pines Scale [24], and one study utilized the burnout subscale of the Professional Quality of Life Measure (ProQoL5) scale, which conceptualizes burnout as an aspect of compassion fatigue [25]. Furthermore, two studies applied bespoke burnout measures that combined items from various other instruments [20, 26].

**Factors Examined in Relation to Burnout: An Overview**

The research investigating the relationships between burnout and Maslach's six areas of work life—workload, control, reward, community, fairness, and values—generally supports Maslach's assertion that these dimensions serve as predictors of burnout. However, certain evidence is limited to specific MBI subscales. Higher scores on the Areas of Worklife Scale [27], indicating greater alignment between the job and the individual, were associated with a reduced likelihood of burnout, either directly [28, 29] or via mechanisms such as higher occupational coping self-efficacy [30] and the presence of civility norms, or conversely, co-worker incivility [31]. The majority of studies exploring job characteristics proposed by the Maslach model focused on workload (n = 31), job control, and reward (n = 10). Although only a few studies (n = 9) explicitly tested the hypothesized relationships between burnout and community, fairness, or values, a total of 39 studies considered “supportive factors,” including relationships with colleagues and leadership. A substantial number of studies investigated factors beyond the Maslach model. Six key areas were identified:

- Working patterns and shift work (n = 15)
- Job characteristics, such as psychological demand and complexity (n = 24)
- Job support derived from relationships and leadership (n = 39)
- Hospital or environmental characteristics (n = 28)
- Staff outcomes and job performance (n = 33)
- Patient outcomes (n = 17)
- Individual attributes, either personal or professional (n = 16)

**Workload and Staffing Levels**

Workload and the characteristics of jobs that contribute to workload, such as staffing levels, were the most frequently examined factors in relation to burnout. Thirty studies found a significant association between high workload and burnout. Of these, 13 studies specifically investigated workload as a predictor of

burnout. Several studies found that workload was linked to Emotional Exhaustion [32, 33, 34, 35, 36], with some also reporting a relationship with Depersonalization and others with Cynicism. Janssen noted that "mental work overload" was a predictor of Emotional Exhaustion [37]. Three studies concluded that workload was associated with both Emotional Exhaustion and Depersonalization [38, 39, 40]. Kitaoka-Higashiguchi tested a burnout model and found that a heavy workload predicted Emotional Exhaustion, which in turn predicted Cynicism [41]. Similarly, a larger study by Greengrass et al. confirmed that high workload was associated with Emotional Exhaustion, which subsequently predicted Cynicism [42]. One study found no association between workload and burnout components [43], while another observed an association between manageable workload and a composite burnout score [44].

Additionally, 15 studies focused specifically on nurse staffing levels, with most reporting that higher nurse-patient ratios or perceived staffing inadequacy were linked to increased burnout. No studies found a relationship between better staffing levels and burnout. Although three studies did not identify a significant association with staffing levels [32, 45, 46], three others found that higher patient-to-nurse ratios were associated with Emotional Exhaustion [47, 48, 49], and in one study, higher ratios were linked to Emotional Exhaustion, Depersonalization, and Personal Accomplishment [50]. One study concluded that Emotional Exhaustion mediated the relationship between patient-to-nurse ratios and patient safety [51]. Akman and colleagues found that fewer patients per nurse were associated with lower burnout composite scores [52], a finding similarly reported by Faller and colleagues [53]. Furthermore, lower registered nurse hours per patient day were associated with burnout, according to a study by Thompson [20]. Newly qualified registered nurses (RNs) who reported being short-staffed were more likely to experience Emotional Exhaustion and Cynicism one year later [54]. Another study linked low staffing adequacy with Emotional Exhaustion [55], while Leineweber et al. observed that inadequate staffing was associated with higher Emotional Exhaustion, Depersonalization, and reduced Personal Accomplishment [56]. Leiter and Spence Laschinger explored the relationship between staffing adequacy and all MBI subscales and found that Emotional Exhaustion mediated the connection between staffing adequacy and Depersonalization [57]. Time pressure was also examined in three studies, all of which concluded that time pressure was associated with Emotional Exhaustion [58, 59, 60]. In conclusion, the evidence indicates that high workload is associated with Emotional Exhaustion, nurse staffing levels influence burnout, and time pressure contributes to Emotional Exhaustion.

