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Exploring Nurses' Burnout in the Neonatal Intensive Care Unit of a Municipal Hospital: Application of the Job Demand and Resource Theory

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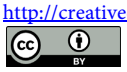

Abstract

Professional nurses play a key role in the care of sick neonates and provide quality care to the patients and their families. Nurses working in low resource settings are stressed by heavy workload and limited resources to render holistic care to babies admitted to the Neonatal Intensive Care Unit (NICU). The study explored work-related burnout and nursing care experiences of professional nurses working in a NICU of a municipal hospital in the Bono East Region of Ghana. The study applied qualitative explorative descriptive design which was guided by the job-demand and resource theory. Data saturation was attained with fifteen participants who were purposively recruited for the study. A semi structured interview guide and participants' observations were used to gather information from participants. Interviews were audio-taped and transcribed verbatim then analyzed using Thematic Content Analysis. The study revealed that nurses had both positive and negative work experiences, with a predominance of negative job demand experience and burnout. Burnout in the NICU usually presents in the form of emotional exhaustion and depersonalization. Positive experiences in team work and job satisfaction were gained from caring for sick newborns. The study revealed personal resource like intrinsic motivation, coping style, self-efficacy and resilience motivated nurses. However, the nurses expressed poor coping in management of burnout associated with work. The JD-R theory facilitated gaining responses from the participants that highlighted various coping strategies when overwhelmed with work or burnout. Participants strategies to manage burnout included team support, supportive unit leadership and family support. Nurses identified organizational policies, heavy workload, lack of extrinsic motivation, equipment and emotional en-

gagement as factors contributing to their job demand and burnout experience. The study proposes broad interventions encompassing both individual and organizational strategies to curtail nurses' burnout. The study concluded that nurses working in acute care settings need to be trained in self-care and health promotion initiative that will improve their wellbeing.

Subject Areas

Nursing

Keywords

Nurses, Burnout, Wellbeing, Neonate, NICU, Job Demand

1. Introduction

Burnout is a syndrome caused by persistent workplace stress that has not been successfully managed [1]. It is characterized by emotional exhaustion, depersonalization and reduced sense of personal accomplishment. Burnout is a significant problem among healthcare professionals, particularly nurses, and can have devastating outcomes for both nurses and patients [2]. According to Maslach and Jackson, professional health caregivers have higher prevalence of burnout [3]. Studies have shown that burnout is a common problem among nurses with prevalence rate ranging from 33% to 63% in advanced countries [4]. This percentage, however, increases in resource constraint settings such as Africa and the Middle East. Nurses have the worse exposure to burnout based on contributing factors such as work overload, extreme working conditions as well as nurses' exposure to high mental and physiological pressure. Worsen levels of burnout are recorded among nurses working in intensive care units such as the NICU [5] [6].

The causes of burnout among nurses can be categorized into job demands, resource demands and personal demands constraints. Job demands constraints include poor working conditions, increased workload and low wages. Resource demands constraints include lack of break, inadequate nursing staff and lack of logistics. Personal demands constraints include emotionally upsetting situations, decreased self-efficacy and lack of organizational or social support. Burnout among nurses can have serious consequences including decreased job satisfaction, reduced quality of care, unjustified absenteeism and increased risk of errors [7] [8]. Burnout can also lead to physical and mental health problems including cardiovascular diseases, psychiatric disorders and gastrointestinal disorders [9] The overall impact of burnout is suffered by the patient as they experience worse patient safety and low care satisfaction [10].

Neonatal intensive care unit (NICU) nurses are at high risk of burnout due to the vulnerable characteristics of their patients [7]. Studies have shown that NICU nurses experience high levels of emotional exhaustion, depersonalization and reduced personal accomplishment. The NICU environment is unique, with nurses

providing complex and precise care to critically ill newborns while supporting the parents.

In Ghana, newborn diseases and mortality is high. 47% of all under five mortalities in the country occur in the neonatal period (first 28 days of life) [11]. Patients at the NICU are often "critically ill requiring fast-paced, complex and precise care, resulting in increased propensity towards errors" [12]. Neonates are wholly dependent on their parents and the nurse to help them survive the critical period of admission. As the nurse provides healing through nursing activities, the parent also provides physical, emotional or financial support to augment the care process. The NICU is different from adult intensive care unit setting based on their patient population, acuity of illness, the effect newborn admission puts on post-natal mothers and the intensity of neonatal health care delivery [13] [14]. Adults are able to verbalize their needs to the nurse as opposed to the newborn [15]. In today's global economic climates, nurses are faced with the expectation of delivering high quality care with limited resources, leading to increased pressure and a heightened risk of burnout [16]. Against the backdrop of Ghana's high neonatal disease and mortality rate, NICU nurses are under immense pressure to ensure the survival of newborns. Therefore, it is crucial to assess the challenges posed by job resources, identify potential solutions and implement interventions that support nurses in providing optimal care to the newborn. Burnout is a significant problem among nurses, particularly those working in NICU settings. Understanding the causes and consequences of burnout is essential to develop effective strategies to prevent and mitigate its effects. By addressing the root cause of burnout among NICU nurses, healthcare organizations can promote a healthier work environment, improve job satisfaction and enhance quality of care provided to patients.

2. Literature Review

2.1. Theoretical Framework

The job-demand and resource theory (JD-R theory) developed by Bakker and Demerouti [17] provides the theoretical framework for this study. This theory posits that job demand and resource can either stress or motivate employees, leading to burnout or engagement. According to JD-R theory, inadequate resources and excessive workload can result in burnout and stress [17]. The theory assesses the job demand, personal resources and job resources to understand how employees deliver care. Over the years, the JD-R theory has been applied to predict burnout, organizational commitment and work engagement among employees as well as identify the negative consequence of burnout. The constructs of the theory examine the interplay of job demands, resource demands and personal demand. These characteristics are present in nearly every job. The theory highlights the importance of these factors as they initiate two distinct processes in the employee: health impairment or motivational processes. Motivational process occurs when employees experience optimal workload and adequate resources leading to organ-

izational commitment through work engagement. In contracts, high job demands, inadequate resources and emotional demands can lead to mental and physical drain resulting in burnout and ultimately, health impairment [17] [18]. The JD-R theory also proposes intervention aimed at enhancing resources to mitigate the negative effects of excessive job demands and wellbeing thereby preventing burnout [17].

