Occupational Stress and Quality of Worklife among Staff Nurses in a Level 1 Private Hospital in Padada, Davao del Sur

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ABSTRACT

Nurses as the major group of health service providers need to have a satisfactory quality of worklife to give desirable care to the patients. Thus, the purpose of this study is to determine the relationship of occupational stress on the quality of worklife of nurses. In doing so, the study employed the descriptive-correlational design involving all employed nurses of a Level 1 Private Hospital in Padada, Davao del Sur. Mean, Pearson product moment correlation *r* coefficient and multiple linear regression analysis were used as statistical tools. Results revealed that the nurses experienced occupational stress most of the time ($\bar{x}$=2.75). In addition, workload has the highest mean score ($\bar{x}$=3.35) among the sources of occupational stress, while conflict with other nurses was found to have the lowest ($\bar{x}$=2.36). The nurses have a moderate quality of worklife in the overall level ($\bar{x}$=2.83). Among its dimensions, control at work was found to have the highest mean score ($\bar{x}$=3.03) while home-work interface have the lowest mean score ($\bar{x}$=2.49). Correlation analysis revealed that conflict with physicians, lack of support, workload, and uncertainty concerning treatment have significant, negative relationships with quality of worklife. Lastly, workload is the only predictor of the quality of worklife of the nurses.

Keywords: Health, Occupational Stress, Quality of Worklife, Descriptive-Correlation, Davao del Sur

CHAPTER 1

INTRODUCTION

Background of the Study

Nursing has changed significantly in the last years with the promotion of higher standards of care, professionalism, and advanced educational attainment. This development may have resulted in increased stress levels for nurses. Work pressures are seen as part of everyday life for health professionals. With this, responding to stress becomes a mismatch between the perceived demands and the ability of the individual to cope with these demands. Such nature of the nursing profession has a spillover effect towards the quality of worklife of the nurses especially among the private sectors.

According to the World Health Organization (WHO) in 2012, 90% of the world population is affected by stress because we live in a time of great demands to be updated and the constant necessity of dealing with new information. This growing concern is strongly present in the nursing field, which is considered by the Health Education Authority in Canada as the fourth most stressful profession in the public sector.

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In Canada, the health needs of Canadians will continue to change based on current trends. By 2022, Canada will be deficient by almost 60,000 of full-time equivalent nurses. Nurses across the country are reporting increased stress and dissatisfaction with nursing, with job-related stress being one of the principal reasons that nurses change jobs. It has been noted that with increased job stress comes lower job satisfaction and higher turnover intention (Toh, S.G., 2011).

In Brazil, self-rated health among nurses was increasingly used as an indicator in international epidemiological studies as a proxy for the "real" or "objective" state of health, and consistently predicts the individual's mortality and decline in functional health. Various studies

have shown the association between socio-economic condition and the presence of chronic illnesses with self-rated health, that nurses' quality of worklife has been marred by stress sources in their functions. This, then, leads to a lot of consequences such as burnout, absenteeism, loss of commitment to the hospital organization, and ultimately, attrition (Bauer et al., 2010).

It has been manifested in the Philippine context that nurses suffered increased workloads as reported by the day shift nurses. Working day shift was reported to be more physically demanding by nurses as it entailed bathing and lifting of patients. These nurses also reported that there was more administration work during the day shift in comparison to night shift. Other occupational-related concerns raised by the nurses include musculoskeletal pain backache, budget constraints, burnout and increased workload due to staff shortages. This means that nurses' occupational-related injuries and illnesses long work hours affect their well-being in the workplace (De Castro et al., 2010).

Occupational stress has been a long-standing concern of the health care industry. This has confronted every hospital and medical organization for decades. To date, no study has been conducted to assess the occupational stress and quality of worklife among nurses especially in a private setting in Davao del Sur. Thus, this study was conducted. The study aimed to determine the level of occupational stress and the quality of worklife among staff nurses in a Level 1 Private Hospital in Padada, Davao del Sur.

Review of Related Literature

This section includes the review of related literature and studies, which pertains to the relationship between occupational stress and quality of worklife of nurses.

Occupational Stress

Occupational stress is happening in hospitals for being unable to find enough nurses willing to work under current conditions in inpatient settings. A study conducted by Aiken et al. (2010) supports this assertion. The researchers conducted a cross sectional study of seven hundred (700) hospitals across five countries and involved 43,329 nurses from Canada (17,450), England (5,006), Germany (2,681), Scotland (4,721), and the United States (13,471). It was an international collaborative effort and investigators developed a questionnaire dealing with perceptions of nurses with respect to their working environments and quality of nursing care, job satisfaction, career plans, and attitudes regarding job stress.

Results showed that low morale, job dissatisfaction, and intent to leave their twenty (20) employers were common across the five nations. A clear majority of Canadian nurses (63.6%) reported the numberof

Work had an important role in individuals' social lives. It provided the support for a regular income, opportunities and personal growth, social identity and self-esteem. But it can have consequences for the worker's health. Such problem was experienced by most hospitals including the Level 1 Private Hospital in Padada, Davao del Sur. The hospital being studied faces certain difficulty of retaining best nurses due to the stressful nature of work it has. Problems such as just compensation, work relationships, longer hours of shift, and opportunities of greener pasture outside the profession besides the decreasing

patients assigned to them increased in the past year, which is particularly disturbing given the widely reported rise in patient acuity levels in an aging Canadian population. These findings imply that, in addition to having responsibility for more clients, staff nurses may also have to take on more responsibilities for managing services and personnel at the unit level, which takes time away from direct patient care and increases their levels of job stress.

In the study of Al-Makhaita et al. (2014), it was found out that there is a demonstrated high prevalence of work-related stress among the studied nurses in both primary and secondary health care levels. In addition, the results of the study showed that such high level of work-related stress can be significantly seen if analyzed by demographic factors. They further noted that high level of work-related stress can be addressed using appropriate strategy in health care organization to investigate stress management in health care settings. Moreover, interventional programs to identify, and relieve sources and effects of stress should be developed including more training, support, and better work conditions.

Numerous studies have shown that nursing is strenuous work and, hence, occupational stress is prevalent among nurses, impacting their quality of work life. Specifically, occupational stress is a major health problem for both nurses and organizations and can lead to burnout, illness, job turnover, absenteeism, poor morale, and reduced efficiency and performance. Shader et al. (2010) found that occupational stress results in increasing turnover rates and leads to more nurses leaving the nursing profession. Moreover, a high level of occupational stress and burnout has been found to reduce nursing practice quality. The definition of nursing practice quality mirrors the skills and expertise required by health practitioners who work in areas where distance, weather, limited sources, and lack of health human resources influence the character of the lives and professional practice. This development is deemed to be one of the reasons why fewer young people are entering the nursing profession.

Nirmanmoh B. et al. (2011) carried out a hospital based cross sectional study on occupational stress among nurses from two tertiary care hospitals in Delhi. Samples were eighty-seven (87) randomly selected staff nurses. Data was collected using self-administered questionnaire on stressors in daily life and at workstation and socio demographic profile. Results revealed (87.4%) of nurses reported occupational stress. Highly stressful sources were Time Pressure, handling various issues simultaneously such as work situation and responsibilities. High level of skill requirement of the job was the most important stressor directly related to nursing profession. The study concluded as high prevalence of stress found among nurses and suggests that the need for stress reduction programs targeting specific important stressors.

Moustaka, E. (2010) investigated a study to assess sources and effects of Work-related stress in nursing at Thrace, Europe. Method of this study using web sites for reviewing various publications and abstracts around the exact theme stress, occupational stress, and nursing. It results that a number of aspects of working life are link with stress, namely work overload and role-based factors such as lack of power, role ambiguity, and role conflict. Threats to career development and achievement, including threat of redundancy, being undervalued and unclear promotion prospects are stressful. Stress is associated with reduced efficiency, decreased capacity to perform, a particular type of hospital unit, stress arises from the physical, psychological, and social aspects of the work environment. High levels of stress adversely affect patient care.

Death and Dying

In the study of Peters, L. et al. (2013) entitled "How Death Anxiety Impacts Nurses' Caring for Patients at the End of Life: A Review of Literature", attitudes are formed as a result of a favorable or unfavorable evaluation of a person, object, or thing and are expected to change over time and with experience. The fear of death is a universal phobia experienced by humans, with societal preference strongly advocating the preservation of life in many fields, such as in medicine. Individuals have their own attitudes towards death influenced by personal, cultural, social and philosophical belief systems that shape a person's conscious or unconscious behaviors. These attitudes are attached to human emotions, which are in turn attached to actions taken towards the object of the emotions in this case, death. Exposure to the processes accompanying the death of others makes individuals conscious of their own mortality, giving rise to anxiety and unease – although how these issues are related is complex. Thus "death anxiety" may be experienced, which is described as a 'negative emotional reaction provoked by the anticipation of a state in which the self does not exist' accompanied by feelings of fear or dread. It is proposed that one reason for a degree of apprehension may be the "unknowable"- what really happens beyond death. These emotional factors experienced by nurses may influence how a nurse cares for a patient in the terminal stages of the patient's life.

