DIFFERENCES IN BURNOUT AMONG HEALTHCARE WORKERS IN THE OUTPATIENT, INPATIENT, AND EMERGENCY DEPARTMENTS OF IMANUEL WAY HALIM HOSPITAL IN BANDAR LAMPUNG

(Thesis)

By

EVRYNA SIPAHUTAR

2218011140

FACULTY OF MEDICINE
UNIVERSITAS LAMPUNG
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Thesis

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Student Name	:	Evryna Sipahutar
Student Number	:	2218011140
Study Program	:	Medical Education
Faculty	:	Medicine

AGREEMENT

1. Supervisory Commission

Bayu Anggileo Pramesona, S. Kep., Ns., MMR., Ph. D., FISQua.
NIP 198660802 200903 1 001

dr. Septia Eva Lusina, S. Ked., Sp. F.
NIP 198660916 202321 2 038

2. Dean of the Faculty of Medicine

Dr. dr. Evi Kurniawaty, S. Ked., M. Sc
NIP 19760120 200312 2 001

VERIFICATION

1. Examiner Team

Chief : **Bayu Anggileo Pramesona, S. Kep., Ns., MMR., Ph. D., FISQua.**

Secretary : **dr. Septia Eva Lusina, S. Ked., Sp. F.**

Examiner
Not Supervisor : **Dr. dr. Rika Lisiswanti, S. Ked., M. Med. Ed.**

2. Dean of the Faculty of Medicine

Dr. dr. Evi Kurniawaty, S. Ked., M. Sc.
NIP 19760120 200312 2 001

Thesis Exam Pass Date: **January 12th, 2026**

STATEMENT

I, the undersigned:

Name	: Evryna Sipahutar
Student ID	: 2218011140
Program	: Pendidikan Dokter
Thesis Title	: Differences in Burnout among Healthcare Workers in The Outpatient, Inpatient, and Emergency Departments of Imanuel Way Halim Hospital in Bandar Lampung

I hereby declare that this thesis is **MY OWN WORK**. If, at a later date, it is proven that there has been plagiarism or fraud in this academic work, I am willing to accept sanctions.

Bandar Lampung, January 12th, 2026

Student,

EVRYNA SIPAHUTAR

BIOGRAPHY

The author was born in Medan on April 12th, 2004, as the fourth of four children of the late Drs. Hormat Parningotan Sipahutar, M.Si and Marintan Lumbantoruan, S.Kep., Ners.

The author attended elementary school at SD HKBP Paandg Bulan Medan, graduating in 2015, then continued her education at SMP Methodist 1 Medan, graduating in 2018, and at SMA Negeri 2 Medan, graduating in 2021. The author then continued her studies as a student in the Medical Education Program at the Faculty of Medicine, Universitas Lampung, in 2022 through the Seleksi Bersama Masuk Perguruan Tinggi Negeri (SBMPTN). During his pre-clinical studies, the author was actively involved in the LUNAR-MRC student organisation and the CIMSA & Permako Medis organisations at the Faculty of Medicine, Universitas Lampung.

FOREWORD

Praise be to God Almighty for His blessings, protection, and wisdom, so that the author could complete the thesis **"Differences in Burnout among Healthcare Workers in The Outpatient, Inpatient, and Emergency Departments of Imanuel Way Halim Hospital in Bandar Lampung"** well and on time as part of the final assignment to obtain a Bachelor of Medicine degree in the Medical Education Study Program, Faculty of Medicine, Universitas Lampung.

In completing this thesis, the author received extensive guidance, input, assistance, criticism, and advice from various parties. With this, the author would like to express his deepest gratitude to:

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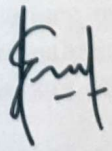
Finally, the author realizes that there are many aspects that can still be improved in this thesis. The author hopes to receive constructive suggestions and criticism from various parties. Hopefully, this work can be beneficial to readers.

Bandar Lampung, January 12th, 2026

Writer



EVRYNA SIPAHUTAR

ABSTRACT

DIFFERENCES IN BURNOUT AMONG HEALTHCARE WORKERS IN THE OUTPATIENT, INPATIENT, AND EMERGENCY DEPARTMENTS AT IMANUEL WAY IMANUEL HOSPITAL, BANDAR LAMPUNG

By

EVRYNA SIPAHUTAR

Background: Burnout among nurses is influenced by the characteristics of the work unit and can reduce service quality. This study aims to determine differences in burnout scores across the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment among nurses in the Outpatient, Inpatient, and Emergency Departments.
Methods: Burnout among nurses is influenced by the characteristics of the work unit and can reduce service quality. This study aims to determine differences in burnout scores across the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment among nurses in the Outpatient, Inpatient, and Emergency Departments.
Results: The median Emotional Exhaustion score was 39 for Outpatient, 36 for Inpatient, and 45 for Emergency. The Depersonalization score was recorded as Outpatient and Inpatient 6; Emergency Department 7. The Personal Accomplishment score was recorded as Outpatient and Emergency 28; Inpatient 24. There was a significant difference in the Emotional Exhaustion score across work departments ($p = 0.023$); the post-hoc test showed a significant difference between the Inpatient and Emergency Departments ($p = 0.006$). Depersonalization ($p = 0.190$) and Personal Accomplishment ($p = 0.131$) did not differ significantly between departments.
Conclusions: There are differences in the level of burnout in the Emotional Exhaustion dimension across work units, with the highest score among nurses in the Emergency Department. Conversely, the dimensions of Depersonalization and Personal Accomplishment did not show significant differences between departments.