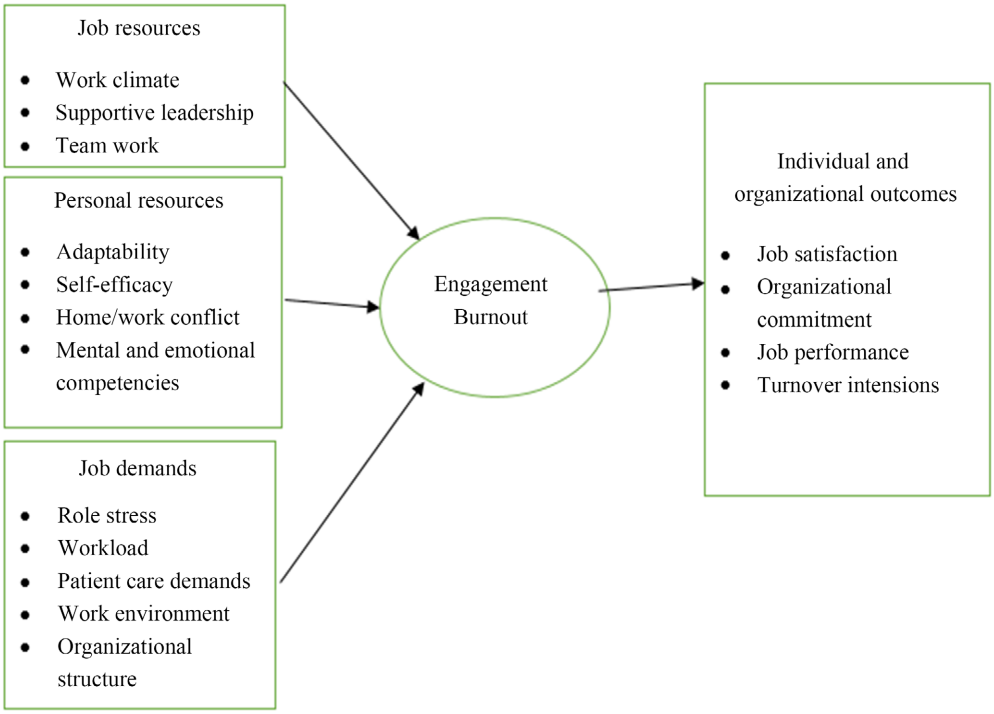

Figure 1. Diagram of job demand and resource theory.

The job demand component encompasses work-related factors that require continuous physical, mental and emotional efforts (See **Figure 1**). These demands can arise from various sources including physical work environment (overcrowding, extreme temperatures and noise), social environment (role conflict, interpersonal conflicts and abuse from coworkers), and organizational aspects (organizational structure and poor leadership). Prolong exposure to extreme job demands can lead to strain on the employees, prompting inappropriate coping mechanisms. The job resource component of the theory refers to factors in the work environment that facilitate the achievement of occupational goals, decrease job demands or kindles professional growth and development [9]. These resources are generated from diverse aspects of the work environment which can be physical, psychological, social or organizational. Physical resources include adequate equipment such as lightening or assistive mechanical devises. Psychological resources are associated with constructive feedback and engaging interaction. Social resources are linked to co-worker support and mentorship. Organizational resources are associated with perceived support from the organization [18].

Personal resources align with employees' self-efficacy, optimism and resilience toward work and the work environment [9]. These resources are factors that increase or decrease the likelihood of burnout and other mental health challenges among employees. The theory suggests that adequate personal resources predict motivation leading to job satisfaction and serves as a buffer to the stain imposed on employees from the work demand and limited resources [18]. Conversely, employees with poor personal resources such as cynicism, professional insufficiencies or depersonalization are more likely to develop burnout [4].

The JD-R theory suggest that Job demand and job resource theory interact to impact employees' wellbeing. The study focuses on exploring the key variables in the theory that significantly influence employees' experiences of work burnout, aiming to understand their impact and relationship to burnout. These factors if present, play a significant role in determining how nurses effectively care for neonate and how institutional and social support can impact their resilience and wellbeing. When these factors are poorly managed, burnout occurs. The impact of job demand and resource on burnout can manifest in various ways including emotional drain, mental demands, work-home interference, role ambiguity, role conflict, role stress and time pressure [17] [18]. These factors can collectively contribute to the development of burnout, highlighting the importance of managing job demands and resources to promote employees' wellbeing.

2.2. Overview of Burnout among Nurses

The concept burnout was introduced by Freudenberger in the 1970s to describe the attitude and reaction of workers experiencing chronic stress particularly in "helping" professions that require constant interpersonal interactions [19]. Burnout is purely occupation-related phenomenon, and its theories explain how the work environment impact the wellbeing and mental health of an organizations' employees [20]. Although burnout is occupation-related, it can have far-reaching consequences that extend beyond the workplace. According to burnout composes three dimensions: emotional exhaustion, depersonalization and low personal accomplishment. The international classification of diseases 11th revision (ICD-11) recognizes burnout as a serious health issue that can threaten an individual's ability to function adequately in an organization [21]. Burnout is a complex phenomenon that can manifest in various ways influenced by broad social, cultural, professional and individual factors [2]. Nurses, in particular, are disproportionately affected by burnout symptoms among healthcare professionals and the health care organization as a whole [1].

The prevalence of burnout among nurses is alarmingly high particularly in specialty areas with rate ranging from between 30% - 80% [21]. Sub-Saharan African has the highest prevalence of burnout symptoms amongst nurses while Europe and central Asia region records lower prevalence [22]. Nurses' working in paediatric specialty, especially in secondary or tertiary healthcare setting, are disproportionately affected by burnout [23]. Despite the well documented prevalence

and risk factors associated with burnout, most studies have focused on high-income countries and adult healthcare settings [2]. In contract, there is a significant knowledge gab regarding burnout among neonatal intensive care unit (NICU) nurses in Africa and sub-Saharan Africa where health systems are underdeveloped and the impact of burnout on health care service delivery is poorly understood [22]. NICU nurses providing round the clock service to critically ill neonates in the NICU are particularly vulnerable to stressed [24].

Burnout hinders nurses' work-life balance. Research suggests that nurses' burnout is linked to intrapersonal and interpersonal characteristics that emanates from their work environment and social life. Demographic characteristics such as age, gender, level of education, marital status and work experience play a significant role in nurses' burnout [23]. Younger nurses are more susceptible to burnout due to their inexperience in the profession which can lead to lower personal sufficiency and fear of committing medical errors in the care of critically ill patients. Male nurses in contrast to their female counterparts tends to experience lower levels of burnout. This disparity is attributed to females' likelihood to emotional reaction to occupational stress, work-family conflict and sleep disorders making them more prone to psychological distress [25]. The level of education and work experience also significantly contributes to nurses' burnout. Inadequate preparation of nurses toward the demands in their unit can impede nurses' ability to deliver quality care and increase the likelihood of medical errors. Nurses who have not received the necessary work-related education are more prone to job burnout [26].

Marital status is another factor influencing nurses' burnout. Single, divorced, and widowed nurses have higher burnout compared to married nurses [26]. This disparity is attributed to positive public attitude towards marriage and negative public attitude towards divorce and widowhood [27]. Burnout can significantly impact personal and family life due to increased levels of exhaustion, depression, low job satisfaction and low quality of life.

Nurses require positive personal resources to effectively manage burnout effectively. Attributes that indicate good adjustment include employees' self-efficacy, optimism and resilience toward work and the work environment as well as good work-life balance [9]. Positive personal resource are predictors to motivation and engagement while negative resources are linked to burnout, disengagement and poor organizational outcomes [18].