Conflict with Physician

According to Patton, C.M. (2014), direct patient contact to health care employees such as physicians, nurses, and technologists work in complex, stressful environments are prone to conflict. Though some of this conflict may result in positive outcomes, much will have the opposite effect. Dysfunctional conflict has the potential to negatively affect the health care workplace on a variety of levels, including impacting the quality of patient care, employee job satisfaction, and employee wellbeing. Therefore, it would behoove hospital managers to learn to recognize the precursors to conflict in order to prevent any ill effects. The purpose of this literature review is to offer an overview of the antecedents and effects of conflict among health care workers. Both positive and negative effects of conflict are addressed.

In the exhortations of Alhusaini (2010), who reported that in his study of nurses in Saudi Arabia that nurses were found to be dissatisfied with the relationship with their co-workers, especially physicians, where they experienced low levels of respect, appreciation and support. Additionally, they had poor communication and interaction with physicians.

Leever et al. (2010) conducted an explorative qualitative study of the medical staff and nurses on one hospital ward. The authors relay that expectations of "communication, mutual respect, professionalism, climate of collaboration, and quality of care" varied among the participants. Conflict, they discovered, "came about through a lack of compliance between the above-mentioned expectations and reality".

Frederich et al. (2010) discuss a case of value differences resulting in micro-level conflict within a hospice inpatient unit. Physician-nurse conflict arose when a nurse refused to follow a physician-prescribed order to administer a potent sedative to a 47-year-old patient. The physician, the patient and the patient's wife had earlier agreed to initiate controlled sedation to the patient, who was seeking to hasten death. A nurse who worked during the previous shift felt uncomfortable with the order as well because it seemed excessive at that point in the patient's disease progression. Health care workers are able to refuse

patient care assignments when they are "ethically or morally opposed to interventions or procedures in a particular case". The polarity of values on the hospice unit created conflict among the physician, the nurses, the patient, and the patient's family.

Inadequate Preparation

In the study of Kamal, S. (2014) entitled "The effect of nurses' Perceived Job Related Stressors on Job Satisfaction in Taif Governmental Hospitals in Kingdom of Saudi Arabia", aimed to determine the main nurse's perceived job related stressors and its relationship with job satisfaction in Taif governmental hospitals in Kingdom of Saudi Arabia. A descriptive correlational cross sectional study was carried out on a convenience sample of one hundred forty-eight (148) nurses using expanded nursing stress and job satisfaction scales. The results have shown that the least stressful subscale was "Inadequate preparation to deal with emotional needs of patients and their families (Feeling inadequately prepared to help with the emotional needs of a patient's family, being asked a question by a patient for which I do not have a satisfactory answer, Feeling inadequately prepared to help with the emotional needs of a patient)" which clearly suggested that staff nurses were avoiding emotional demands of the patients as evidenced by least mean (N=148, Mean = 2.42) for the inadequate preparation to meet emotional need of the patient). Factor of the intense emotional support that is needed for the patient and family is yet another burden of stress placed on nurse.

Lack of Support

MacKusick, C.I. (2010) conducted a study entitled "Why Are Nurses Leaving? Findings from an Initial Qualitative Study on Nursing Attrition". Most participants felt a lack of support in the workplace at many levels, and these registered nurses were most troubled when the lack of support arose from their peers. This also extended vertically to feelings that management and physicians did not support the registered nurses in clinical practice. Moral distress has been identified as pervasive problems that may lead to job dissatisfaction, nurse burnout, and nursing attrition. Study participants originally believed they could make a valuable contribution through clinical nursing, yet they believed they never could return to nursing practice in that context. All the nurses expressed guilt about not working clinically, but none were willing to return to clinical practice. A lack of support is a primary reason for nurses to leave professional practice. Lack of support and moral distress all have been documented subsequently as associated with job dissatisfaction and nursing attrition The findings from the current study also suggest retention efforts should focus on work environments, including recognizing and then eliminating vertical indifference. The combination of these two elements ultimately led interviewee to leave clinical nursing.

In the findings of Battu et al. (2014), who mentioned that lack of support are one of the major management-related issues that stress the nurses out. This failing relationship with co-workers then becomes a potential source of dissatisfaction and motivation on nurses, thus affecting their worklife, in addition with lack of participation in decisions made by the nurse manager, lack of recognition for their accomplishments, and lack of respect by the upper management.

Conflict with Other Nurses

According to De Dreu et al. (2010), conflict is distinct from other 'dark-side' constructs that exist including aggression, incivility, and bullying. Although these constructs share the fact that parties are interdependent and have opposing interests, values, or beliefs, conflict need not involve intent to harm another party and need not cause negative outcomes. Although it is recognized that conflict does have negative outcomes, particularly if based upon personality disagreements, one of the most important recent contributions of the conflict literature has been to enhance understanding of the conditions under which conflict exerts positive outcomes.

According to the study of Almost, J.M. (2010), results suggest that intragroup relationship conflict is stressful, no matter how it is managed. Relationship conflict produces negative emotional reactions in individuals such as anxiety, mistrust, or resentment, frustration, tension, and fear of being rejected by other team members. As a result, relationship conflict is hard to manage, leaving people with increased pressures and less ability to manage them. Core self evaluation had a negative direct effect on job stress, suggesting that an individual's core self evaluation may be more effective in reducing an individual's stress level than their ability to manage relationship conflict. Individuals who are well adjusted, positive, self-confident, and efficacious with a strong belief in themselves are able to use effective coping mechanisms when managing stressors such as conflict, and subsequently are able to reduce their level of stress.

Intra-group relationship conflict was directly and positively related to job stress. Nurses who reported high levels of intragroup relationship conflict were more stressed in their job, which included being upset by something happening unexpectedly, feeling nervous and stressed, feeling overwhelmed by difficulties at work and not feeling on top of things at work. These results are

consistent with numerous other studies which have found that conflict has been identified as a source of stress within nursing work environments.

Several studies have also found that relationship conflict produces frustration, tension, and job stress. When compared to conflict with patients or doctors, nurses report that conflict with other nurses is the most stressful and leads to increased anxiety, emotional strain and physical strain. Nurses who are highly stressed are more likely to report lower levels of job satisfaction, organizational commitment, and higher intent to leave their job. When individuals are upset with one another, they experience negative emotions, which, in turn, lead to personal frustration and job dissatisfaction.

Workload

In the study of Hui Min Thian, J. et al (2015) entitled "Relationships among Stress, Positive Affectivity, and Work Engagement among Registered Nurses", aimed to identify sources of work stressors among registered nurses and examine the interrelationships among stress, positive affectivity, and work engagement. A descriptive-research design was conducted. A sample of one hundred ninety-five (195) full-time nurses was recruited from a tertiary hospital in Singapore. Data were collected via self-reported questionnaires and then analyzed using descriptive statistics and path analyses. Work stressors experienced by most nurses were workload, time pressure, inadequate reward, inadequate patient interaction, and unmanageable emotional demands of job. Positive affectivity had a significant negative relationship with stress in the past month but had a significant positive relationship with three components of work engagement. Worksite interventions may be developed to help nurses manage stress. Findings suggested that the most frequently-reported stressor for nurses was work overload. This may be because nurses working in general wards in Singapore provide direct care to patients with diverse health conditions, prepare patients for various investigation and treatment procedures, deal with patients' and families' emotional problems, complete abundant paperwork, among others.

Workload has been demonstrated to be one of the most frequent stressors. In a study of one hundred two (102) nurses in a Chinese intensive care unit, excessive workload was the most frequently cited source of workplace stress. This was a result of the nursing shortage with fewer nurses to care for more patients. Workload, shift work, overtime, and covering for absent colleagues were the most common identified stressors in other studies. It was investigated and perceived occupational stress and related factors among public health nurses, and reported that personal responsibility and workloads were the major sources of occupational stress. Excessive workload was also included as a major contributor to stress among hospital based Brazilian nurses. Heavy workload may be due to the physically arduous work of nursing jobs, as well as due to organizational pressures when there is a nursing shortage. Lack of confidence and competence in the nursing role can have a synergistic relationship with workload, creating high stress scores (Li, J., 2010).

In the pronouncements of Chen et al. (2010), who reported in their study that about 81.2% of the nurses believed that they had high workload. They added that shortage in human resources and increase of nurses' workload act as pressure factors among nurses, which lead to professional and organizational desertion.