Keywords: burnout, emergency department, inpatient, nurses, outpatient

ABSTRAK

PERBEDAAN BURNOUT PADA TENAGA KESEHATAN DI INSTALASI RAWAT JALAN, RAWAT INAP, GAWAT DARURAT RUMAH SAKIT IMANUEL WAY IMANUEL BANDAR LAMPUNG

Oleh

EVRYNA SIPAHUTAR

Latar Belakang: *Burnout* pada perawat dipengaruhi oleh karakteristik unit kerja dan berpotensi menurunkan kualitas layanan. Penelitian ini bertujuan untuk mengetahui perbedaan skor *burnout*, pada dimensi *Emotional Exhaustion*, *Depersonalization*, dan *Personal Accomplishment*, perawat di Instalasi Rawat Jalan, Rawat Inap, dan Gawat Darurat.
Metode: Penelitian *cross-sectional* ini dilaksanakan di Instalasi Rawat Jalan, Rawat Inap, and Gawat Darurat RS Imanuel Way Halim Bandar Lampung pada periode Agustus–Desember 2025. Sampel sebanyak 115 perawat diperoleh secara *proportional random sampling*. *Burnout* diukur menggunakan *Maslach Burnout Inventory-Human Services Survey* (MBI-HSS). Analisis perbandingan antar-kelompok menggunakan Kruskal-Wallis.
Hasil: Nilai Median *Emotional Exhaustion* tercatat Rawat Jalan 39; Rawat Inap 36; Gawat Darurat 45, skor *Depersonalization* tercatat Rawat Jalan dan Rawat Inap 6; Gawat Darurat 7, seandgkan skor *Personal Accomplishment* tercatat Rawat Jalan dan IGD 28; Rawat Inap 24. Terdapat perbedaan bermakna pada skor *Emotional Exhaustion* antar unit kerja ($p = 0{,}023$); uji post-hoc menunjukkan perbedaan signifikan antara Rawat Inap dan Gawat Darurat ($p = 0{,}006$). *Depersonalization* ($p = 0{,}190$) dan *Personal Accomplishment* ($p = 0{,}131$) tidak berbeda signifikan antar unit.
Kesimpulan: Terdapat perbedaan tingkat *burnout* pada dimensi *Emotional Exhaustion* berdasarkan instalasi kerja, dengan skor tertinggi pada perawat di Instalasi Gawat Darurat. Sebaliknya, dimensi *Depersonalization* dan *Personal Accomplishment* tidak menunjukkan perbedaan yang bermakna antar instalasi.

Kata Kunci: *burnout*, instalasi gawat darurat, instalasi rawat inap, instalasi rawat jalan, perawat

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CHAPTER 1
INTRODUCTION

1.1 Background

Burnout Syndrome is a condition of physical and psychological exhaustion characterised by decreased concentration, negative self-image, and decreased work performance (Reza and Soliha, 2021). Individuals experiencing burnout often experience a decline in work motivation and self-confidence. If left unaddressed, burnout can have a significant negative impact on physical health, psychological well-being, and overall quality of life (Nadiva and Cahyadi, 2022). Burnout has emerged as a widespread occupational phenomenon, affecting various service professions such as nurses, doctors, lecturers, teachers, prison officers, personnel officers, and social workers (Low et al., 2019; Kumari and Raghuramapatruni, 2023; Cadena-Povea et al., 2025).

Undang-undang No. 17 of 2023 defines health workers as any person who devotes themselves to the field of health and has acquired knowledge or skills through health education for certain professions that require special authority to carry out health efforts. Health workers include general practitioners, specialists, dentists, nurses, midwives, pharmacists and pharmacy assistants, nutritionists, laboratory analysts, sanitarians, physiotherapists, public health workers, as well as medical technicians and other health professions in accordance with laws and regulations (UU RI No. 17, 2023).