Nurses' burnout can significantly impact the quality care delivered to patients as well as hinder organization growth and improvement. The consequences of Burnout include reduced quality of care, increased risk of complications, delayed recovery, prolong hospital stay, low patient satisfaction and increased hospitalization cost [28]. Nursing care related consequence of burnout include increased medical errors and increased risk of behavioral disorders such as smoking, alcohol consumption and illicit drugs use; high physical and psychological problems including anxiety, exhaustion, depression, sleeplessness and bad eating habits. Ulti-

mately, Burnout among nurses can result in absenteeism, low job satisfaction and reduced quality of work output [29].

2.3. Coping with Job Demand and Burnout among Nurses

Job demands and burnout have profound emotional, physical and social effect on nurses [30]. Compared to other healthcare workers, nurses face more demands with limited work autonomy, fewer career development opportunities and less alternative to transition into other professions. When job demands become overwhelming and resources are scarce, nurses are thrust into stressful and health threatening reality. Despite putting their own needs aside to care for the patients, nurses must develop coping strategies to manage these situations [15]. This distress can have far-reaching consequences, affecting not only the nurses work output but also the patients' wellbeing, and the nurses social functioning both at the work place and the community.

Burnout can disrupt the delicate balance of nurses' social and occupational lives posing challenges such as family discord, anxiety, depression, marital or partner discord and behavioral changes [10] [31]. Although nurses may attempt to adjust to the distress by utilizing previous coping skills and experience, significant worsening of relationships with colleagues, patients' relatives, family and friends can still occur [32].

Fortunately, internal strengthen mechanisms, social services and support groups can aid nurses in dealing with challenges imposed by excessive job demands and burnout [11] [33]. Effective interventions such as counselling and self-care initiatives can minimize stress and help nurses regain their equilibrium [34]. Nurses are uniquely positioned to provide insight into the gaps within healthcare support systems that hinder their ability to identify burnout and seek needed support. Their experiences will serve as a vehicle to render better and efficient cognitive and social services through knowledge sharing and practices [10] [15] [24].

Coping strategies adopted by nurses experiencing burnout include distancing from work and friends, avoidance, planned problem-solving and emotional support from families [24]. These cognitive and behavioural strategies are used to alleviate stressful situation by either focusing on the problem or on the emotions experienced [11]. In a Ghanaian cross sectional study involving 134 registered general nurses, found respondents identified work-family conflict, work demand, family demand as their main source of burnout. To cope with demands and overcome the burnout, respondents emphasized the importance of emotional, spiritual, and psychosocial support from families and colleagues [35]. Social services, such as counselling, nurses training on burnout and self-care, and facility support groups, can aid nurses deal with psychological, emotional, and practical issues accompanying burnout [24]. By empowering nurses to minimize stress and regain their equilibrium, healthcare organizations can promote a healthier and more supportive work environment, ultimately benefiting both nurses and patients.

Education and counseling on how to approach death and support grieving fam-

ilies can be beneficial to the nurses [7] [27]. Burnout associated with emotional engagement or mortality of a neonates is common and can be overwhelming. To make sense of the illness and suffering of newborn, nurses often seek comfort and explanation beyond the material world [11]. This can lead to stronger spiritual background which help nurses accept the death as one of the unfavourable outcomes of newborn illness. Nurses develop varied philosophies to help them cope with the daily struggle of neonatal illnesses and mortalities. Although not all nurses will rely on religious support to adapt to the newborn illness and bereavement, a religious orientation can influence feelings about the meaning of life, coping, justice, fairness, guilt, altruism and attitude towards life [11] [14]. The importance of colleagues, supportive leadership and friends cannot be overstated. Research highlights the tremendous psychosocial role these support systems play in nurses' lives as they cope with burnout [11]. Work colleagues turn to be more understanding and show empathy, whiles family and friends help maintain a sense of normalcy and connections to their non-burnout self [14]. Despite the high distress rate, nurses can exhibit optimism, resilience and a positive outlook in the face of burnout and extreme work demands with the support of friends, family and unit leaders [11] [36].

Intervention such as job crafting, job training, job redesigning and strength-based assignment to jobs can help nurses and organizations to reduce burnout. Job redesigning, an organizational level aims to modify and restructure jobs to enhance employees' wellbeing [17]. Job crafting, an individual-level initiative, enables employees to develop meaning in their work by improvising standard means to ensure task are performed effectively. Employees training on the job is an organizational level intervention where employees are provided retraining in relation to their jobs, technical skills and knowledge in relation to their current job demands or departments.

3. Methodology

3.1. Philosophical Underpinnings of Qualitative Research, Approach and Design

This qualitative research is grounded in the theoretical foundation of Ontological relativism and epistemological constructionism [37]. Ontological relativism posits that reality is subjective and can vary depending on individual interpretation [37] [38]. Epistemological constructivism, on the other hand, suggests that knowledge is constructed by individuals based on their experiences and interaction with the world [37] [38]. The flexibility of qualitative research in obtaining data made it an ideal method for this study. The interpretive, humanistic, and naturalistic philosophy of qualitative research emphasizes subjectivity acknowledging that multiple reality exists rather than a single objective truth. This approach allows participants to communicate and express themselves freely providing a richer understanding of their experience and perspectives [37] [39]. By employing these frameworks, researchers can gain more nuanced understanding of complex phenomena and

perspective that may not be captured by traditional or objective research method. This approach allows for a more contextualized understanding of nurses' burnout experience, ultimately providing valuable insight into the complexities of the phenomenon.

The research design was an exploratory descriptive qualitative design. This approach was used because the researcher aimed to explore the lived work-related experience of nurses in the NICU of a municipal hospital, focusing on their interaction with patients and their families. A qualitative method with thematic-content analysis guided by the job demand-resource theory was used to analyze the data. By adopting an exploratory descriptive approach, the study obtained a rich and nuanced understanding of the complexities involved in nursing care in the NICU. The research setting is the neonatal intensive care unit of a municipal hospital in the Bono East Region of Ghana. The NICU of this hospital was chosen for the study because it is the major referral center for a significant portion of the Bono-East Region. The unit renders services for sick neonate born in its environs as well as some facilities in the Ashanti Region. The unit has an in-patent ward and out-patient department with a 25 bed capacity and an annual admission of 800 - 1000 cases [40]. The NICU has an outreach nursing team that conducts home visits for neonates and to follow-up on those who miss treatment or review appointments. The NICU has 19 nurses, and two medical doctors [40].

The study targeted all registered nurses working in the NICU for over one year. Rotating and auxiliary nurses were excluded. This was to ensure that only nurses who have frequent experience with newborn care practices were enrolled on to the study. A total of 15 nurses participated in the study which employed purposive sampling to recruit readily available participants enthusiastic to partake in the study. Data collection was conducted through semi structured interviews using an in-person approach. The interview guide had four major sections. Section one explored participant's background, level of education and years of experience in the NICU. Section two explored work experiences, patient environment and personal environment. Participants were asked to provide details about their work life. Also participant gave narratives about lifestyle when they are not at work. The guide probed for participants to provide details about specific factors that make caring for sick neonates challenging or pleasurable. The fourth section explored burnout support and health-promoting lifestyle strategies of the participants.