**Job Control, Reward, Values, Fairness, and Community**

Seven studies examined the impact of job control on burnout. Galletta et al. found that low job control was associated with all MBI subscales [40], as did Gandi et al. [61]. Leiter and Maslach identified that control predicted fairness, reward, and community, which, in turn, influenced fairness and values, with values predicting all MBI subscales [35]. Low control was found to predict Emotional Exhaustion only for nurses working the day shift [62], and Emotional Exhaustion was significantly related to control over the practice setting [63]. However, two studies reported no effect of job control on burnout [44, 64]. Reward

was found to predict Cynicism [35] and burnout on a composite score [44]. Shamian et al. observed that a higher score on the effort-reward imbalance scale was associated with Emotional Exhaustion, and higher scores on this scale also correlated with burnout as measured by the Copenhagen Burnout Inventory (CBI) [65]. Value congruence, defined as the alignment between job requirements and individuals' personal principles [7], was also considered. Value conflicts were linked to a composite burnout score [44]. One study concluded that nurses with high value congruence reported lower levels of Emotional Exhaustion compared to those with low congruence, while nurses with low congruence experienced more severe Depersonalization than those with high congruence [66]. Low value congruence was found to predict all three MBI dimensions [35] as well as burnout measured by the Malach-Pines Burnout Scale [67]. Two studies examined social capital—defined as a social structure that benefits members through trust, reciprocity, and shared values—and both concluded that lower social capital in the hospital predicted Emotional Exhaustion [33, 36]. One study showed that fairness predicted values, which in turn predicted all MBI subscales [35]. Two studies explored community, with one finding that community predicted a composite burnout score [44], while the other found no significant relationships [35]. Although not directly addressed in Maslach's terms, other studies demonstrated associations with potential causal factors, many of which align with Maslach's theoretical framework. In conclusion, there is evidence suggesting that control over the job is linked to reduced burnout, and value congruence is associated with lower Emotional Exhaustion and Depersonalization.

**Working Patterns and Shift Work**

Fifteen studies explored the effects of shift work and work patterns on burnout. The evidence regarding the association between night work, weekly working hours, and burnout was mixed, though more consistent results emerged regarding long shifts and burnout, as well as the potential protective effects of schedule flexibility. Night shifts were linked to burnout (composite score) [68] and Emotional Exhaustion [62], although two studies did not find significant associations [69, 70]. The type of shift pattern also played a role, with permanent shifts not influencing burnout levels, whereas irregular shifts were associated with higher burnout scores. Nurses working more shifts reported higher burnout composite scores [68], though this did not hold in another study [69]. Overtime work was linked to higher burnout levels, while on-call requirements did not show significant associations with burnout dimensions. The number of weekly hours worked did not significantly predict burnout in two studies [25, 53], although one study found that higher weekly hours were correlated with increased Emotional Exhaustion and Depersonalisation. Long shifts (12 hours or more) were consistently associated with higher burnout across all MBI subscales and Emotional Exhaustion [49]. Shorter shifts were found to be protective against burnout in a study using the ProQoL5 scale [25]. In terms of protective factors, higher schedule flexibility was linked to reduced Emotional Exhaustion [46], while the ability to schedule days off was associated with lower burnout composite scores. More than 8 days off per month correlated with lower burnout [69], and a positive scheduling climate was protective of Emotional Exhaustion only. In summary, evidence indicated that ≥12-hour shifts were associated with increased

Emotional Exhaustion, while schedule flexibility appeared to reduce Emotional Exhaustion.