According to data from the World Health Organisation (WHO) in 2020, the global nursing population reached 27.9 million, equivalent to 59% of all global health workers (WHO, 2020). Kemenkes RI reported that in 2020, there were 428,234 nurses in various health facilities, or 40.85% of the total national health workforce. Other health professions included midwives (23.24%), pharmacists and pharmaceutical staff (7.24%), general

practitioners (6.33%), biomedical technicians (5.13%), specialists (3.58%), and public health workers, nutritionists, dentists, and physical and occupational therapists as the remaining group (Kemenkes RI, 2021). Nurses, as the largest health professional group, can experience burnout, potentially reducing the quality of nursing services by increasing the risk of clinical fatigue and decreasing patient satisfaction and safety (Borges et al., 2021). In addition, nurses also play a role as the largest health professional group, with the intensity of their involvement in providing direct care continuously for 24 hours through a shift work system, and the consistency of literature findings showing the high prevalence of burnout in the nursing profession. Therefore, burnout among nurses is an important indicator of the burden of burnout among healthcare workers in general (Borges et al., 2021; Galanis et al., 2023; Kecklund and Axelsson, 2016).

The phenomenon of burnout among nurses has been the focus of much international research. A global meta-analysis by Ge et al. noted that burnout rates have remained significant over the past ten years in more than 30 countries (Ge et al., 2023). Another study by Galanis et al. suggests that after the COVID-19 pandemic, approximately 91.1% of nurses experienced higher burnout than other healthcare workers (Galanis et al., 2023). In the United States, nearly 50% of nurses reported experiencing emotional exhaustion daily or several times a week (Martin et al., 2023). Meanwhile, the prevalence of burnout among nurses was recorded at 41.1% in Hong Kong (Indah *et al*., 2024). A study by Febriana & Rochmawati reported that 44% of nurses in Greece reported discomfort in nursing practice, and 42% in the United Kingdom indicated psychological effects due to burnout (Febriana and Rochmawati, 2023)

A survey by the Persatuan Perawat Nasional Indonesia (PPNI) found that 50.9% of nurses in Indonesia experience burnout, characterised by symptoms such as dizziness, fatigue, decreased friendliness, lack of rest, and pressure from excessive workloads and disproportionate compensation

(Zuniawati and Pringgotomo, 2022). Another study by Pinarsih et al. on inpatient nurses at Dr. A. Dadi Tjokrodipo Regional General Hospital reported that 21.2% of respondents experienced high levels of burnout, and analysis showed a significant relationship between excessive workload and perceived appreciation with the occurrence of burnout (Pinarsih et al., 2023). Additionally, another study by Rohman et al. conducted at Serui Regional General Hospital in Papua reported a burnout prevalence of 27.7% (Rohman et al., 2023).

Based on research by Kurniawan et al. at a referral hospital in Bali, 41.9% of nurses experienced high levels of burnout (Kurniawan et al., 2022). Research by Maramis & Cong at Advent Hospital in Manado found that 49% of nurses experienced moderate burnout (Maramis and Cong, 2019). Another study at Wava Husada Hospital in Malang noted that 44.9% of nurses experienced high levels of burnout (Putri et al., 2023). Research on nurses at Atma Husada Hospital in Samarinda reported that 56% of respondents experienced burnout (Ramand and Fadly, 2017). Another study by Pramesona et al. at a tertiary referral hospital in Lampung found that 54.8% of nurses in the COVID-19 isolation ward experienced burnout (Pramesona et al., 2021).

Undang-undang No. 17 of 2023 defines a hospital as a health care facility that provides comprehensive individual services, including promotion, prevention, curative, rehabilitative, and palliative care, by providing three main types of services: inpatient care, outpatient care, and emergency care. In line with this, Permenkes No. 40 of 2022 specifies that outpatient services include all observation, diagnosis, treatment, medical rehabilitation, and other supporting services provided without the obligation for patients to stay overnight at the health facility, while inpatient services include a series of observation, diagnosis, treatment, medical rehabilitation, and supporting services that require the patient to stay in the hospital during the treatment period (Kemenkes RI, 2022a). Permenkes No. 47 of 2018 states that

emergency services are focused on medical interventions that must be carried out immediately to save lives or prevent disability (Kemenkes RI, 2018).

The extensive hospital service framework directly affects the intensity of nurses' tasks, as reflected in the high prevalence of burnout among nurses. Nurses working in inpatient and outpatient units face high levels of work stress due to heavy workloads. If this pressure is not managed properly, nurses can experience physical, emotional, and mental exhaustion, which ultimately leads to burnout. Research conducted at Dr. Soetarto Hospital in Yogyakarta shows that 67.1% of nurses in inpatient units experience moderate burnout, while severe burnout is experienced by 31.1% of inpatient nurses and 27.07% of outpatient nurses at Z Hospital in Batu City (Fatimah and Yugistyowati, 2022; Wijayati and Marianingsih, 2024).

The Emergency Department demands high levels of interaction and mobility, as well as efficient time management, diagnostic accuracy, and protocol compliance (Nurbaeti et al., 2022; Karaeng, 2024). This work environment is highly stressful because nurses must care for patients in critical, life-threatening conditions, which requires high concentration, deep clinical expertise, and quick response skills (Tunny and Rochmaedah, 2023). Studies in the emergency rooms of hospitals in Tangerang and Tulungagung noted that 40–58% of nurses experienced severe burnout, indicating a significant psychological burden in emergency room services (Lestari et al., 2022; Permatasari et al., 2023).