Uncertainty Concerning Treatment

The study of Mohite, N. et al. (2014) entitled "Occupational Stress among Nurses Working at Selected Tertiary Care Hospitals" assessed occupational stress among nurses working at tertiary care hospital. Job related stress increasingly large disorder among nurses stress has a cost for individual in term of health, wellbeing and for organization in term of absenteeism and turnover which indirectly affect quality of patient care. The study was conducted on one hundred (100) staff nurses. Modified expanded nurses stress scale was used and requires 15-30 minutes to salve for each questionnaire. Majority (49%) of nurses had reported frequent occurrence of stress, due to uncertainty of concerning treatment. Whereas maximum (48%) of nurses had reported frequent occurrence of stress, due to dealing with patient. Nurses have to face frequent occurrence of stress which could have negative impact on organizational climate in the future. Out of all considered causes of stress, uncertainty of concerning treatment factor is the responsible for frequent occurrence of stress among majority of nurses. Special measures to address the source of stress to improve their performance and hence will positively affect on quality of care given to the patients.

Quality of Worklife

Bhuvaneswari et al. (2013) in their article examined the Quality of worklife among employees in Neyveli Lignite Corporation Limited, Tamilnadu. The findings revealed that majority of the respondents are satisfied with their job, nature of job, salary, co-operation with colleagues, training and development, freedom to work, rewards & recognitions, social & cultural programs, health, safety & welfare measure and quality of worklife. It was also found out that all the employee benefits and other facilities show above neutral on satisfaction.

Nayeri et al. (2011), who found out in a study involving 360 clinical nurses working in the hospitals of Tehran University of Medical Sciences that quality of worklife is at a moderate level among 61.4% of the participants, and that only 3.6% of the nurses reported that they were satisfied with their works. None of those who reported the productivity as low reported their work life quality to be desirable. They have suggested, considering the results, that managers should adopt appropriate policies to promote the quality of worklife and productivity.

Chib, S. (2012), conducted a study on quality of worklife and organizational performance at work place of a private manufacturing unit, Nagpur, India through a structured questionnaire containing thirty one (31) items related to six (6) variables, organizational performance, job satisfaction, quality of worklife, wage policy, company policy and union policy. The researcher has formulated two models, one is organization performance depends on quality of worklife, job satisfaction, wage policy, company policy and union participation and the other one is quality of worklife which depends on organization performance., job satisfaction, wage policy, company policy and union participation. The collected data were analyzed using simple percentage, regression and correlation analysis. The study revealed that both the models stand true and quality of worklife had significant relationship with organizational performance.

Job and Career Satisfaction

In the study of Chinomona, R. (2010) entitled "The Influence of Quality of Work Life on Employee Job Satisfaction, Job Commitment and Tenure Intention in the Small and Medium Enterprise Sector", employee job satisfaction and job commitment are essential in implementing higher performance work systems that contribute to a company's financial performance. However, financial performance cannot be sustained unless the non-financial underpinnings of employee job satisfaction, job commitment and hence productivity is improved. In this study, it is expected that when employees derive economic or socio-psychological satisfaction from their job, they will not contemplate leaving the company, but rather they will be motivated to stay longer. Economic satisfaction occurs for instance, when the employees are content with the reward system.

Hosseini, S. M. (2010) argues that career satisfaction, career achievement and career balance are not only the significant variables to achieve good quality of worklife but quality of worklife or the quality of work system as one of the most interesting methods creating motivation and is a major way to have job enrichment which has its roots in staff and managers' attitude to motivation category that is more attention to fair pay, growth opportunities and continuing promotion improves staff's performance which in turn increases quality of worklife of employees.

Ganguly, R. et al. (2010), the researcher aimed at the study of nature of the perceived quality of worklife of the university employees, the nature of their job satisfaction, the nature of association between quality of worklife and job satisfaction. The results indicate that the selected group of university employees perceived different aspects of their quality of worklife as either uncongenial viz. Autonomy, top management support and worker's control mainly or they have had a certain amount of dilemma to comment on a few other aspects such as personal growth opportunities and work complexity mainly bearing the potential involving a slight trend of negative opinion.

According to the study of Rubel, M.R.B. (2014) entitled "Quality of Worklife and Employee Performance: Antecedent and Outcome of Job Satisfaction in Partial Least Square", employees are the main drivers of the success of the perceived supervisory support is also found to organization. Organization having a satisfied workforce generates employee satisfaction and productivity can achieve and sustain the gaining position in the organization. The most interesting finding of this competitive market through exploring the performance of study is that employees of developing country like their employees. The result of the study indicated that supervisor behavior, compensation and benefits and work life balance all have positive significant influence on job satisfaction where compensation and benefits has the highest impact. On the contrary, job character is found having insignificant effect on job satisfaction. Last, job satisfaction was found positively and significantly related with employee in-role performance.

General Well - Being

Given the time and energy people spend at work, it is important that work be a place where people are generally satisfied and happy. Additionally, work affects not only the employee's physical but also the general well-being and general quality of worklife. Thus, employers and occupational health experts need to understand the components that comprise a healthy work experience (Requena, 2010).

Worrall & Cooper (2010) found in their recent survey showed that a lower level of well-being at work place was not good for organization. It leads to overall production loss and it increases in the long run.

Control at Work

In the study of Michie, S et al. (2010) entitled "Reducing Work Related Psychological ill Health and Sickness Absence: A Systematic Literature Review", it has revealed the following: key work factors associated with psychological ill health and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; lack of control over work; lack of participation in decision making; poor social support; and unclear management and work role. There was some evidence that sickness absence was associated with poor management style. Successful interventions that improved psychological health and levels of sickness absence used training and organizational approaches to increase participation in decision making and problem solving, increase support and feedback, and improve communication. It is concluded that many of the work related variables associated with high levels of psychological ill health are potentially amenable to change. This is shown in intervention studies that have successfully improved psychological health and reduced sickness absence. Of the two studies addressing sickness absence, one found a negative association with job demands, while the other found no association with control over work. Among other hospital workers, work overload and pressure, role ambiguity, lack of control over work, and lack of participation in decision making were all found to be associated with distress.

In the findings of Manzo et al. (2012), who verbalized that a certain degree of nurses' work dynamics partially explains the high percentage for the low freedom reported; that is, tasks are planned throughout the work shift, however, sometimes it is impossible to perform them due to the several interruptions (emergency situations, lack of staff, among others), causing nurses to feel powerless and consider having low control over work. A moderate quality of worklife as manifested in the dimension of control at work is means that the nurses feel somewhat comfortable making some decisions during the execution of tasks at the hospital. In this case, answers would be linked to the conception of control over the tasks performance, which can be understood or valued regardless of a broader definition of the work process (power relationships within the institution).

Home-Work Interface

According to the study of Vijaimadhavan, P. et al. (2013) entitled "An Empirical Study on Relationship among Quality of Worklife and its Factors" results revealed that work family interference is positively correlated to Family work interference (.642, p=.000) specific job purpose (.205, p=.000), motivation (.156,p=.0000) self efficacy (.139, p=.000) Interpersonal communication, (.111, p=.000) efforts by employer (.96, p=.000) at 5% level. This shows that the work/family interference and family/work interference are highly influential for women professionals. While other factors show very low but positive relationship. The findings were also supported by previous studies on work/family & family/work interference which shows that the strongest positive association of work home interference was with job demands.

Working Conditions

In the study of Rethinam, G. S. et al. (2010) entitled "Work Condition and Predictors of Quality of Worklife of Information System Personnel", the physical work condition was derived based on the interaction between the means of job demand and job control. Four types of physical work condition, namely, passive (low demand, low control), active (high demand, high control), low strain (low demand, high control) and high strain (high demand and low control) are described in the model. Whereby the physiological work conditions, namely, learning and stress are derived based on the consequences of the level of demand and control in work.

The contemporary Information and Communications Technology (ICT) work environment in Malaysia provides more meaningful work to the Information System (IS) personnel compared to the advanced countries. This is indicative of a positive physiological work condition that applies the principles and practices of the concept of Quality of Worklife. It enables the Information System (IS) personnel in Malaysia to experience good Quality of Worklife. The constant review of the changes in the work condition factors due to the advancement in Information and Communications Technology (ICT) would enable the maintenance and enhancement of the existing level of Quality of Worklife. It is essential for the human resource practitioners to be alert to the changes of work environment in relation to Quality of Worklife. It is concluded that Information System (IS) personnel are enjoying their profession as they have substantial control and support in their job although the nature of their job is demanding. The selected work condition factors show that to some extent they have influence on Quality of Worklife. Organizational support, job control and job demand are the significant predictors of Quality of Worklife. Therefore, if these components of work environment are ignored by the management, there would have substantial impact on the Quality of Worklife of Information System (IS) personnel.

Occupational Stress and Quality of Worklife

According to the study of Nowrouzi, B. (2013) entitled "Quality of Worklife: Investigation of Occupational Stressors among Obstetric Nurses in Northeastern Ontario", the results suggest that place may be an important influence on the stress and quality of worklife of obstetrical nurses. Importantly, the nurses in Sudbury, the largest city with the largest participating hospital in the study were cross-trained in their practice of obstetrics. The nurses in the other three locations were not cross-trained. Given this circumstance, location of cross-training as a possible factor in decreasing stress and enhancing quality of work life warrants further investigation. Hospital size, size of the community, continuing education opportunities, organizational structure and leadership, are some additional factors meriting investigation for their possible impact on quality of worklife and stress among nurses.