**Psychological Demands and Job Complexity**

Twenty-four studies provided evidence that job demands and job-related factors, such as role conflict, autonomy, and task variety, were linked to various dimensions of burnout. Eight studies investigated psychological demands, revealing that higher psychological demands increased the likelihood of experiencing all burnout dimensions. High psychological demands were specifically linked to greater odds of Emotional Exhaustion [62], and emotional demands, particularly hindrances, contributed to burnout [67]. One study, using the Effort-Reward Imbalance Questionnaire, found a correlation between job demands and all burnout dimensions [79], while another study showed that demands predicted burnout measured as a composite of Emotional Exhaustion and Cynicism. However, one study reported no association between job demands and burnout, and Rouxel et al. concluded that higher job demands exacerbated both Emotional Exhaustion and Depersonalisation [64]. Four studies focused on task nature and variety, showing that job content quality, such as skill variety and task significance, influenced Emotional Exhaustion through intrinsic work motivation [37]. Skill variety and task significance were both associated with higher Emotional Exhaustion, and task significance also correlated with Personal Accomplishment [60]. Jobs devoid of administrative tasks were less likely to lead to Depersonalisation, while clearer task guidelines reduced Emotional Exhaustion and enhanced Personal Accomplishment [58]. Patient-related factors were examined in four studies, with findings indicating that nurses caring for suffering patients or those with complex needs were more prone to Emotional Exhaustion and Cynicism. Similarly, caring for terminal patients and making life-sustaining treatment decisions increased the likelihood of burnout (measured as a composite score). Patient care-related stress was associated with burnout composite scores, as was patient violence and conflicts with patients.

Role conflict, which occurs when incompatible expectations are placed on an individual by multiple roles, was identified as a predictor of Emotional Exhaustion [41]. This was corroborated by Konstantinou et al. and Levert et al., who found that role conflict was associated with both Emotional Exhaustion and Depersonalisation, and role ambiguity correlated with Emotional Exhaustion and Depersonalisation, though not Personal Accomplishment [34, 39]. Andela et al. highlighted emotional dissonance, the mismatch between felt and required emotions, as a mediator between job-related factors (e.g., workload, patient characteristics, team issues) and Emotional Exhaustion and Cynicism. Rouxel et al. found that perceived negative display rules exacerbated Emotional Exhaustion [64]. Autonomy was linked to Emotional Exhaustion and Depersonalisation [60], with one study showing it was associated only with Depersonalisation [43]. Low autonomy affected Emotional Exhaustion via organizational trust. While two studies found no effects of autonomy on burnout [58, 63], low decision-making at the ward level was associated with higher burnout scores across all MBI subscales. Decision latitude was found to impact Personal Accomplishment alone [36], but in another study, it was related to Emotional Exhaustion. High decision latitude was associated with greater Personal Accomplishment and lower

Emotional Exhaustion [33, 41]. In conclusion, high job and psychological demands were strongly associated with Emotional Exhaustion, as was role conflict. Patient complexity was linked to burnout, while task variety, autonomy, and decision latitude were protective factors against burnout.

**Working Relationships and Leadership**

Evidence from 39 studies suggests that positive support factors and working relationships, including supportive relationships with physicians, leadership support, positive leadership styles, and teamwork, can help protect against burnout. Twelve studies examined nurse-physician relationships, with negative relationships correlating with all burnout dimensions, while quality nurse-physician relationships were associated with lower Emotional Exhaustion and Depersonalisation but did not impact Personal Accomplishment [50]. Other studies indicated a link between poor nurse-physician relations and Emotional Exhaustion only [55], with some studies reporting positive nurse-physician collaborations as predictors of higher Personal Accomplishment [36, 57]. In some cases, no associations were found between nurse-physician relationships and burnout [56, 63]. Leadership support was also considered in twelve studies, revealing mixed results. Low support from nurse managers was linked to all MBI subscales in one study, while two others found it protective against Emotional Exhaustion only [58]. Further studies suggested that support from leaders could alleviate Depersonalisation and increase Personal Accomplishment. However, low trust in leadership had a negative impact on burnout levels. Studies also highlighted the impact of the nurse manager's ability, with some showing associations with reduced Emotional Exhaustion and increased Personal Accomplishment [46, 50].

Fourteen studies explored the role of leadership styles in burnout, with evidence showing that different leadership styles influenced burnout through various mechanisms. Boamah et al. found that authentic leadership, characterized by high self-awareness and transparency, led to greater empowerment, which subsequently reduced Emotional Exhaustion and Cynicism [54]. Authentic leadership also reduced workplace bullying, which in turn reduced Emotional Exhaustion [88]. Transformational leadership was associated with improved work environments and reduced burnout [44]. Studies further indicated that empowering leadership predicted trust in leaders, which reduced burnout composite scores. In terms of teamwork and social support, co-worker cohesion was associated with Depersonalisation [58], and team collaboration issues predicted negative outcomes on all MBI subscales [38]. Support from peers and colleagues was protective against Emotional Exhaustion [60, 67], with co-worker support decreasing the likelihood of burnout. However, interpersonal conflict, role conflict, and workplace bullying were found to negatively impact burnout [31]. In summary, strong relationships with physicians, leadership support, positive leadership styles, and teamwork were identified as protective factors against burnout, while poor interpersonal relationships, lack of support, and negative leadership were associated with higher burnout levels.