In the nursing profession, burnout can significantly affect the quality of healthcare services. Burnout has the potential to trigger anxiety disorders, depression, and insomnia. These conditions can threaten patient safety, as nurses experiencing emotional exhaustion show an increased risk of errors in medication administration and medical procedures (Handoko, 2022). If left unaddressed, this phenomenon will degrade the quality of hospital

services and undermine public trust in nurses' professionalism (Cesilia & Kosasih, 2024; Indiawati et al., 2022; Warandi and Hapsari, 2022). Burnout in nurses is measured using the Maslach Burnout Inventory - Human Services Survey (MBI-HSS) (Dall'ora et al., 2020).

Previous studies have shown that nurses have higher levels of burnout than other health professionals, especially those working in high-pressure environments such as inpatient wards and emergency rooms. However, studies specifically comparing burnout among nurses in outpatient, inpatient, and emergency settings remain limited. The differences in burnout among nurses in these three units have not been extensively studied, especially in the context of private hospitals, making it an area of research that warrants further investigation (Hariani et al., 2023; Indryan and Suhana, 2022; Wienanda et al., 2024).

This study was conducted at Imanuel Way Halim Hospital, Bandar Lampung, because, to date, no specific study has compared burnout among healthcare workers in outpatient, inpatient, and emergency care facilities. As the only Type B Hospital in Bandar Lampung, Imanuel Way Halim Hospital has a comprehensive service capacity with simultaneous outpatient, inpatient, and emergency patient flows (Budi and Kusumapradja, 2022). The research results are expected to provide an empirical basis for management in designing burnout prevention interventions tailored to the characteristics of each unit, as well as supporting the formulation of policies aimed at improving the welfare of nurses and the overall quality of health services (Hariani et al., 2023; Indryan and Suhana, 2022).

1.2 Problem Formulation

Based on the previous explanation, the research question can be formulated as follows: Is there a difference in burnout among healthcare workers in outpatient, inpatient, and emergency care units at Imanuel Way Halim Hospital, Bandar Lampung?

1.3 Research Objectives

1.3.1 General Objectives

The general objective of this study was to determine the differences in burnout among healthcare workers in the outpatient, inpatient, and emergency departments of Imanuel Way Halim Hospital in Bandar Lampung.

1.3.2 Specific Objectives

1. To determine the frequency distribution of respondents in terms of age, gender, education level, marital status, and work unit.
2. To determine the average burnout score consisting of the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment among health workers, particularly nurses, in the outpatient, inpatient, and emergency departments of Imanuel Way Halim Hospital.
3. To determine the level of burnout based on the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment among healthcare workers, particularly nurses, in the outpatient, inpatient, and emergency departments of Imanuel Way Halim Hospital.
4. Analyse the differences in average burnout scores consisting of the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment based on work units.

1.4 Benefits of Research

1.4.1 For Hospital Management

1. Provide information related to burnout among healthcare workers, especially nurses, in outpatient, inpatient, and emergency care facilities, so that hospitals can evaluate the working conditions of healthcare workers, especially nurses.

2. Assisting hospital management in designing more effective strategies or policies to reduce burnout among healthcare workers, especially nurses, in accordance with the characteristics of the service unit.
3. Supporting efforts to prevent and manage burnout among healthcare workers through data that can be used in workload planning, psychosocial support, and workplace improvements.

1.4.2 For Nurses and Healthcare Workers

1. Provide an understanding of burnout conditions that can occur in daily healthcare services, while raising awareness of the importance of maintaining mental health in the workplace.
2. Encourage the creation of a work environment that is more concerned with the psychological well-being of healthcare workers, especially nurses.

1.4.3 For Future Researchers

1. Serve as a reference for further research that seeks to examine burnout among healthcare workers, particularly nurses, with a broader scope of variables or more in-depth methods.
2. Encourage further research related to interventions or strategies that can be used to reduce burnout among healthcare workers, especially nurses.
3. Open up opportunities for further research evaluating the effectiveness of specific burnout interventions in outpatient, inpatient, and emergency care settings based on the characteristics of the healthcare workers.

CHAPTER II
LITERATURE REVIEW

2.1 Burnout

2.1.1 Definition of Burnout

Burnout is a condition of physical, emotional, and mental exhaustion that arises from prolonged involvement in emotionally demanding work situations. This condition is described as a psychological syndrome consisting of three main aspects, namely emotional exhaustion, depersonalization, and reduced personal accomplishment. Some experts even categorise burnout as a response to stress. Individuals experiencing burnout generally lose direction and are unable to meet their job demands effectively. This condition can also occur when someone works intensively without paying attention to their personal needs (Alam, 2022; Maslach and Leiter, 2016).

Negative self-perceptions, decreased concentration, and the emergence of unconstructive work behaviours characterise burnout. This condition can create an unpleasant work atmosphere, reduce dedication and commitment to work, and lead to decreased performance and achievement. In addition, individuals experiencing burnout tend to withdraw from the work environment and avoid social involvement (Alam, 2022).