The study also contributes to understanding of work ability in relation to the occupational health of obstetrical nurses. In order to be high functioning, workplaces need to maximize the employees' actual and potential skills and ameliorate and working conditions. In northern Ontario, positive work settings are important to the recruitment and retention of nurses, and therefore, further study of occupational stress among nurses working in this geographic area.

In this study, total stress scores were not statistically significant in determining a high Quality of Worklife among the nurses at the four hospital locations. Higher reported stress levels have been identified as a factor of nurses likely to plan to leave their nursing positions within twelve (12) months in rural and remote practice settings in Canada. An employee's intention to leave eighty-eight (88) is also related to their job satisfaction. A dissatisfied workforce performing below his or her full potential is a considerable cause for concern, particularly at a time when government, employers and educators are promoting continuous learning as a way of building a cohesive, healthy, and knowledgeable workforce. Nevertheless, the negative implications of cross-training may be mitigated through skillful management, increased social supports in the workplace and through bolstering career and educational opportunities.

Theoretical Framework

This study was anchored to the Systemic Stress: Selye's Theory of General Adaptation Syndrome (GAS). According to Hans Selye (2013), stress results when the body's normal homeostatic mechanisms fail to provide the body with sufficient means to adapt the demands made on it. It proceeds in three stages: (a) The alarm reaction comprises an initial shock phase and a subsequent counter shock phase. The shock phase exhibits autonomic excitability, an increased adrenaline discharge, and gastro-intestinal ulcerations. The counter shock phase marks the initial operation of defensive processes and is characterized by increased adrenocortical activity; (b) If noxious stimulation continues, the organism enters the stage of resistance. In this stage, the symptoms of the alarm reaction disappear, which seemingly indicates the organism's adaptation to the stressor. However, while resistance to the noxious stimulation increases, resistance to other kinds of stressors decreases at the same time; and (c) If the aversive stimulation persists, resistance gives way to the stage of exhaustion. The organism's capability of adapting to the stressor is exhausted, the symptoms of stage (a) reappear, but resistance is no longer possible. Irreversible tissue damages appear, and, if the stimulation persists, the organism dies.

Selye pointed out that stimuli may or may not cause stress, depending upon what he termed sensitization. Certain bodily conditions such as illness, fatigue, anxiety or certain glandular states may make the body more likely than the usual to react stressfully to stimuli.

The theory of Hans Selye supported the study. Stress affects an individual as if stressor continues beyond body's capacity, person exhausts resources and becomes susceptible to an illness. It also affects the individual's activity in which the person cannot perform the tasks effectively and efficiently.

Furthermore, this study also anchored to Betty Neuman's Systems Model in which it provided a comprehensive holistic and system-based approach to nursing that contains an element of flexibility. The theory focused on the response of the patient system to actual or potential environmental stressors and the use of primary, secondary, and tertiary nursing prevention intervention for retention, attainment, and maintenance of patient system wellness. The Neuman systems model was a nursing theory based on the individual's relationship to stress, the reaction to it, and reconstitution factors that were dynamic in nature. According to Neuman's Theory, the central core of the model consists of energy resources (normal temperature range, genetic structure, response pattern, organ strength or weakness, ego structure, and known or commonalities) that are surrounded by several lines of resistance, the normal line of defense, and the flexible line of defense. The lines of resistance represent the internal factors that help the patient defend against a stressor, the normal line of defense represents the person's state of equilibrium, and the flexible line of defense depicts the dynamic nature that can rapidly alter over a short period of time.

The theory of Neuman supported the study in which, stressors like the environment described as environmental forces that interact with and potentially alter system stability. If the person affected by these stressors, the body function is also affected. The person cannot function well and may result to problems with regards to work.

This research is also anchored to the Job Demand-Control-Support (JDCS) of Karasek (1979), which was an expansion of the Job Demand-Control model framework used to define the concepts of stress and quality of worklife in the nursing work environment. The framework has dominated research on occupational stress. According to the model, the highest strain occurs in a work environment when demands are high, control is low, and social support is low. Social support at work, was later added to the model; as a result, the demand-control support model was defined. This revised model postulates that the highest risk of illness is expected in employers with high demand, low control, and low social support in the workplace. This additional component of the model emphasizes the psychological and social factors people experience in the work environment were underpinned in social and interpersonal relations among participants in the work setting.

In addition, the study also hinged on the Quality of Worklife (QWL) Model espoused by Van Laar, Edwards and Easton (2007). Accordingly, Quality of Worklife (QWL) was defined as the way in which work was good for an individual in the broadest context and in the way an employee would evaluate their job. Its distinguishing elements were a concern about the impact of work on people as well as on organizational effectiveness and the idea of participation in organizational problem solving and decision making. Quality of Worklife (QWL) not only affects job satisfaction but also satisfaction in other life domains. Furthermore, the association between work and non-work life domains and work-related stress were factors that should conceptually included in Quality of Worklife (QWL).

The above theories provided a basis for determining the intention of this research. It is the intention of this study to determine whether the occupational stress would significantly affect the quality of worklife of nurses. This study therefore adopted the four theories as bases in testing the relationship and influence of occupational stress among staff nurses and their quality of worklife.

Conceptual Framework

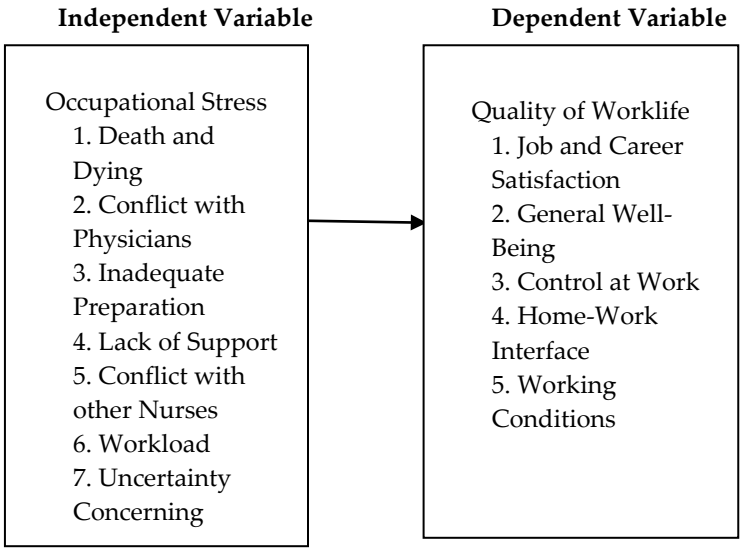

Figure 1. Research Paradigm

Figure 1 illustrates the conceptualized framework of the study, which contains the independent and dependent variables of the study. The conceptualized paradigm examines the relationship and influence of occupational stress with its sources (death and dying, conflict with physicians, inadequate preparation, lack of support, conflict with other nurses, workload, uncertainty concerning treatment) with quality of worklife with its indicators (job and career satisfaction, general well-being, control at work, home-work interface, working conditions). The arrow pointing from the first box to the second box is the hypothesized relationships that the study sought to test.

Statement of the Problem

The study aimed to determine the level of occupational stress and the quality of worklife among staff nurses in a Level 1 Private Hospital in Padada, Davao del Sur.

Specifically, the study sought to answer the following questions:

1. What is the level of occupational stress experienced by the respondents in the following sources:
   - 1.1 Death and Dying;
   - 1.2 Conflict with Physicians;
   - 1.3 Inadequate Preparation;
   - 1.4 Lack of Support;
   - 1.5 Conflict with other Nurses;
   - 1.6 Workload; and
   - 1.7 Uncertainty Concerning Treatment?
2. What is the quality of work life of the respondents in terms of:

2.1 Job and Career Satisfaction;
2.2 General Well-Being;
2.3 Control at Work;
2.4 Home-Work Interface; and
2.5 Working Conditions?

3. Is there a significant relationship between occupational stress and quality of work life?

4. Which among the sources of occupational stress significantly affect the quality of worklife?

Hypotheses

The study was guided by the following null hypotheses tested at 0.05 level of significance:

Ho1: There is no significant relationship between occupational stress and quality of worklife.

Ho2: None of the sources of occupational stress significantly affect quality of worklife.

Definition of Terms

The following terms were operationally defined in this study for uniformity and better understanding:

Conflict with Other Nurses. This refers to the source of stress experienced by the respondents such as conflict with nurse supervisor, floating to other units that are short-staffed and difficulty in working with a particular nurse or nurses inside and outside the unit.

Conflict with Physicians. This refers to the source of stress experienced by the respondents such as criticism and conflict with physician, fear of making mistakes in treating a patient, disagreement concerning the treatment of patient and making a decision concerning a patient when the physician is unavailable.