Participants provided informed consent before the interview, which was digitally recorded. The interview was conducted in the hospital conference room to ensure privacy and minimal interruption. Participants were assured anonymity, confidentiality, benefit of the study and possible harm. Data collection until saturation was reached. To ensure confidentiality, field notes and tape recorder were stored securely; and media file were password-protected. Participant information was coded with pseudonyms. Data analysis was conducted using thematic-content analysis which involved familiarizing oneself with the data, generate initial codes, creating themes, reviewing themes, defining and identifying themes, and produc-

ing the report.

3.2. Ethical Consideration

Ethical approval for the study was obtained from the Ghana Health service ethics and research committee (GHS-ERC). Additional approval was sort from the hospital management as well as the head of department of neonatal intensive care unit. The study adhered to ethical principles including justice, fairness, Respect for person, Beneficence. Participation in the study was strictly voluntary and participants were informed of their right to discontinue the study at any moment. Measures were employed to ensure no harm befell any of the participants.

3.3. Limitation of Study

The research focused exclusively on professional nurses working in NICU. Consequently, the burnout experiences of others health care professionals working in the NICU was not explored. However, literature suggests that co-worker factors also influence nurses' burnout experiences.

4. Data Analysis and Findings

Four major themes and twelve (12) sub-themes emerged from the data. The major themes and sub-themes have been depicted and supported with anonymized verbatim quotations from the study participants. The study explored the experiences of nurses' burnout in relation to caring for sick newborn under nurses' job demand, job resource availability, personal demand and nurses' burnout experience and interventions. The narrative of the nurses revealed varying positive and negative experiences whiles caring for sick neonates. For each concept, both negative and positive experienced are outlined. During analysis, member checking was done with four participants to verify their socio-demographic data.

4.1. Participants Socio-Demographic Characteristics

Fifteen participants (professional nurses) working in the NICU took part in the study. Twelve females and three males participated in the study. The age of the participants ranged from 24 - 48 years. The mean age of the respondents was 34 years. One (1) was between the age of 20 - 24; eight (8) of the participants were between the ages of 25 - 30; three (3) were between the ages of 31 - 35; two (2) between the ages of 36 - 40 and one (1) between 41 - 48 years. Three (3) of the participants were registered nurses with Bachelor of science degree (BSc in nursing). The remaining twelve (12) were registered general nurses (RGN) with diploma degrees from varying nursing training institutions in Ghana. All participants were Ghanaians from different regions and ethnicity across the country. Fifteen (15) of the participants were Akans, one (1) Ewe, one (1) Ga-Adangbe and two (2) Northerners. Thirteen participants (13) were Christians and the remaining two (2) Muslims. All participants were employed and active at work with regular monthly income, however three (3) had extra source of income aside their

regular salary. The work experience of participants ranged from 2 - 15 years. Ten (10) participants had worked for 2 - 4 years; three (3) had worked for 5 - 9 years and the remaining two (2) had worked for over ten years. Five (5) participants are married with children and ten (10) were single. One participant is a single parent. Apart from one participant, none of the study participant have had their newborn admitted to the NICU.

4.2. Theme One: Nurses Job Demand Experience in the Care of Sick Newborns

The theme explored the experiences of nurses in relation to their work demand and the work environment while caring for sick neonates. Four sub-themes emerged from the data collected. These were organizational structure and policies, heavy work load, poor physical environment and team work. Although most nurses reported negative job demand experiences, they seem to have adjusted to their job and the work environment.

4.2.1. Challenges with Management and Policies Implementation

All participant mentioned the impact of organizational structure and policies as a significant challenge in achieving their work goal. The current organizational structure limited nurses assess to their unit managers and facility heads, making it difficult for nurses to communicate their challenges. Participants expressed lack of interaction with management, feeling that their concerns were not being heard.

"*Getting to see the nurse manager or any member of management is not difficult but as to whether what you are there for will be done or they will even listen to you is the problem*." (P7)

"*Our facility managers are with us but they seem so far. You cannot get your issues across to them because they do not listen*." (P8)

Managerial decision with direct impact on the nurses are taken without engaging the them. Most nurses channel their challenges through the unit managers whom they felt were not doing enough to advocate on their behalf. However, 8 participants said that immediate decisions regarding the unit were discussed with them and their views were sought.

"*you are not involved. There are some key discussions you chance upon. Let's say the nurse in-charge is discussing something with someone and you chance upon it then she will include you. Or let's say she comes back from HOD meeting and there is a general information then she informs you. Sometimes she will tell few people and then you have to hear from some other people*." (P2)

Participants also reported receiving late information about meetings and organizational activities making it impossible for some them to participate in discussion and decisions. In most instance, participants said they were informed of new directives that impacts their work but they are not allowed to contribute in the decision-making process.

"*I was complaining to in-charge that the duration for notifying and sending some memos are too short. Let's say the meeting is tomorrow—a general meeting*

or something, the memo is sent around 2pm *today. Let say you are at work or came for night duty, you are expected to be there; but that* 2pm *you are preparing for the night. And then you have to think of how to come back for that meeting, I think the duration for meeting is too short. Sometimes you get it in the night then the next morning there is a meeting. I think that is not good.*" (P2)

Most participants expressed discomfort when interacting with the facility heads citing negative experience with some management members. They said:

"*Some management members talk to use like JHS* (*Junior High School*) *children. Even you can't talk to primary children like that. We are adults with our own kids and all.*" (P7)

"*the least said about our management the better. They are doing what they can but their attitude towards staff is not the best.*" (P8)

Some participants also felt undervalued by facility heads, attributing this to managements' inability to provide the needed resources of the ward:

"*they don't appreciate our work. If they did, they would try to provide us with the necessary items to work. Instead, the in-charge will say she has requested for these items constantly but facility leadership hasn't provided. They don't appreciate us or maybe they do. But their action doesn't show it*". (P1)

Some national policies on newborn care presented challenges for participants. Despite adhering to these policies, participants faced difficulty, particularly when parents disagree with policy guidelines. Some stipulated:

"*The SOP for maternal and child health guides most of our activity in the NICU. However, when parents want to go against these guidelines it becomes a challenge. We sometimes even have to involve the police to get them to comply.*" (P7)

4.2.2. Heavy Work Load

Participants described the demanding nature of their work in the NICU, highlighting the various task involved in caring for critically ill babies. Some stated:

"*We handover and take over. We assess our babies to know those who are doing well and those are not. Immediately those who are not doing well we do our baseline vital signs for them before the routine vital signs. We check, then those that we need to act promptly we act.*" (P3)

"*caring of babies entails a lot...resuscitation, performing kangaroo mother care, assisting and positioning of babies to feed. Ensuring every baby is free from infections; doing intense vitals and serving of medication to babies.*" (P5)