**Work Environment, Staff Outcomes, and Patient Care in Relation to Burnout**

Burnout, particularly Emotional Exhaustion, Cynicism, and Depersonalization, is a major concern in healthcare settings. Several factors contribute to burnout, including work environment, hospital characteristics, staff outcomes, and patient care quality. Studies show that a positive work environment, as measured by the PES-NWI scale, is linked to reduced burnout, particularly Emotional Exhaustion. Higher structural empowerment, where employees have more control over their work, is also associated with lower levels of Emotional Exhaustion and Cynicism. Organizational support and trust in the organization act as protective factors, reducing burnout levels. However, organizational characteristics such as hospital type and care model have mixed effects. While some studies found that working in smaller hospitals or hospitals with a strong quality care foundation reduced burnout, others found no consistent patterns across different settings.

Burnout significantly impacts staff outcomes, particularly job satisfaction, intention to leave, and job performance. Emotional Exhaustion and Cynicism were consistently linked to higher turnover intentions, while Emotional Exhaustion often mediated the relationship between involvement in decision-making and the intention to leave. Burnout also negatively impacts job performance, particularly task and contextual performance. Missed care, sickness absence, and general health were affected by burnout, with Emotional Exhaustion being a key predictor of absenteeism and health issues. Burnout, especially in new nurses, was linked to mental health problems and depression, further complicating staff well-being. Burnout negatively influences patient care and safety. High levels of Emotional Exhaustion and Depersonalization were associated with poorer quality of care, lower patient safety ratings, and higher rates of adverse events such as medication errors and infections. Burnout also affected error reporting, with nurses experiencing high Emotional Exhaustion less likely to report near misses or adverse events. Additionally, patient falls and patient dissatisfaction were linked to higher burnout levels, particularly Depersonalization. Interestingly, burnout was not associated with hospital-acquired pressure ulcers.

Certain individual characteristics, such as younger age, lack of a bachelor's degree, and high work-life interference, were found to increase susceptibility to burnout. However, demographic and personality factors did not show consistent or conclusive relationships with burnout across studies. Burnout in healthcare professionals is influenced by multiple factors, including work environment, organizational support, individual characteristics, and job-related stressors. While some factors, like structural empowerment and positive work environments, help mitigate burnout, other factors such as work-life interference and job insecurity exacerbate its effects. Burnout not only affects the well-being of healthcare staff but also compromises patient care, leading to poor quality of care, safety issues, and increased healthcare errors. Addressing burnout requires a holistic approach, considering both organizational and individual factors to improve staff well-being and patient outcomes.

## Conclusion

Burnout in nursing is a significant challenge for healthcare organizations, with profound effects on both healthcare providers and patient care. The evidence reviewed consistently underscores the relationship between various work-related factors, including workload, job control, staffing levels, and reward, with burnout in nurses. The high workload, often compounded by inadequate staffing, was the most frequently cited contributor to emotional exhaustion and depersonalization, two primary components of burnout. Studies also highlighted the negative impact of low job control and lack of appropriate rewards on nurses' psychological well-being. Furthermore, this review explored the broader organizational and individual factors contributing to burnout, such as value conflicts, fairness, and interpersonal relationships within the workplace. Value congruence, where there is alignment between the nurse's personal values and the values of the organization, was found to mitigate emotional exhaustion and depersonalization. On the other hand, a lack of social support and low community engagement among colleagues exacerbated burnout. Another crucial factor identified was the effect of shift work and working hours on burnout. While the evidence regarding the direct impact of night shifts was mixed, it was generally found that irregular shifts and long working hours were strongly associated with higher burnout levels. In contrast, schedule flexibility and permanent shifts were linked to lower burnout levels. The findings of this review align with the Maslach Burnout Inventory (MBI) framework, which suggests that burnout is not only a response to work-related stressors but also a complex interaction between organizational factors and individual coping mechanisms. Additionally, burnout should be seen as a process rather than a fixed state, with early interventions focusing on workload management, increasing job control, and promoting a positive work environment. Healthcare administrators must implement structural changes that address workload, staffing, and job support to alleviate burnout. Organizational strategies should include ensuring adequate staffing levels, fostering positive interpersonal relationships, offering recognition and rewards, and providing opportunities for professional development. Addressing burnout proactively is essential to ensure the health and productivity of the nursing workforce, ultimately leading to improved patient care outcomes.