Control at Work. This refers to the quality of worklife by the respondents such as being able to voice opinions and influence changes in any of work, being involved in decisions that affect members of the public in own area of work and being involved in decisions that affect in own area of work.

Death and Dying. This refers to the source of stress experienced by the respondents when taking care of a dying patient and during patient's death.

General Well-Being. This refers to the quality of worklife by the respondents such as life is close to ideal, feel well at the moment, that things work out well, is satisfied with life and feel reasonably happy all things considered.

Home-Work Interface. This refers to the quality of worklife by the respondents such as the employer provides adequate facilities and flexibility to fit work in around family life, the current working hours/patterns suit personal circumstances and having a line manager who actively promotes flexible working hours/patterns.

Inadequate Preparation. This refers to the source of stress experienced by the respondents when they are inadequately prepared to help with the emotional needs of the patient's family and when they are being asked by a patient to which, they do not have a satisfactory answer.

Job and Career Satisfaction. This refers to the quality of worklife by the respondents such as having a clear set of goals and aims to enable one to do the job, encouraged to develop new skills, when done a good job it is acknowledged by line manager, satisfied with the training received in order to perform present job and have the opportunity to use own abilities at work.

Lack of Support. This refers to the source of stress experienced by the respondents such as lack of opportunity to openly talk, share experiences and feelings with other unit personnel about the problems on the unit including patients.

Occupational Stress. This refers to sources of stress which includes death and dying, conflict with physicians, inadequate preparation, lack of support, conflict with other nurses, work load, and uncertainty concerning treatment causing stress for nurses in the workplace and examine stress in psychological, physical and social work environments. This will be measured using the Nursing Stress Scale (NSS).

Quality of Worklife. This refers to the factors such as job and career satisfaction, general well-being, control at work, home-work interface and working conditions. This will be measured using the Work Related Quality of Life Scale (WRQLS).

Uncertainty Concerning Treatment. This refers to the source of stress experienced by the respondents when they received inadequate information from physician regarding the medical condition of a patient, when the physician's order appears to be inappropriate as a treatment to the patient, when the physician is not present during the medical emergency situation, does not know what a patient or a patient's family need to know about the patient's medical condition and its treatment, and the uncertainty regarding the operation and functioning of specialized equipment.

Working Conditions. This refers to the quality of worklife by the respondents such as working in a safe environment, the employer provides with the needs to do the job effectively and that the working conditions are satisfactory.

Workload. This refers to the source of stress experienced by the respondents such as too many tasks required for clerical works, unpredictable staffing and scheduling, breakdown of computer, not enough time to

complete all nursing tasks and not enough staff to adequately cover the unit.

Significance of the Study

This research endeavored to benefit the following sectors and stakeholders:

Hospital Management. Through this study, the management of the Hospital will be provided with information and basis in determining the extent of occupational stress and the status of quality of worklife of the nurses. The study can be a further basis of the management to review the possible sources of occupational stress of its nurses and develop intervention programs to address the problems specified.

Nurses. The study would benefit the nurses because it may help in improving the hospital's environment considering that a stress-free environment will result to a better quality of worklife among staff nurses. They will also primarily benefit in the intervention program(s) to be implemented by the hospital's management, if any.

Hospital Nursing Service Administration. The study can be a practical basis for the nursing service administrators to improve the quality of worklife of the nurses by identifying the most influential occupational stressors in the studied hospital.

Future Researchers. For the future researchers, the study would serve as an underpinning scholarly work as well as a basis to glean causal or predictive relationship of factors aside from occupational stress towards quality of worklife. The research can also be an additional reference of the researchers in their current researches.

CHAPTER 2

METHODOLOGY

This chapter presents the research design, participants, instruments, data gathering procedure, ethical considerations, data analysis and scope and limitations that were employed in the study.

Research Design

This study employed the descriptive - correlational research design. In a descriptive research, phenomena being studied were being described and consider one variable at a time, and typically describe what appears to be happening and what the important variables seem to be (Gay and Ary, 1992). Meanwhile, correlational research investigates the nature of the relationship between two or more variables and the theoretical model that might be developed and tested to explain these resultant correlations. In addition, the purpose of correlational research is to determine the relations among two or more variables (Creswell, 2002).

Applying this to the study, it was descriptive because it described the extent of occupational stress and quality of worklife among nurses in a Level 1 Private Hospital in Padada, Davao del Sur and it was correlational because it established the relationship between the two variables under study.

Setting

The study was conducted in a Level 1 Private Hospital located in Padada, Davao del Sur. The hospital started its operation last December 1, 2012. It has an approved bed capacity of 36 beds but can accommodate up to 50 patients in certain occasions. It provided hospital services such as admissions, out-patient consultations, X-rays, ultrasounds, laboratories, operations and maternal delivery. It has specialists in Pediatrics, Internal Medicine, Cardiology, OB-GYNE, Surgery, Orthopedics, Anesthesiology, Dermatology, Dental and Ophthalmology. There are two nursing stations in the hospital namely, Nurse Station 1 (NS1) and Nurse Station 2 (NS2). The Nurse Station 1 covers seven (7) private rooms, one (1) semi – private room, one (1) obstetrical ward and one (1) pediatric ward. The Nurse Station 2 covers one (1) male ward, one (1) female ward, one (1) surgical ward and two (2) isolation rooms.

The hospital has functional Emergency Room, Operating Room, Delivery Room and Neonatal Intensive Monitoring Care Unit. The Emergency Room has minor surgery room, internal examination room and with four beds. The Operating Room caters minor and major operations. The Delivery Room caters normal delivery and obstetrical and gynecological minor operations.

Shown in Figure 1 is the map that marked the location of the hospital in Padada, Davao del Sur.

Figure 2. Map Showing the Locale of the Study

Participants

Primary data were gathered through the use of adopted and modified survey questionnaires which were distributed to the thirty-nine (39) staff nurses currently employed in the said Level 1 Private Hospital in Padada, Davao del Sur at the time the study was conducted. Universal sampling via complete enumeration was utilized. However, as part of the ethical considerations of the research, those staff nurses who refused to participate in the survey were excluded.

Measures

Primary data were gathered using the adopted and modified survey-type questionnaires. There were two types of questionnaires.

The first adopted questionnaire was the Nursing Stress Scale (NSS) by Gray-Toft and Anderson (1989). This was the most widely used measurement of stress for nurses. This scale contained thirty four (34) items and designed to describe situations that have been identified as causing stress for nurses in the performance of their duties. Seven major sources of stress closely related to the conceptual categories of stress include: death and dying, conflict with physicians, inadequate preparation, lack of support, conflict with other nurses, workload, and uncertainty concerning treatment. The scale utilized a four-point Likert scale as follows: 1- Never (This means that the stressor has not been experienced); 2 – Occasionally (This means that the stressor has been experienced occasionally); 3 – Frequently (This means that the stressor has been experienced frequently); and 4 – Very Frequently (This means that the stressor has been experienced very frequently).

As to the overall mean, the following scale was utilized: 1.00 - 1.75 Never (Low); 1.76 - 2.50 Occasionally (Moderate); 2.51 - 3.25 Frequently (High); and 3.26 - 4.00 Very Frequently (Very High).

The second instrument tool was the modified version of the Work Related Quality of Life Scale (WRQLS) by Van Laar (2007). From twenty four (24) items, it was reduced to twenty (20) items which undergone pre-test. The overall result of Cronbach's Alpha was 0.887 and all items were above 0.8, ranging from 0.873 to 0.902. Furthermore, the measure provided greater relevance to healthcare workplace than any previous measure of WRQLS. A psychometric analysis of the QWL found five factors underpinning people's quality of worklife including job and career satisfaction, general well-being, control at work, home-work interface and working conditions. Individual item responses were added together to obtain a total score. The scale utilized a five-point likert scale which as follows: 1 – Strongly Disagree (This means very low quality of worklife); 2 – Disagree (This means low quality of worklife); 3 – Neutral (This means moderate quality of worklife); 4 – Agree (This means high quality of worklife); and 5 – Strongly Agree (This means very high quality of worklife).

As to the overall mean, the following scale was utilized: 1.00 - 1.80 Strongly Disagree (Very Low); 1.81 - 2.60 Disagree (Low); 2.61 - 3.40 Neutral (Moderate); 3.41 - 4.20 Agree (High); and 4.21 - 5.00 Strongly Agree (Very High).

Procedures

In order to have systematic and organized collection of data, the researcher formulated a logical course of action, which was followed to achieve efficient data gathering process.

1. The researcher asked permission in writing from the Medical Director of the Level 1 Private Hospital in order to conduct the research.

2. Permission letters were sent through e-mail to the authors of the questionnaires that were adopted.

3. A letter of request asking permission to conduct survey was given to the nurses who voluntarily agreed to participate in the study at their free time.