2.1.2 Etiology and Symptoms of Burnout

Burnout is an individual-level psychological experience characterised by affective changes (emotional exhaustion), cognitive changes (attention and executive function impairment), motivational changes, and a subjective evaluation of work. All of these dimensions are perceived as maladaptive experiences that cause distress, functional dysfunction, and discomfort. The etiology of burnout is closely related to the mismatch between worker characteristics and job demands

(person-job misfit). Burnout can also arise from an imbalance between the effort expended and the rewards or recognition received from work. Predisposing factors such as excessive workload, limited control or autonomy at work, inadequate reward systems, perceptions of unfairness, and value conflicts create chronic interactions between job demands and limited resources, thereby promoting the development of burnout (Maslach et al., 2001; Maslach and Leiter, 2019).

The clinical manifestations of burnout include emotional exhaustion, decreased personal efficacy or achievement, impaired cognitive functioning, increased emotional and interpersonal distress symptoms, changes in work behaviour patterns (decreased performance), and increased organisational complaints and distress. These changes have far-reaching consequences for both individual well-being and organisational productivity (Khammissa et al., 2022).

2.1.3 Pathophysiology of Burnout

Repeated or chronic exposure to burnout activates two main stress response pathways, namely: (1) the hypothalamic-pituitary-adrenal (HPA) axis and (2) the autonomic nervous system (ANS). Repeated activation of these two systems alters the secretion of stress hormones, namely cortisol and catecholamines, causing physiological response patterns to become deregulated or flattened over time (Morera et al., 2020).

Persistent burnout responses subsequently modulate the immune system, causing changes in cytokine balance, such as an increase in pro-inflammatory cytokines and changes in anti-inflammatory mediators, leading to micro-inflammation that mediates somatic symptoms (fatigue, pain, digestive disorders) and contributes to tissue dysfunction (Kany et al., 2019).

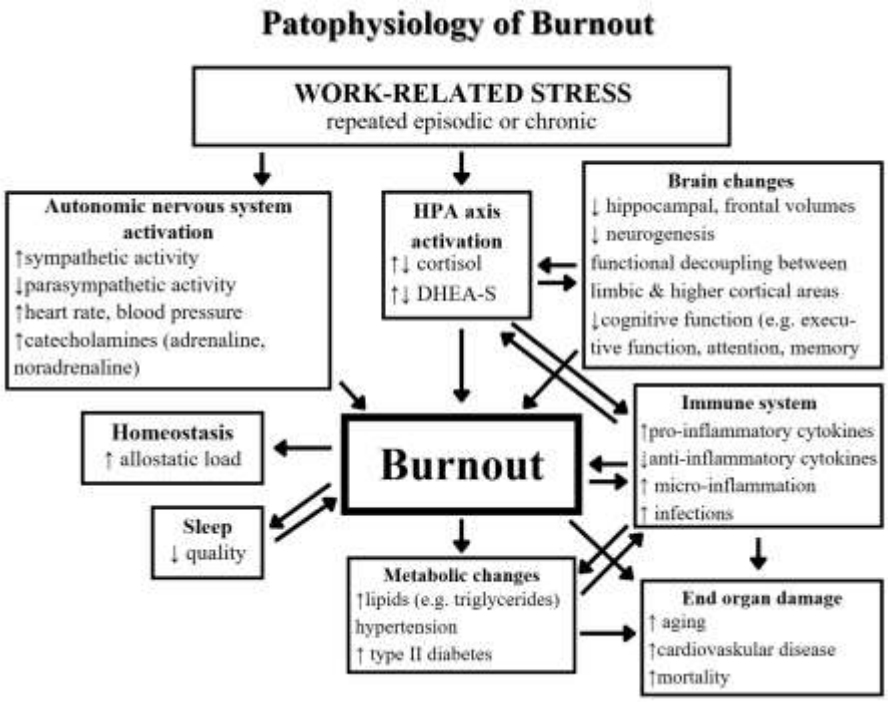

Figure 2.1 Pathophysiology of Burnout.
(Tarazona, 2023)

At the brain level, exposure to burnout and hormonal or immunological changes are associated with structural and functional changes, such as relative atrophy in the hippocampus and changes in the prefrontal cortex, which explain the cognitive dysfunction (attention, working memory, executive function) and emotional regulation often found in burnout (Morera et al., 2020).

The accumulation of these systemic changes is known as allostatic load, which involves disturbances in metabolic homeostasis, including elevated lipid profiles, hypertension, and glucose disorders. Over time, this leads to an increased risk of damage to target organs, particularly the cardiovascular system (Konlan et al., 2022). Additionally, sleep disturbances and reduced rest quality act as factors that exacerbate all of the above pathways (reinforcing HPA/ANS dysfunction, inflammation, and cognitive deficits), thereby creating a maladaptive cycle that maintains and worsens burnout (Alotiby, 2024).