Due to limited staffing, these nurses were not assigned specific task during their shift. Instead, they worked collectively to ensure all babies received necessary care before the close of the shift. Some participants noted:

"*at the NICU we don't assign duties. You do all care activities together. Vital signs, medication, education. We all assist. We do everything collectively. Everyone does something.*" (P3)

However, this collective approach sometimes led to inadequate care as responsibilities were not clearly defined. Some participants noted:

"*This sometimes makes the care for the babies inadequate. You tend to omit some rules and do things that are not your responsibility. At some point in time when we realize we go back to rectify it but time has elapsed.*" (P4)

Participants consistently reported a heavy work load in the NICU, primarily due to understaffing and excessive number of babies on admission. Some participant said:

"*They are more than the strength of staff nurses on duty, you become exhausted.*" (P3)

"*When the babies are many and you are only two at post, it will be very stressful but when you are many, it helps to reduce your stress.*" (P5)

The night shift was particularly challenging, with participants experiencing exhaustion due to the duration and intensity of their duties. In a month the nurses have at least three sets of night duties without adequate rest.

"*The night shift comes with lots of duties…serving medication, receiving new admissions. But then the issue of getting exhausted has much to do with the night shift. When you resume sometimes, you feel like you haven't had enough rest. So you resume work feeling so much exhausted and you can't work effectively.*" (p3)

Four participants have worked in other departments aside the NICU. Comparing to other departments, participants rated the NICU as having the worse workload.

"*for OPD the work wasn't that massive for you get so exhausted. But the NICU you seem always exhausted*" (p3)

"*I prefer any other ward to the NICU. The staff are friendly but the workload is too much*" (p9)

"*the room is small and there is always congestion, there is no proper ventilation. I was having breathing challenges when I was pregnant. I used to come and sit outside for some time which also distract the work*". (P4)

4.2.3. Patient Care Demands and Conflicts

Participants highlighted the demands of patient care in the NICU, including the need to support parents in the care of the neonates.

"*for babies who are not doing well, when parents are there, they see the efforts the staff have put in to help the baby to survive. Later on, we don't pray for that but when it happens and the baby is gone* (*dead*) *they appreciate and tell us that we did well.*" (p3)

Nurses played a crucial role in guiding inexperienced parents in caring for their babies.

"*Some of the mothers are new to the care of babies. We educate them on newborn care. We help them to position the babies to breast, change diaper, wear their baby clothes amongst others.*" (P10)

Despite their best efforts, conflicts arose between nurse and some patients relatives due to misunderstanding about the baby's care and treatment. Some babies are sent to NICU from maternity without giving the family or care-giver clear information concerning the child's condition and indications for admission.

"*The babies come on admission without the midwives telling the relatives what is wrong with the baby. Later on, the father will come or even the mother and say they are unaware of the reason the child should be admitted and sometimes this leads to arguments.*" (P10)

Participants also reported conflicts arising from the need to perform invasive procedures, restrict visitors and enforce strict hygiene protocols. Performing some evasive procedures for the baby can also led to conflicts though the consent of the parent was sort:

"*our medications for the neonate are in intravenous form most often. When their cannula comes off and you take the baby to pass another line, sometimes the love—that kind of emotion the mother has for the baby—they sometime tell you don't pass the line again.*" (P3)

Some parents are unwilling to have their neonates admitted to NICU due to financial constraints, limited information, fear of the unknown and uncomfortable environment.

"*their treatment is expensive. The mothers complain about not being able to pay the bill.*" (P11)

"*some parents come in and they don't know why the baby was admitted or needs to be admitted. The men often complain about where their wives will stay as the baby is on admission.*" (P1)

Despite these conflicts, participants prioritized the wellbeing of the babies in their care and duties. The developed coping mechanism to overlook the behavioral issues of the family members. They stated

"*I have learned to overlook their behaviour. In the long run the baby is my primary responsibility not the whole family.*" (P9)

"*It's not easy but I prefer their insults to dealing with a mortality. Though their words hurt, I want to go home knowing I cared for the baby well and he is still alive.*" (P11)

4.3. Theme Two: Job Resource Experience

Participants identified resource availability as a crucial factor affecting the care of the sick newborns. Resource availability is influenced by the work environment and patient-related factors.

4.3.1. Availability of Logistic

Inadequate infrastructure and logistics hindered the care of neonate. both institution and parents are expected to provide essential items for newborn care such as equipment, clothing and toiletries, etc. Some participants said:

"*The mothers provide the things we use directly on the babies like their dress, diaper and wipe. Then the hospital gives us the equipment*" (P1)

"*Some mother come in labour with nothing; not even a cot sheet to cover the baby up. You have to improvise or find every means possible to cover the baby and keep warm. This sometimes makes the work frustrating*". (P8)

Participants highlighted challenges with oxygen supply to the unit that had ad-

verse outcomes for some of sick neonate.

"*What happened was the oxygen got finished but the baby was fine. So, setting up a new one, then we realized that there was no oxygen in other cylinders available. As in all the cylinders were empty. So we had to go to emergency (150 meters from NICU) to get oxygen and the baby was just deteriorating.*" (P2)

4.3.2. Motivation

Most reported lack of extrinsic motivation from the facility heads however, their intrinsic motivation stemmed from the love for the profession, the desire to save life and the satisfaction of successful treatment. Additionally, patients comfort and family appreciation of their work were also significant motivation.

"*When you are working at the NICU of this hospital, you just have to be ready for hard work without any motivation. We have complained but nothing comes out of it*". (P11)

"*The hospital doesn't give us any allowance or consignment to motivate us. Personally, I have motivation in seeing the baby go home or meeting their parents in town and they appreciating what we did for them whiles on admission.*" (P10)

4.3.3. Team Work and Supportive Staff

All participants reported positive work relation amongst health professionals in the unit. The relationship was described as cordial and friendly. The nurses said:

"*Our relationship is cordial. I like the team work here* (*NICU*). *We are all one happy family.*" (P12)

"*it's very loving and friendly. Every day I am learning something new; meeting new cases, learning around the cases, having discussions. I have come to appreciate the team work.*" (P2)

4.4. Theme Three: Burnout Experiences of Nurses

The study revealed that nurses' burnout and job demand influence their care attitude toward sick neonate. Most participants demonstrated a positive care attitude which was shaped by their clinical judgement, use of their senses. work environment, social life and the supportive relationship from their relatives and colleague care workers.