4. The second instrument undergone reliability test.

5. Upon the approval of the request, the researcher made arrangements with the hospital in the conduct of the survey.

6. Informed consents were secured from the respondents.

7. A maximum of one week was set by the researcher to fully disseminate and retrieve the questionnaires handed to the nurses.

8. After gathering and collating all the answered questionnaires, responses were collated, analyzed using statistical tools and interpreted.

9. Data were analyzed using Statistical Products and Service Solutions Version 16 (SPSS 16.0). Significant findings from the analysis were summarized with which conclusions and recommendations were drawn.

Ethical Considerations

Ethical consideration was ensured and followed by the researcher through securing permission from the College of Medical Entrepreneurship of Davao Doctors College in the conduct of the study.

Participation in the study was voluntary and was based on the staff nurses ability to give informed consent. Before giving the informed consent, the researcher explained the purpose of the study and was mentioned expressly to the respondents that their responses were treated confidentially and anonymously, and that their participation was voluntary. The respondents were informed that it would be impossible to identify individual answers because no names will be reflected in the questionnaires.

After which, all data and information gathered were kept strictly confidential and will not be accessed by any other party without prior permission from the respondents.

In addition, the researcher asked permission from the authors of the questionnaires that were adopted.

Statistical Tools

This research employed the following statistical tools in order to analyze the data:

Mean. This was used to determine the level of the occupational stress and quality of worklife of the respondents.

Pearson product moment correlation coefficient. This was used to determine the extent and significance of the relationship between occupational stress and quality of worklife.

Linear regression analysis. This was used to determine the degree of influence of occupational stress towards quality of worklife.

Scope and Limitations of the Study

This study aimed to determine the relationship between occupational stress and quality of worklife of nurses in a Level 1 Private Hospital in Padada, Davao del Sur. The influence of occupational stress towards quality of worklife was also investigated.

Moreover, the respondents of the study were the thirty-nine (39) staff nurses currently employed in the hospital.

The study utilized universal sampling via complete enumeration and descriptive-correlational research design, which sought to determine the relationship between the two variables under study. The study also utilized the two (2) adopted survey-type questionnaires – the Nursing Stress Scale (NSS) and the modified adopted survey-type questionnaire on the Work Related Quality of Life Scale (WRQLS).

The research setting was the Level 1 Private Hospital in Padada, Davao del Sur. The study was conducted from September 01, 2015 to December 31, 2015.

CHAPTER 3

RESULTS AND DISCUSSION

This chapter presents, analyzes, and interprets the data based on the problems identified in the study.

1. What is the level of occupational stress experienced by the respondents in the following sources:
1.1 Death and Dying;
1.2 Conflict with Physicians;
1.3 Inadequate Preparation;
1.4 Lack of Support;
1.5 Conflict with other Nurses;
1.6 Workload; and
1.7 Uncertainty Concerning Treatment?

Table 1. Level of Occupational Stress Experienced by the Respondents

Items	Mean	Description	Level of Stress
Death and Dying	2.46	Occasionally	Moderate
Conflict with Physicians	2.62	Frequently	High
Inadequate Preparation	2.62	Frequently	High
Lack of Support	2.90	Frequently	High
Conflict with other Nurses	2.36	Occasionally	Moderate
Workload	3.35	Very Frequently	Very High
Uncertainty Concerning Treatment	2.66	Frequently	High
Overall Mean	**2.75**	**Frequently**	**High**

Legend: 1.00 -1.75 Never (Low); 1.76 - 2.50 Occasionally (Moderate); 2.51 – 3.25 Frequently (High); 3.26 – 4. 00 Very Frequently (Very High)

Table 1 summarized the responses of nurses of a Level 1 Private Hospital in Padada, Davao del Sur relative to their experienced sources of occupational stress, which include death and dying, conflict with physicians, inadequate preparation, lack of support, conflict with other nurses, workload, and uncertainty concerning treatment.

The overall mean was found to be 2.75, which is described as frequently. This means that the nurses of a Level 1 Private Hospital experienced occupational stress most of the time. This further implies that the nurses experienced a high level of occupational stress. Such finding is similar to the study of Al-Makhaita et al. (2014), that there was indeed a demonstrated high prevalence of work-related stress among the studied respondents (nurses) in both primary and secondary health care levels. In addition, they found out that such high level of work-related stress can be significantly seen if analyzed by demographic factors. They further noted that high level of work-related stress can be addressed using appropriate strategy in health care organization to investigate stress management in health care settings. Moreover, interventional programs to identify, and relieve sources and effects of stress should be developed including more training, support, and better work conditions.

Furthermore, it can be gleaned in the table that the source of occupational stress with the highest mean score is workload, having an overall mean of 3.35, which is described as "very frequently". This means that the nurses from the Level 1 Private Hospital are collectively experiencing stress when it comes to having strenuous workloads most of the time, if not always. This further implies that the nurses have very high exposure to stress when it comes to unpredictable staffing and scheduling, too many non-nursing tasks required, lack of provision of emotional support to patients, and lack of personnel to adequately cover the area. The results of the study are comparable with the findings of Li (2010), who averred that workload has been demonstrated to be one of the most frequent stressors. In a study of one hundred two (102) nurses in a Chinese intensive care unit, excessive workload was the most frequently cited source of workplace stress. This was a result of the nursing shortage with fewer nurses to care for more patients. Work load, shift work, overtime, and covering for absent colleagues were the most common identified stressors in other studies. It was investigated and perceived occupational stress and related factors among public health nurses, and reported that personal responsibility and workloads were the major sources of occupational stress.

On the other hand, conflict with other nurses was found to have the lowest mean score among the sources of occupational stress having an overall mean of 2.36, which is described as "occasionally". This means that the nurses from the Level 1 Private Hospital are collectively experiencing stress when it comes to experiences of having conflict with other nurses at an occasional rate. This further implies that the nurses have somewhat moderate exposure to stress when it comes to having conflict with other nurses, their supervisor(s), taking in criticisms and dealing with attitude problems of other nurses. The results of the study is comparable with the findings of Almost (2010), whose results suggest that intra-group relationship conflict is stressful, no matter how it is managed. Relationship conflict produces negative emotional reactions in individuals such as anxiety, mistrust, or resentment, frustration, tension, and fear of being rejected by other team members. As a result, relationship conflict is hard to manage, leaving people with increased pressure and less ability to manage them. Nurses who reported high levels of intra-group conflict relationship were more stressed in their job, which included being upset by something happening unexpectedly, feeling nervous and stressed, feeling overwhelmed by difficulties at work and not feeling on top of things at work. Nurses who are highly stressed are more likely to report lower levels of job satisfaction, organizational commitment, and higher intent to leave their job.

2. What is the quality of work life of the respondents in terms of:

2.1 Job and Career Satisfaction;
2.2 General Well-Being;
2.3 Control at Work;
2.4 Home-Work Interface; and
2.5 Working Conditions?

Table 2. Quality of Worklife of the Respondents

Items	Mean	Description
Job and Career Satisfaction	3.02	Moderate
General Wellbeing	2.84	Moderate
Control at Work	3.03	Moderate
Home-Work Interface	2.49	Low
Working Conditions	2.64	Moderate
Overall Mean	**2.83**	**Moderate**

Legend: 1.00 – 1.80 Strongly Disagree (Very Low); 1.81 – 2.60 Disagree (Low); 2.61 – 3.40 Neutral (Moderate); 3.41 – 4.20 Agree (High); 4.21 – 5.00 Strongly Agree (Very High)

Table 2 summarized the responses of nurses of a Level 1 Private Hospital in Padada, Davao del Sur relative

to their quality of worklife, which are assessed in the areas of job and career satisfaction, general wellbeing, control at work, home-work interface and working conditions.

The overall mean was found to be 2.83, which is described as moderate. This means that the overall quality of worklife experienced by the nurses in a Level 1 Private Hospital is in the middle of extremes, which implies that the parameters are on the average: not that high but not too low. This is in conformity with the findings of Nayeri et al. (2011), who found out in a study involving 360 clinical nurses working in the hospitals of Tehran University of Medical Sciences that quality of worklife is at a moderate level among 61.4% of the participants, and that only 3.6% of the nurses reported that they were satisfied with their works. None of those who reported the productivity as low reported their work life quality to be desirable. They have suggested, considering the results, that managers should adopt appropriate policies to promote the quality of worklife and productivity.

Looking at the table, control at work was found to have the highest mean among the indicators of quality of worklife, having an overall mean of 3.03, which is described as "moderate". This means that the nurses from the Level 1 Private Hospital are collectively experiencing a moderate quality of worklife, implying that the nurses feel able to voice opinions and influence changes in any area of work, involved in decisions that affect members of the public in my own area of work and involved in decisions that affect in own area of work. This is similar to the findings of Manzo et al. (2012), who verbalized that a certain degree of nurses' work dynamics partially explains the high percentage for the low freedom reported; that is, tasks are planned throughout the work shift, however, sometimes it is impossible to perform them due to the several interruptions (emergency situations, lack of staff, among others), causing nurses to feel powerless and consider having low control over work. A moderate quality of worklife as manifested in the dimension of control at work means that the nurses feel somewhat comfortable making some decisions during the execution of tasks at the hospital. In this case, answers would be linked to the conception of control over the tasks performance, which can be understood or valued regardless of a broader definition of the work process (power relationships within the institution).