2.1.4 Dimensions of Burnout

Burnout is a psychological syndrome characterised by three main dimensions, namely: (1) emotional exhaustion, (2) depersonalization or cynicism, and (3) reduced personal accomplishment. Emotional exhaustion describes a condition in which individuals feel mentally and emotionally drained due to prolonged workloads, leading to emotional distance from their work. Meanwhile, depersonalization emerges as a defence mechanism, in which individuals begin to show cynicism or indifference towards colleagues and patients. The final component, reduced personal accomplishment, refers to negative perceptions of one's competence and productivity, which lead to a decline in self-confidence in performing work tasks. Burnout is not just ordinary fatigue, but a condition that has a significant impact on the decline in professional performance, work motivation, and the physical health of individuals (Maslach and Leiter, 2016).

2.1.4.1 Emotional Exhaustion

The first dimension, emotional exhaustion, is a core aspect of burnout. This condition occurs when individuals feel emotionally and physically drained from excessive, prolonged work demands. Common symptoms include feeling deeply tired when thinking about work, difficulty starting work activities every morning, reluctance to interact with coworkers or patients, and physical complaints such as headaches or digestive problems. This emotional exhaustion can weaken an individual's capacity to engage in their work actively (Maslach and Leiter, 2016).

2.1.4.2 Depersonalization

In response to ongoing emotional exhaustion, individuals tend to develop defensive attitudes, such as depersonalization. Depersonalization is referred to as a psychological defence mechanism characterised by cynical and negative attitudes

toward work, maintaining emotional distance from service recipients, and decreased empathy and personal involvement. Individuals begin to view patients or coworkers inhumanely, which significantly reduces the quality of interpersonal relationships in the work environment (Maslach and Leiter, 2016).

2.1.4.3 Personal Accomplishment

The third dimension, namely a decline in personal achievement, reflects feelings of failure and incompetence in performing work tasks. Individuals feel that their efforts are not producing meaningful results, their competence is being questioned, and their contributions are not being appreciated. This has an impact on declining productivity and work quality, as well as eliminating the sense of pride in previous professional achievements (Maslach and Leiter, 2016).

These three dimensions influence each other in forming the burnout cycle. Prolonged emotional exhaustion can trigger depersonalization, and persistent depersonalization ultimately erodes work accomplishment. This decline in accomplishment then exacerbates emotional exhaustion, creating a negative cycle that is difficult to break without proper intervention (Maslach and Leiter, 2016).

The classification of burnout levels into low, moderate, and high categories in the MBI-HSS is based on dividing each subscale score into predetermined ranges. After the scores on the Emotional Exhaustion subscale are calculated, they are categorised into three groups: scores < 19 indicate low burnout; scores 19–26 indicate moderate burnout; and scores > 26 reflect high burnout. Furthermore, subscale scores of < 6 on Depersonalization are classified as low burnout; scores of 6–9 as moderate burnout; and scores > 9 as high

burnout. Meanwhile, on the Personal Accomplishment subscale, scores < 34 are categorised as low, 34–39 as moderate, and> 39 as high. Thus, burnout levels in nurses are classified systematically based on scores on the three MBI-HSS subscales (Maslach and Jackson, 1981).

2.1.5 The Impact of Burnout

The effects of burnout, as described by Leiter and Maslach, include various aspects of loss, both in terms of energy, work enthusiasm, and self-confidence (Alam, 2022).

2.1.5.1 Impact on Labor

a. Burnout is Lost Energy

Burnout can cause individuals to experience significant physical and emotional exhaustion, accompanied by prolonged stress and feelings of overwhelm. This condition is often accompanied by sleep disturbances and a tendency to withdraw from social environments. As a result, an individual's work ability declines, which directly impacts productivity and work effectiveness (Alam, 2022).

b. Burnout is Lost Enthusiasm

In a state of burnout, interest and enthusiasm for work decline dramatically. Activities that were previously enjoyable become burdensome. A decline in creativity and emotional engagement with work also affects the quality of work produced, which tends to be minimal and suboptimal (Alam, 2022).

c. Burnout is Lost Confidence

When energy and emotional engagement with work decrease, workers become less effective in performing their duties. Over

time, this triggers self-doubt and lowers self-confidence. Studies show that role ambiguity, low intrinsic motivation, and role conflict are factors correlated with work fatigue. The impact is seen in decreased commitment to the organisation, job satisfaction, workforce performance, and increased intention to change jobs (Alam, 2022).