4.4.1. Clinical Judgement

Participants emphasized the importance of clinical judgement and sensory awareness in caring for newborns, who cannot express their needs verbally, emotionally or physically. They stated

"*you have to use your clinical judgement well and you have to be observant. Because the baby will not tell you this is where I have pain or this is what is happening at the moment. Most often its by observation that you see that this baby is having some illness which you have to intervene. At the NICU you use your senses all the time.*" (P3)

"*The babies are special. Even the healthy ones look so fragile not to speak of the sick. Especially the asphyxiated ones. Your senses must be active all the time. You*

use yourself so much that you get home and all you think about is the baby." (P10)

Participants noted that caring for the sick newborn requires additional effort and intuition. They are constantly vigilant, as newborn could not communicate their needs. Some participants stated:

"*at the adult ward, even if you don't go to the patient and something is happening they cry for you to know that this is what is happening. They call you to let you know this is what is happening. They tell you this is where I feel the pain. At the NICU it does not happen that way. Baby is vomiting, if you don't go there you will not know that the baby is vomiting. Baby is aspirating if you dot go there you will not know so it means most of the time you have to be walking from baby to baby. You don't have time to be seated at the nurse's station like the adult ward. When baby is on oxygen, sometimes they take off the oxygen prongs so you have to be moving around to do things.*" (P3)

4.4.2. Job Satisfaction

Participants expressed job satisfaction associated with the joy of seeing babies respond to treatment and the cooperation of families in the care of the neonate. Nurses felt pleased at their ability to help the sick newborn and their families to survival the admission period and get discharged satisfactorily. Some said

"*I feel very good taking care of sick babies. especially with the asphyxia babies, maybe you bag (manual ventilation) for a while and baby becomes responsive and the baby survives. It gives you this great joy. You have also helped somebody otherwise dying back to life.*" (P1)

"*it is enjoyable working with the babies than the adults. When the babies are crying and you try to calm them, the reaction they give you is always satisfying.*" (P6)

Additionally, some participants had developed resilience and gained knowledge about newborn care due to their work at the NICU. Some shared their personal growth:

"*Initially I was afraid of babies but with time I have learn to care for them and understand them*" (P11)

"*I learned a valuable lesson when I had to deal with an empty oxygen cylinder. Now I always check the oxygen availability and flow meter before settling down to start my shift*". (P2)

4.4.3. Social life

Participants reported a significant impact of their work on their social life, with limited interaction with family and friends. The demanding nature of NICU work affected their ability to attend social gatherings. Some shared their experience:

"*At the OPD latest by* 7pm, *afternoon shift is closed. You get the opportunity to see them* (*friends*) *before they go home but at the NICU you close around 8:40 or 9pm so you don't have that opportunity.*" (P3)

"*I don't remember the last time I went to church or even attended a social function. It's mostly about work and even if the weekends are free you are too tired to*

go anywhere." (P9)

All participants reported experiencing burnout which rose from their emotional involvement in caring for sick neonate. The stressful and overwhelming nature of NICU'S work, led to varying degree of burnout. One participant noted some staff members refused to be assigned to the NICU due to its exhausting nature:

"*for this hospital, in our setting, you assign nurses to the emergency they willingly go, to the maternity they go they don't have any problem. But if you tell any staff you are taking them to NICU then the person starts lamenting profusely. Even though some of them haven't worked here, they are aware and we those working here too know, that its very exhausting, very very exhausting place to work*." (P3)

4.4.4. Emotional Exhaustion

Participant expressed that though working in the NICU is physically exhausting they experienced emotional exhaustion, particularly when a newborn die during their shift. The emotional toll was intensified by the affection they developed for the baby and their families. The death of babies had a profound impact on participants. They expressed feeling grief, guilt and regret.

"*the death of the babies does affect me. Seeing someone carry pregnancy for nine months only for the baby to expire is usually painful. You know within you that you have done your part but the baby didn't survive, you grieve over it for a while and the let go*" (P4)

"*death of the neonate is a worrying situation but sometimes you have to just accept it so that you do not lose any of the remaining babies; just put in your best to save the other babies. To keep worrying about the lost one can make you lose focus in taking care of the other babies*". (p5)

Participants reported that the emotional exhaustion they experienced had long term effects including changes in their behaviour and interaction with others.

"*the death of the neonate bothers me but what can I do about it? because death is not something you expect a new born to experience. Considering the efforts, you have put in for that baby*." (P5)

"*after all these years in the NICU, when a babies and I go home, I am unable sleep. I keep thinking about what happened at work*." (P6)

When they die on my shift, I wish I didn't come to work that day. Aside the emotional stress, dealing with the family is difficult. Even when they leave the ward after everything, when I see them in town, I feel uncomfortable." (P11)

Participants developed personal coping mechanisms to deal with emotional exhaustion as no formal support systems were in place. There is no well laid down intervention for nurses during or after emotionally stressful event in the ward. None of the participant had had any training on how to manage such emotions. The nurses have developed their own means of dealing with such situations. Some said:

"*I just sit down for a while and grieve then console myself that its meant to*

happens. At some point in time we will die but then no doubt if this baby had survived will have lots of challenges. You console yourself with that then you are good to go but then we don't have the type of person who will talk to you or console you. You console yourself and that's it." (p4)

"*When it happens I make sure I get busy on the ward till I close. The problems arise when you are home alone with your thoughts. Sometimes I can't eat, I can't sleep. Just thinking…what if this or that has been done.*" (P10)

4.4.5. Depersonalization

Some participants reported changes in their persona due to interaction with patient relatives particularly when relative fail to comply with instruction aimed at helping the baby.

"*This unit has changed my personality. I used to care so much about the babies but I have come to release that not all my patients deserve the stress I put myself through at work.*" (p9)

"*it's not my nature to see thing go wrong but I have stopped talking about the same thing over and over. It's like you are pouring water on rock. I just give up after several explanation and the mother does not want to comply.*" (P11)

One participant shared a disturbing experience:

"*I once heard a colleague say 'it's your child so please do as you please'. This is a senior colleague who has so much patience and always making the mothers feel good in the ward. The next day the baby died from aspiration which the woman has been severally advised about by almost every staff. When the baby died I couldn't understand my feelings. I didn't really feel the way I normally do. I knew my concern for that family had disappeared.*" (P10)

4.4.6. Personnel Competence

Although participants did not report a decline in their professional competence, some expressed their desire to leave the unit due its stressful nature which they believe could impact their ability to provide optimal care.

"*NICU is very stressful. Sometimes you feel like at some point in time you should be rotated to other ward that are less busy so you will also have some rest. And then leadership says you have to be there so you continue to be there. You do what you can but always do your best.*" (P3)

Some participants had pursued additional training to enhance their skills in caring for the sick new born. One participant said:

"*I also take in-service trainings, workshops to enhance my activities at the NICU and care for the babies.*" (P4)

4.5. Theme Four: Nurses Cope with Job Demand and Burnout at the NICU

This theme explored how nurses' cope with daily work activities at the NICU. This theme stems from strategic plans and actions taken by nurses to overcome negative experiences. Participants were unaware of burnout in relation to their duties.