On the other hand, the indicator of quality of worklife with the lowest mean scores is home-work interface, having an overall mean of 2.49, which is interpreted as "low". This means that the nurses from the Level 1 Private Hospital are collectively experiencing low quality of worklife, implying that the employer of nurses provides adequate facilities and flexibility to fit work in around family life, the current working hours/patterns suit personal circumstances and having a line manager who actively promotes flexible working hours/patterns.

The results of the study are somewhat contradictory to the findings of Vijaimadhavan et al. (2013), whose study revealed that work family interference is positively correlated to family work interference, specific job purpose, motivation, self efficacy, interpersonal communication and efforts by employer. The findings in the study showed that the work/family interference and family/work interference are highly influential.

3. Is there a significant relationship between occupational stress and quality of worklife?

Table 3. Correlation between the Sources of Occupational Stress and Quality of Worklife of the Respondents

Independent Variable (*x*)	Dependent Variable (*y*)		
	r_{xy}	Probability	Decision on Ho
Death and Dying	-0.169^{ns}	0.305	Accepted
Conflict with Physicians	-0.348**	0.030	Rejected
Inadequate Preparation	-0.311^{ns}	0.054	Accepted
Lack of Support	-0.600**	0.000	Rejected
Conflict with other Nurses	-0.268^{ns}	0.099	Accepted
Workload	-0.621**	0.000	Rejected
Uncertainty Concerning Treatment	-0.378**	0.018	Rejected

** Significant at $p \leq 0.05$

The data in Table 3 showed the correlation of the variables, namely, occupational stress and quality of

worklife of nurses working in a Level 1 Private Hospital in Padada, Davao del Sur.

It can be gleaned in the results that conflict with physicians was found to be significantly and negatively relate with quality of worklife, having an r-value of -0.348 with a p-value of 0.030 that is less than 0.05. This means that there exists an inverse relationship between conflict of nurses with physicians and quality of worklife. This entails that the lesser the conflict, the higher the quality of worklife. This is similar with the exhortations of Alhusaini (2010), who reported that in his study of nurses in Saudi Arabia that nurses were found to be dissatisfied with the relationship with their co-workers, especially physicians, where they experienced low levels of respect, appreciation and support. Additionally, they had poor communication and interaction with physicians.

Moreover, lack of support was also found to be negatively yet significantly relate with quality of worklife, having an r-value of -0.600 with a p-value of 0.000 that is less than 0.05. This means that the more stressed the nurses are in terms of getting support from their management, the lesser their quality of worklife will be. This is consistent with the findings of Battu et al. (2014), who mentioned that lack of support is one of the major management-related issues that stress the nurses out. This failing relationship with co-workers then becomes a potential source of dissatisfaction and motivation on nurses, thus affecting their worklife, in addition with lack of participation in decisions made by the nurse manager, lack of recognition for their accomplishments, and lack of respect by the upper management.

In the same manner, workload was also found to significantly yet negatively correlate with quality of worklife, having an r-value of -0.621 with a p-value of 0.000 that is less than 0.05. This entails that the more stressed the nurses are in their workload, the lower their quality of worklife will be. This is coherent with the pronouncements of Chen et al. (2010), who reported in their study that about 81.2% of the nurses believed that they had high workload. They added that shortage in human resources and increase of nurses' workload act as pressure factors among nurses, which lead to professional and organizational desertion.

Finally, it was also found out that uncertainty concerning treatment negatively yet significantly relate with quality of worklife, having an r-value of -0.378 with a p-value of 0.018 that is less than 0.05. This entails that the more stressed the nurses are of being uncertain concerning treatment of patients, the lower their quality of worklife will be. This is analogous with the findings of Mohite (2014), who said that out of all considered causes of stress, uncertainty of concerning treatment factor is responsible for frequent occurrence of stress among majority of nurses. Thus, special measures to address the source of stress to improve their performance are needed, and hence, will positively affect on quality of care given to the patients.

4. Which among the sources of occupational stress significantly affect the quality of worklife?

Table 4. Regression Results Showing the Sources of Occupational Stress that Affect the Quality of Worklife of the Respondents

Independent Variables	*B*	t-ratio	Probability	Decision on Ho
(Constant)	4.285	10.300	0.000	
Death and Dying	-0.074	-0.434	0.667	Accepted
Conflict with Physicians	-0.126	-0.676	0.504	Accepted
Inadequate Preparation	-0.023	-0.175	0.862	Accepted
Lack of Support	-0.200	-1.559	0.129	Accepted
Conflict with other Nurses	-0.128	-1.409	0.169	Accepted
Workload	**-0.231****	**-2.245**	**0.032**	**Rejected**
Uncertainty Concerning Treatment	-0.136	-0.947	0.351	Accepted

F = 4.191, p = 0.002 R^2 = 0.486

** Significant at $p \leq 0.05$

A further test of causality was required since some of the correlates exhibited significant relationship in the previous test. Hence, Table 4 showed the result of the regression analysis seeking to identify which among the sources of occupational stress affect the quality of worklife of nurses working in a Level 1 private hospital in Padada, Davao del Sur.

Results of the multiple linear regression analysis showed that if among all sources of occupational stress, workload of nurses was found to be the only significant variable that affects quality of worklife of nurses, having a standardized beta coefficient (β = -0.231) with a p-value of 0.032, which is less than 0.05. This means that every mean increase of workload leads to a 0.231 mean decrease of quality of worklife, holding other variables constant.

Also indicated in the table was the ANOVA results which display the F- and p-values. Note the value of the F statistic and its significance level (in this case, $p < 0.05$). The

value of F was found to be 4.191 with p-value of 0.002, which is statistically significant at a level of 0.05 or less. This suggests a linear relationship among the variables – sources of occupational stress and quality of worklife. This further implies that the resulting regression model is significantly-different from zero. Statistical significance at a 0.05 level means there is a 95 percent chance that the relationship among the variables is not due to chance. The table also showed the value of the R^2, which is 0.486. This means that 48.6 percent of quality of worklife of nurses is attributed to their workload.

The results above corroborated with one of the theories used in the study, which is the Systems Model of Betty Neuman. This is in relation to the fact that the individual's relationship to stress, the reaction to it, and reconstitution factors that are dynamic in nature, as proven by the significant effect of workload on their quality of worklife. The theory of Neuman also supported the study in which stressors like the environment described as environmental forces that interact with and potentially alter system stability. If the person affected by these stressors, the body function is also affected. The person cannot function well and may result to problems with regards to work.

Likewise, Toh (2011) averred that increased job stress may lower job satisfaction and higher turnover intention. This can be contextualized in the current setting that nurses suffered increased workloads as reported by the day shift nurses. Working day shift was reported to be more physically demanding by nurses as it entailed bathing and lifting of patients. The study also confirmed Nowrouzi's (2013) pronouncements, adding that place may be an important influence on the stress and quality of worklife of obstetrical nurses.

CHAPTER 4

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents the summary, conclusions and recommendations of the study based on the problems and objectives set at the beginning of this investigation.

Summary

1. In terms of occupational stress, the overall mean was found to be 2.75, which is described as frequently. This means that the nurses of a Level 1 Private Hospital experienced occupational stress most of the time. In addition the source of occupational stress with the highest mean score is workload, having an overall mean of 3.35, which is described as "very frequently", while conflict with other nurses was found to have the lowest mean score among the sources of occupational stress having an overall mean of 2.36, which is described as "occasionally".
2. In terms of quality of worklife, the overall mean was found to be 2.83, which is described as moderate. This means that the overall quality of worklife experienced by the nurses in a Level 1 Private Hospital is on the average: not that high but not too low. Among the dimensions of quality of worklife, control at work was found to have the highest mean among the indicators of quality of worklife, having an overall mean of 3.03, which is described as "moderate", while the indicator of quality of worklife with the lowest mean scores is home-work interface, having an overall mean of 2.49, which is interpreted as "low".
3. Four sources of occupational stress were found to have significant relationship with overall quality of worklife: conflict with physicians, having an r-value of -0.348 with a p-value of 0.030; lack of support, having an r-value of -0.600 with a p-value of 0.000; workload, having an r-value of -0.621 with a p-value of 0.000; and uncertainty concerning treatment, having an r-value of -0.378 with a p-value of 0.018. All values are lesser than 0.05.
4. In the regression analysis, workload of nurses was found to be the only significant variable that affects quality of worklife of nurses, having a standardized beta coefficient (β = -0.231) with a p-value of 0.032, which is less than 0.05.