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**إجهاد الممرضين: تحدي يواجه مديري الرعاية الصحية - مراجعة محدثة**

**الملخص:**

**الخلفية:** يُعدّ إجهاد الممرضين قضية شائعة في أنظمة الرعاية الصحية، تؤثر على رفاهية الممرضين، أدائهم الوظيفي، ورعاية المرضى. يرتبط إجهاد الممرضين بشكل رئيسي بالضغوط المتعلقة بالعمل والعوامل التنظيمية مثل عبء العمل، السيطرة على الوظيفة، والعلاقات بين الأفراد. على الرغم من وجود العديد من الدراسات التي تحقق في الإجهاد، إلا أن الفهم الشامل لعوامله وآثاره ما يزال غامضًا. تهدف هذه المراجعة المحدثة إلى تجميع الأبحاث حول العوامل المساهمة وآثار إجهاد الممرضين.

**الهدف:** تستعرض هذه المراجعة العوامل الرئيسية المرتبطة بإجهاد الممرضين، مثل عبء العمل، السيطرة على الوظيفة، المكافأة، والمجتمع، وتستكشف تأثير الإجهاد على أداء الممرضين، نتائج المرضى، وفعالية المنظمة. كما تقوم المراجعة بتقييم صحة نماذج الإجهاد الحالية في بيئات الرعاية الصحية.

**المنهجية:** تم إجراء مراجعة منهجية للأدبيات، مركزة على الدراسات المنشورة منذ عام 2010 التي تناولت الإجهاد بين الممرضين. حددت المراجعة الدراسات التي استخدمت مقاييس مختلفة للإجهاد، بما في ذلك استبيان ماسلاش للإجهاد(MBI) ، وقامت بتصنيف النتائج استنادًا إلى الأبعاد الستة لحياة العمل التي اقترحها ماسلاش (عبء العمل، السيطرة، المكافأة، المجتمع، العدالة، والقيم). تم أيضًا أخذ عوامل أخرى خارج إطار MBI في الاعتبار مثل العمل بنظام الورديات، مستويات التوظيف، والدعم الوظيفي.

**النتائج:** تؤكد النتائج أن عبء العمل، مستويات التوظيف، ونقص السيطرة على الوظيفة هي العوامل الرئيسية المساهمة في الإجهاد بين الممرضين. أظهرت الدراسات بشكل مستمر أن عبء العمل المرتفع ونسب التوظيف المنخفضة تؤدي إلى الإرهاق العاطفي وفقدان الشخصية. بالإضافة إلى ذلك، يزيد نقص السيطرة على الوظيفة، قلة المكافآت، وصراعات القيم من الإجهاد. كما حددت المراجعة الدور الوقائي للدعم الوظيفي، العلاقات الإيجابية في مكان العمل، ومرونة الجدول الزمني.

**الاستنتاج:** يُعدّ إجهاد الممرضين قضية متعددة الأبعاد تتأثر بالعوامل التنظيمية والفردية. لتخفيف الإجهاد، يجب على مديري الرعاية الصحية التركيز على تحسين مستويات التوظيف، تعزيز السيطرة على الوظائف، وتعزيز بيئة عمل داعمة. يمكن أن تقلل التدخلات الشاملة التي تعالج الجوانب الهيكلية والنفسية لعمل الممرضين من الإجهاد وتحسن الرضا الوظيفي، والأداء، ونتائج رعاية المرضى.

**الكلمات المفتاحية:** إجهاد الممرضين، الرعاية الصحية، عبء العمل، التوظيف، السيطرة على الوظيفة، استبيان ماسلاش للإجهاد، الإرهاق العاطفي، فقدان الشخصية.