Though some had reported tiredness, changes in personality and unable to handle their work load or adverse circumstance like death, they had never identified it as situation to seek help towards. Participants adapted various coping mechanism including reading, talking to relative, sleeping and engaging in house chose. Some participants share their experience:

"*Well I do get exhausted or over burden very often but I have never thought of it as something to seek help for.*" (P2)

"*I am always tired even when resuming from off days. That's how our work is. You always come in tired.*" (P15)

"*You keep thinking about how the day has been. Mostly I call my mother.*" (P11)

"*I even told a senior colleague of mine about always being tired but as time went on, before I will sleep, I have to watch a movie or read and fall asleep.*" (P6)

"*I mostly talk to my husband about work especially when there is a death.*" (P14)

4.5.1. Lack Supports System

Participants developed diverse means to deal with their day to day negative experiences including self-consolation, relaxation technique and support from family members. Some participants expressed:

"*You console yourself then you are good to go but then we don't have the type of person who will talk to you or console you. You console yourself and that's it.*" (p3)

"*Gets some food and relax for some minutes.*" (P4)

"*No one has been assigned to us for support or counselling. If I lose a baby, you just have to console yourself.*" (14)

4.5.2. Adjustment of Work Schedules

Participants suggested creating better schedules to reduce exposure to longer work duration and limiting the chance of burnout.

"*At the unit we have to make adjustment about our roster so that people will not be stressed out because of their schedule*". (P3)

5. Discussion

5.1. Participants Demographic Characteristics

The study participants were predominantly youthful with all of them aged between 24 and 48 years. All participants had at least the past 2 years work experience. The study sample consist of 3 males and 12 females, reflecting the female dominated nature of the nursing profession [41] [42]. Majority of participants identified as Christians and all held had tertiary education background in nursing from accredited nursing training colleges or universities, demonstrating knowledge of their roles and duties [43] [44].

5.2. Job Demand Experiences

The study findings indicate that work demand experiences were influenced by or-

ganizational structure and policies, heavy work load, poor physical work environment and workplace conflicts. Participants reported adverse job demand experience than positive ones. This finding aligns with research from various geographical location, which identified negative experience with job demands and this was linked with heavy work load, organizational politics and work place conflict [8] [16] [26] [29].

The study indicated majority 81.8% of participants were affected by poor organizational structure and policies characterized by poor management-staff relationship, challenges accessing administrative leaders and limited staff involvement in decision making. Decision making was typically done at the managerial level with unit leaders involving staff in the immediate decision affecting the unit and work. The poor organizational structure and leadership styles strongly influences nurses behaviour towards facility meetings and decision making. This finding is consistent with previous studies, which emphasized that staff view decision making as being imposed by administration rather than being discussed [45]. Staff nurses experience less involvement in decision making when nurse managers decide on professional practice, governance and leadership [46] [47]. In contracts, institutions that promote unit-based decision making tend to have greater professional nursing practice and provide better quality patient care [48] [49]. Nurses involvement in decision making can help build successful and effective organization as well as build their self-confidence [45] [50].

The study highlighted the heavy work load of nurses in the NICU, affecting almost all participants. All participants had worked continuously in the NICU for at least two years and eight had experience in other departments confirmed that the workload in the NICU is extreme compared to other wards. This excessive work-load can lead to missed care and poor outcomes for the newborn. Other research support this finding, indicating that unique characteristics of the newborn, the work in the NICU is different from other units [51]. A study by Tubbs-Cooley *et al.*, 2018, linked poor care practices to increases infant-to-nurse ratio, highlighting the significant association between heavy workload and missed nursing care [52].

The physical work environment was also reported to be poor with participants describing it as hot, poorly ventilated and over crowed. This was consistent with studies showing that poor physical work environment such as overcrowding, poor lighting and limited work space contribute to burnout [53]. These factors can cause psychological and behavioral problems such as fatigue, impatience, medical errors and inefficiencies [54].

The study also explored the impacted by job strain and burnout on participants' relationship. Six married participants reported benefiting from their relationships in managing job stress and burnout; receiving financial and emotional support from their spouses. In contrast, nine unmarried participants, including two engaged and seven single individuals relied mainly on parents and siblings for support when experiencing burnout. This finding is consistent with studies noting

that burnout affects family interaction, increased levels of exhaustion, depression and low job satisfaction [55].

5.3. Resource Demand Experience

The study revealed that nurses had limited resource available to work effectively, making it challenging to work to meet job demands and causing stress and burnout. Participants were overburdened by the resource constraints contributing to caregiving stress and potentially decreasing the quality of care provided to the newborn and their parents.

Despite resource challenges, participants reported immense family support of newborn during hospitalization. Parents showed concern and interest in their child's treatment, often experiencing sleepless nights. This finding is consistent with previous, which noted that newborn admission can evoke unfavourable feelings such as concern, doubt, and anxiety in the parent. This is apparent as most families turn to break down from the joy of the newborn's birth to living in vulnerability and uncertainty [56]-[58].

Frequent nurse-family conflicts were also reported often due to misunderstanding or limited information provided to families. Participants noted that some families' inability to cooperate with nurses contributes to burnout. Previous studies have identified similar issues, stressing the importance of effective communication and information sharing to reduce conflicts. "Health workers' attitude, patience and support in paediatric management is integral to adherence and maintaining the patient in their treatment trajectory" [13] [59]

The cost of newborn treatment was a significantly contributor to the conflict with parents. Participants observed that financial constraints influenced parents' decision regarding their child's treatment. Although Ghana's National Health insurance Scheme offers coverage for newborn, it does not cover all expenses including oxygen therapy, medication, surgeries and essential scans [13] [14] [58].

Despite these challenges, participants provided care for newborns before seeking payment from parents. This finding is consistent with another Ghanaian study which highlighted the importance of healthcare professional providing care despite financial constraints [13].

Nurses intrinsic motivations played a crucial role in handling increasing job demands. Participants reported that their motivation was enhanced when they successfully cared for babies to good health. However, extrinsic motivation from managers was no longer expected. This finding contrasts other related study, Kootahi *et al.*, which identified extrinsic factors such as wage, support, job security and carrier development opportunity as influencing job motivation. Nurse managers awareness of nurses working condition and relationship with colleagues can support their work environment and boost their resilience and motivation [60].

Participants lacked resources to carry out care duties effectively despite being enthusiastic about healthcare activities. The nurses believed they were giving their best to their patients but felt that facility managers did not appreciate their work

output. This is consistent with Sodeify *et al.*, 2013 who in their study reported that nurses lack support from their work place and they consider nurse managers to be ignorant of their job needs and professional values [61]. According to Kousar *et al.*, 2018, both human and material resources are crucial in improving the work environment of nurses as well as improve work satisfaction [62].

Participants reported positive working relationship with other nurses with no friction or conflict among nurses and other cadre of health care professional. This finding is consistent with Piquette *et al.*, who observed that inter-professional collaboration among health workers in the intensive care unit is common and lead to quality patient outcomes [63]. However, this findings contract with other studies that reported frictional encounters between nurses and physicians with physicians displaying dominance over nurses [64].