Conclusions

Based on the analysis of the data and interpretation of the results, the following conclusions were made:

1. The nurses were found to have very high level of occupational stress in workload. Moreover, they also exhibited high occupational stress in terms of lack of support, uncertainty concerning treatment, conflict with physicians and inadequate preparation, and moderately stressed in terms of death and dying and conflict with other nurses.
2. The nurses were found to have a moderate quality of worklife in working with the Level 1 Private Hospital in general. They exhibited moderate quality of worklife in the areas of job and career satisfaction, general wellbeing, control at work and working conditions, but low in terms of home-work interface.
3. Occupational stress in terms of conflict with physicians, lack of support, workload, and uncertainty concerning treatment have significant yet negative relationship with quality of worklife of nurses. This means that the

higher the occupational stress, the lower the quality of worklife of the nurses would be in these dimensions.

4. Workload is the only significant and the best predictor of the quality of worklife of the nurses of the studied Level 1 Private Hospital in Padada, Davao del Sur.

Recommendations

Based on the findings and conclusions of the study, the researcher proposed the following recommendations:

1. For the management of the Level 1 Private Hospital, it is recommended that the findings and information herein would be provided to them as basis in determining the extent of occupational stress and the status of quality of worklife of the nurses. They can use the study as a further basis of the management to review the possible sources of occupational stress of its nurses and develop intervention programs to address the problems specified.
2. For the nurses, it is recommended that they will be aware of the results of the study in consensus in order to help in improving the hospital's environment, such that the study indicated that a stress-free environment will result to a better quality of worklife among staff nurses. They are also encouraged to participate in any intervention program(s) to be developed and implemented by the hospital's management, if there are any.
3. For the nursing service administrators of the Hospital, they are encouraged to adopt and utilize the practical implications of this research as in the improvement of the quality of worklife of the nurses by identifying the most influential occupational stressors. They are encouraged to review the work schedules and workload of each nurses and review the setup of manpower in order to streamline the operations and minimize stress of the nurses.
4. For the future researchers, it is recommended that long-term and broader researches will be conducted, with consideration to other variables to be identified.

REFERENCES

Aiken, L.H. et al. (2010). Nurses' Reports On Hospital Care In Five Countries. Health Affairs. Volume 20(3): p. 43-53.

Alhusaini (2010). Obstacles to the Officiency and Performance of Saudi Nurses at the Ministry of Health, Riyadh Region: Analytical Field Study. Riyadh, Saudi Arabia, Ministry of Health.

Al-Makhaita et al. (2014). Predictors of Work-Related Stress among Nurses Working in Primary and Secondary Health Care Levels in Dammam, Eastern Saudi Arabia. Journal of Family & Community Medicine, Vol. 21(2), p. 79.

Almost, J.M. (2010). Conflict within Nursing Work Environments: Concept Analysis. Journal of Advanced Nursing. Vol. 53(4), p. 444-453.

Battu et al. (2014). Quality of Work Life of Nurses and Paramedical Staff in Hospitals. International Journal of Business and Administration Research Review, Vol. 2(4), p. 200-207.

Bauer et al. (2010). Occupational stress and Self-Rated Health among Nurses. Latin American Journal of Nursing. Vol. 21(2), p. 475-483.

Bhuvaneswari, P. (2010). A Study on Quality of Work Life Among Employees in Neyveli Lignite Corporation Limited,Tamilnadu.,Research Journal of Commerce & Behavioural Science.

Chen et al. (2010). Turnover Factors Revisited: A Longitudinal Study of Taiwan- Based Staff Nurses. International Journal of Nursing Studies, Vol. 45(2), p. 277-285.

Chib, S. (December, 2012). Quality of Work Life and Organisational Performance Parameters at Workplace. SEGi Review, ISSN 1985-5672, Vol. 5, No.2. p. 36-47.

Chinomona, R. et al. (2010). Soft Power and Desirable Relationship Outcomes in Zimbabwe Distribution Channels. African Journal of Business. Volume. 11(2), p. 20-55.

De Castro et al. (2010). Occupational Health. Philippine Journal of Nursing. Vol. Vol. 21, p.16.

De Dreu, C.K.W. et al. (2010). Conflict in the Workplace: Sources, Dynamics, and Functions Across Multiple Levels of Analysis. New York. p. 3-54.

Frederich et al.(2010). Physician – Nurse Conflict. American Journal of Nursing. Vol. 167(10), p. 1310-1315.

Ganguly, R. et al. (2010). Quality of Worklife and Job satisfaction of a group of University Employees,

Asian Journal of Management Research. p. 209-216.

Hans Selye (2013). Stress and the General Adaptation Syndrome. British Medical Journal. Vol. 1(4667), p. 1383.

Hosseini, S.M. et al. (2010). Quality of Work Life(QWL) and Its Relationship with Performance, University Of Firouzkouh Branch,Tehran.

Hui Min Thian, J et al. (2015). Relationships among Stress, Positive Affectivity, and Work Engagement among Registered Nurses", Scientific Research Publishing Inc. Volume 6, p.159.

Kamal, S. (2012). The Effect of Nurses' Perceived Job Related Stressors on Job Satisfaction in Taif Governmental Hospitals in of Saudi Arabia. Journal of American Science. Volume 8(3).

Karasek (1979). The Job Demand-Control (-support) Model and Psychological Well-Being: A Review of 20 years of Empirical Research. Work & stress, Vol. 13(2), p. 87-114.

Leever et al. (2010). Conflicts and Conflict management in the Collaboration between Nurses and Physicians–A qualitative study. Journal of Interprofessional Care, Vol. 24(6), p. 612-624.

Li, J et al. (2010). Workplace Stressors, Coping, Demographics and Job Satisfaction in Chinese Intensive Care Nurses. Nursing in Critical Care.Volume13(1). p.12-24.

MacKusick, C.I. (November/December, 2010). Why Are Nurses Leaving? Findings From an Initial Qualitative Study on Nursing Attrition. MEDSURG Nursing. Vol. 19/No. 6.

Manzo et al. (2012). Nursing in the Hospital Accreditation Process: Practice and Implications in the Work Quotidian. Latin American Journal of Nursing, Vol. 20(1), p. 151-158.

Michie, S et al. (2010). Reducing Work Related Psychological ill Health and Sickness Absence: A Systematic Literature Review. Volume 60. Issue 1.

Mohite, N. et al. (June, 2014). Occupational Stress among Nurses Working at Selected Tertiary Care Hospitals" International Journal of Science and Research (IJSR) Volume 3 Issue 6.

Moustaka, E. (2010). Sources and Effects of Work-related Stress in Nursing. Health Science Journal, Vol. 4(4).

Nirmanmoh B. et al (January, 2011). Occupational Stress amongst Nurses from Two Tertiary Care Hospitals in Delhi, India. AMJ;3(11). p. 731-738.

Nowrouzi, B. (2013). Quality of Worklife: Investigation of Occupational Stressors among Obstetric Nurses in Northeastern Ontario. International Journal of Occupational Medicine and Environmental Health. Vol. 28(3), p. 571- 586.

Patton, C.M. (2014). Conflict in Health Care: A Literature Review. The Internet Journal of Healthcare Administration. Volume 9 Number 1.

Peters, L. et al. (2013). How Death Anxiety Impacts Nurses' Caring for Patients at the End of Life: A Review of Literature. The Open Nursing Journal. 2013. Volume 7: p.14–21.

Requena, F. (2010). Social Capital, Satisfaction and Quality of Life in the Workplace. Social Indicators Research. Volume 61(3). p. 331-360.

Rethinam, G. S. et al. (2010). Work Condition and Predictors of Quality of Work Life of Information System Personnel. Journal of Vocational Behaviour. V. 58. p. 414-435.

Rubel, M.R.B. (2014). Quality of Work Life and Employee Performance: Antecedent and Outcome of Job Satisfaction in Partial Least Square World Applied Sciences Journal. Volume 31 (4). p. 456-467.

Shader, K. et al. (2010). Factors Influencing Satisfaction and Anticipated Turnover for Nurses in an Academic Medical Center. Journal of Nursing Administration. Volume 31(4): p. 210-216.

Toh, S.G. (2011). Systematic Review on the Relationship Between the Nursing Shortage and Job Satisfaction, Stress and Burnout Levels among Nurses in Oncology/Haematology Settings.

International Journal of Evidence-based Healthcare.Vol. 10(2), p. 126-141.

Van Laar et al. (2007). The Work-Related Quality of Life Scale for Healthcare Workers. Journal of Advanced Nursing, Vol. 60(3), p. 325-333.

Vijaimadan, P. (2013). An Empirical Study on Relationship among Quality of Worklife and its Factors. Procedia-Social and Behavioral Sciences.Vol. 152, p. 108-111.

WHO (2012). Occupational Stress of Nurses. Paulista Minutes of Nursing. Vol.25(SPE2),p. 151-156.

Worrall, L. et al. (2010). The Quality of Working Life: Managers Health and Well- Being. Executive Report, Chartered Management Institute.