2.1.5.2 Impact on Society and the Health System

a. Decline in Service Quality and Patient Safety

Burnout among healthcare workers reduces clinical alertness, diminishes decision-making accuracy, and weakens interprofessional communication, thereby directly jeopardising the quality of care and patient safety. This condition increases the likelihood of incidents that endanger patients and lower hospital service standards (Handoko, 2022).

b. Increase in the Frequency of Medical Errors and Medical Incidents

Healthcare workers experiencing burnout are more prone to procedural and medication errors due to emotional exhaustion and decreased cognitive function. This condition increases the incidence of medical errors and near misses, which have a significant impact on patient clinical outcomes and require corrective intervention from institutions (Siregar and Hariyati, 2021).

c. Decline in Productivity and Increase in Absenteeism and Turnover of Health Workers

Burnout leads to decreased productivity, increased absenteeism, and increased turnover. This condition increases the administrative and operational burden on healthcare facilities, including the need to recruit, orient, and train

replacement staff, disrupt service continuity, and potentially increase institutional costs (Handoko, 2022).

d. Service Disruption and Economic Burden on Health Facilities

Burnout that triggers work schedule disruptions, increased absenteeism, and turnover among healthcare workers causes service disruptions, such as longer waiting times and delays in referrals, and places an economic burden on healthcare facilities through direct costs (incident remediation, compensation) and indirect costs (recruitment, orientation, and training of new staff, as well as potential revenue losses due to decreased patient trust) (Agustin, 2022).

Burnout has been shown to impact the quality of healthcare services significantly. At the national level, research in Indonesia shows a fairly strong negative relationship between nurse burnout and patient satisfaction, particularly in inpatient units and emergency rooms, with a correlation coefficient of -0.42. These findings confirm that burnout not only affects the well-being of healthcare workers, but can also reduce the quality of care received by patients (Gomez-Garcia et al., 2022; Kurniawan et al., 2023; Siregar and Hariyati, 2021).

2.1.6 Burnout Measurement Tools

Measuring instruments that can be used to measure burnout include:

2.1.6.1 Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is the most widely used instrument for measuring burnout levels. There are four variants of the MBI, namely the Human Services Survey (MBI-HSS), Educator Survey (MBI-ES), Student Survey (MBI-SS), and General Survey (MBI-GS). The MBI-HSS is designed to assess burnout among professionals in the public service sector, while

the MBI-ES is specifically used to measure burnout among educators. The MBI-SS, which is an adaptation of the MBI-GS, is used to assess burnout among students. Meanwhile, the MBI-GS can be applied generally to assess the prevalence of burnout in various types of work (Maslach and Jackson, 1986; Widhianingtanti and Luijtelaar, 2022).

Burnout occurs when job demands exceed an individual's capacity, leading to emotional exhaustion, cynical attitudes toward work, and a decreased sense of accomplishment. In this study, burnout was measured using the MBI-HSS (Lim et al., 2020). The use of the MBI-HSS as the primary instrument in this study is based on a strong scientific foundation. First, the MBI-HSS has been widely recognised as the gold standard for measuring burnout among professionals in the public service sector, including healthcare workers, thereby enabling valid comparisons across studies and populations. Second, this instrument can comprehensively measure the three main dimensions of burnout, namely emotional exhaustion, depersonalization, and reduced sense of accomplishment, each of which has a theoretical basis and relevant empirical support in the context of nursing practice (Williamson et al., 2018).

The MBI-HSS is a comprehensive, standalone instrument that does not need to be combined with organisational or interpersonal measurement tools. A study in Spain reported that the overall internal consistency of the MBI dimensions ranged from 0.71 to 0.88, indicating high reliability across a diverse sample of nurses (Aguayo et al., 2011). Another study in the Netherlands confirmed the validity of the three-factor structure of the MBI and found that the scale distinguished between employees who experienced burnout and those who did not, without the need for

additional instruments (Schaufeli et al., 2011). Another study in Italy concluded that various modification attempts, both by deleting questionnaire items and adding latent dimensions, failed to improve model fit significantly, so there was no methodological basis for overhauling the existing set of items or the theoretical framework of burnout (Loera et al., 2014). Thus, the use of the MBI-HSS in its entirety is sufficient to capture aspects of burnout in nurses without the need to add organisational or interpersonal questionnaires (Aguayo et al., 2011; Schaufeli et al., 2011; Loera et al., 2014).

2.1.6.2 Copenhagen Burnout Inventory (CBI)

The Copenhagen Burnout Inventory (CBI) was developed to place fatigue or exhaustion at the core of burnout measurement. This instrument includes 19 questions divided into three subscales: personal burnout (6 items), work-related burnout (7 items), and client-related burnout (6 items). Each statement is designed in both positive and negative forms to avoid double-meaning bias. Measurements are taken using a Likert scale with a response range of 1 (never), 2 (rarely), 3 (sometimes), 4 (often), and 5 (always) (Kristensen et al., 2007).

2.1.6.3 Oldenburg Burnout Inventory (OLBI)

The Oldenburg Burnout Inventory (OLBI) consists of 16 statements that assess emotional exhaustion and detachment from work. Each statement is rated on a 4-point Likert scale from 1 (strongly disagree) to 4 (strongly agree). This instrument excels at measuring burnout prevalence across various types of work because it comprehensively assesses emotional, physical, and cognitive exhaustion. Some items are designed with positive loading, so the assessment results must be reversed (reverse scoring). A higher total score indicates greater exhaustion and

detachment, suggesting a higher potential for burnout (Runyon et al., 2022).