Nurses were supportive of each other, acting as buffer to support colleagues experiencing burnout. Unit leaders' availability and support were also appreciated. Literature highlights the importance of support from unit leaders and colleagues in promoting commitment, effectiveness and high self-esteem [65]-[67]. Nurses personal life influenced their care attitude toward sick neonate. Clinical judgment, social life and supportive staff were key factors identified to contribute to this. Other studies conducted in Ghana reinforce this finding, highlighting the importance of financial, spiritual, and emotional support in helping nurses cope with workplace issues [13] [68].

Participants gained great satisfaction from successful recovery and safely discharge of newborns. This led to building good relationship with the family [13]. However, the demanding nature of their work affected their social and religious life limiting their ability to attend to social events and interact with family and friends. Social support during stressful times affects one's perspective on life's purpose, coping skills, and work-life balance [36].

5.4. Nurses Burnout Experience

Burnout was a common occurrence among all participants with vary of degree of severity. Emotional exhaustion was the most significant component, often linked to the death of the newborn. Neonatal death rate in the unit were high at 28.4/1000 live birth; exceeding the national figure of 20.2% (NND 2022 report). Participants employed various coping mechanisms including emotional avoidant behaviour, develop new strategies or seeking support from others to manage burnout. These findings were similarly reported by Poku *et al.*, 2020, who stated that nurses in low resource setting are at prone to emotional exhaustion due to death and discomfort of patients, inter-professional conflict and lack of support from nurse managers [69]. Some participants develop behavioural changes to overcome emotional exhaustion. However, Boland *et al.*, 2019, noted that avoidant behaviour can worsen burnout among nurses as compared to problem-focus behaviour [70]. Despite emotional trauma, associated with their work, participants reported no support system in the work place to manage burnout. Though burnout is a well-

known occurrence in ICU's these nurses where not taught self-care or health promotional activities to cope with frequent emotional turmoil of their occupation.

Depersonalization associated with occupational burnout can be exhibited as annoyances, anxiety, depression, sleeplessness and bad eating habits [71]. Participants reported similar findings due to their care giving roles. Despite reporting these symptoms, participants have not taken any initiative manage them effectively. The foundation of newborn and parent care relies on the relationships between health professionals and parents. These interactions enable healthcare professionals to gain in-depth knowledge about the baby's state and facilitate parents' involvement in caring for their unwell newborn. Participants reported changes in attitude toward parents who do not follow care standards. Non-adherence had severe consequences, including extended hospital stays, infants neglect, death, reduced service quality, increased risk of complications, low patient satisfaction, and higher hospitalization-related costs [2] [72].

Worthy of note, in this study, all participants lacked knowledge about burnout despite experiencing symptoms such as emotional exhaustion, personality changes and lack of enthusiasm to continue working in the NICU. The lack of knowledge hindered their ability to seek professional help. These findings are consistent with Forbi, G. 2021, who reported that 43.5% of nurses were unaware of burnout thus affecting their ability to seek help and gain skill in managing nursing-related burnout [68].

5.5. Nurses Cope with Job Demand and Burnout at the NICU

All participants had reported to at least one associated symptom of burnout to their unit leader. This findings supports Evenstad, 2015 research, which suggested that burnout among nurses maybe under reported and those reported are not given the needed attention [16]. Participants identified personal coping measures to mitigate job demands and burnout. These coping skills includes sleeping, reading book, performing house chaos, calling family members and discussing burnout experience with spouses. These findings are consistent other studies, which reported that participants used self-reflection, participatory programs, family support and supportive colleagues to cope with burnout [36] [61] [70] [73].

Some participants chose to gain more knowledge in newborn care as mean of coping. Further studies and knowledge acquisition help nurses to develop informed choices about care for themselves and their patients' relatives during emotional periods. Self-care activities for nurses assisted them in developing a thorough understanding of recognizing and reporting work pressures and burnout experiences. This finding is consistent with studies that found nurses who receive psychological support, such as counselling, had guidance on navigating the chal lenging course of nursing job in the NICU [73]. A combination of personal-driven and organizational intervention helped to decrease the occurrence of extreme job demands and burnout among nurses [17] [74].

Nurses reported difference in attitude towards job demands and burnout.

While some developed an avoidant behaviour, other tried to improvise their work to suit their current statue of mind. Job grafting is known to support employees to cope better with burnout [17] [18] [74].

5.6. Evaluating of the Job Demand and Resource Theory on This Research

The job demand resource theory developed by Bakker and Demerouti [17] was instrumental in guiding this study. The theory facilitated the exploration of job demands and burnout experiences of nurses caring for sick newborns. The researchers utilized the construct of job demand resource theory and observed the outcomes in term of interventions or coping skills. The JD-R theory posits that nurses' motivation and wellbeing are influence by the amount of work they perform, the availability of resources and their personal ability and skills to manage workload and utilize resource effectively. The theory assumes that nurses' dissatisfaction and burnout stems from higher job demands with inadequate resources. Personal resources such as resilience, adaption and fortitude enable nurses to overcome work demand without adversely affecting their well-being.

The study revealed that nurses had both positive and negative work experiences, with a predominance of negative job demand experience and burnout. The JD-R theory helped elicit responses from the participants highlighting various coping strategies when overwhelmed with work or burnout. These strategies included team support, supportive unit leadership and family support. Nurses identified organizational policies, heavy workload, lack of extrinsic motivation, equipment and emotional engagement as factors contribute to increase their job demand and burnout experience. Nurses' personal resources were influenced by intrinsic motivation such as love for the profession, happiness in assisting patients and family to recovery and supporting puerperal mothers in caring for their newborn. The JD-R theory proposes broad interventions encompassing both individual and organizational strategies. The study's finding highlights the importance of addressing job demands and resources availability to mitigate burnout and promote nurses' well-being.

6. Conclusion

The study revealed nurses in the NICU faced significant challenges in their work environment despite experiencing positive team work. Nurse-patient relationship was vital in providing quality care for the babies but conflicts with patient relatives were common. The extensive family support the baby has makes it tolerable for nurses to provide care. Nurses relied heavily on their clinical judgement and self-awareness to care for newborn, given their unique features. However, this leads to limited social lives outside of work, heightened job demands and burnout. Nurses experience some degree of burnout with low job satisfaction. Emotional exhaustion, linked to dealing with newborn deaths, was major concern for burnout. Unfortunately, nurses lacked the support to manage high job demand or burnout

leading to avoidance behaviour and impaired physical, social and psychological wellbeing.

This study aimed to identify areas for quality improvement, inform policies and develop intervention to support nurses' well-being. The results highlight the need for proactive interventions to facilitate nurses' assignment to high-demand wards. Also Enhance nurses' knowledge and awareness of burnout for early identification and better treatment outcomes. Provide supportive feedback for nurses to determine priorities for occupational support, improvement in logistics, identify areas of support for the nurse as well as institute institutional measures for burnout.

Conflicts of Interest

The authors declare no conflict of interest.

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Abbreviations

GHS-ERC	Ghana Health Service-Ethics and Research Committee
JD-R	Theory Job Demand-Resource Theory
NICU	Neonatal Intensive Care Unit
OPD	Out-Patients' Department
WHO	World Health Organization