2.2 Nurse

2.2.1 Definition of Nurse

Nurses are defined by the International Council of Nurses (ICN) in 2025 as professionals who have received nursing education grounded in science, skills, and nursing philosophy, and who are legally regulated to practice nursing in accordance with professional standards in their country. Nursing services themselves include promotive, preventive, rehabilitative, and mitigative efforts, which are provided comprehensively to individuals, families, groups, and communities, both healthy and sick, through nursing care, education, advocacy, counselling, leadership, management, and innovation in nursing practice (White et al., 2025; Kemenkes RI, 2023).

In accordance with national regulations, Kemenkes Regulation No. 17 of 2021 on the Implementation of Nursing Practice stipulates that every nurse must possess professional competence, as evidenced by a certificate and official registration issued by the Indonesian Nursing Council. In addition to having technical expertise, nurses are also health workers who interact most closely with patients, thus playing a central role in the implementation of care (Kemenkes RI, 2021; Riasari, 2021).

The nursing work environment plays an important role in increasing work engagement and preventing burnout. A healthy work environment is characterised by high trust between staff and management, an organisational culture that supports communication and collaboration, and a work climate that ensures employees' physical, emotional, and psychological well-being. Thus, optimising the work environment is a key strategy for maintaining the quality of

nursing care and reducing the risk of chronic fatigue (Roshida et al., 2023).

2.2.2 Nurse Function

Nursing functions are divided into three categories: independent, dependent, and interdependent (Amrullah, 2023).

2.2.2.1 Dependent Function

It is the autonomous function of nurses to provide nursing care without relying on other professions. In carrying out this role, nurses make independent decisions based on professional judgment to meet basic human needs, such as physiological needs (oxygenation, fluid and electrolyte balance, nutrition, activity), the need for safety and comfort, affection, self-esteem, and self-actualization (Amrullah, 2023).

2.2.2.2 Independent Function

Describes the performance of nursing tasks based on instructions or directions from other health workers. This function usually arises in the context of task delegation, for example, from a specialist nurse to a general nurse, or from a primary nurse to an implementing nurse, in order to ensure effective and efficient continuity of service (Amrullah, 2023).

2.2.2.3 Interdependent Functions

This is a function carried out collaboratively within a multidisciplinary team, with interdependence among team members. This function is important in complex clinical situations that require cooperation among various professions, such as doctors and nurses, in the treatment and monitoring of therapeutic effects, to achieve optimal health outcomes for patients (Amrullah, 2023).

2.2.3 The Role of Nurses

According to the Health Sciences Consortium, the role of nurses encompasses various professional aspects of health care delivery (Yuliarni, 2023).

2.2.3.1 As a Nursing Care Provider

Nurses provide nursing care, identifying patients' basic needs and delivering systematic nursing services through a nursing process approach. This process enables nurses to establish nursing diagnoses, design appropriate interventions, implement actions, and evaluate the results, both in simple and complex situations (Yuliarni, 2023).

2.2.3.2 As Client Advocate

Nurses act as client advocates, helping patients and their families understand medical information from healthcare professionals and supporting decision-making related to nursing interventions. In this role, nurses are also responsible for protecting patients' rights, including the right to information, adequate care, privacy, autonomy, and compensation for medical negligence (Yuliarni, 2023).

2.2.3.3 Educator

Nurses act as educators by providing patients with education to improve their understanding of their health conditions, disease symptoms, and medical procedures. The goal is to encourage behavioural changes that support healing and health maintenance efforts (Yuliarni, 2023).

2.2.3.4 Coordinator

Nurses act as coordinators in healthcare teams. Their duties include planning, organising, and directing so that the services

provided are integrated, focused, and tailored to patient needs (Yuliarni, 2023).

2.2.3.5 Collaborator

Nurses also collaborate with other health professionals, such as doctors, nutritionists, physiotherapists, and others. In this role, nurses participate in identifying service needs, interprofessional discussions, and formulating future services (Yuliarni, 2023).

2.2.3.6 Consultant

Nurses can act as consultants by providing professional information and advice to clients on various aspects of nursing care. This role is generally performed at the request of clients in order to understand the objectives and benefits of the nursing interventions they receive (Yuliarni, 2023).

2.2.3.7 Reformer

Nurses act as innovators, namely as agents of change who encourage renewal in the nursing service system. This role is carried out through strategic planning, cross-sector collaboration, and the implementation of systematic changes oriented towards improving the quality of nursing services (Yuliarni, 2023).

2.2.4 Classification of Nursing Work Units

Nursing services consist of three main units, namely outpatient care, inpatient care, and emergency care, where the Nursing Services Division is responsible for managing these three services as well as implementing quality control, cost control, and patient safety in each unit (Kemenkes RI, 2019).

2.2.4.1 Outpatient Department

Based on the Kemenkes Agreement, outpatient nursing services include all observation, diagnosis, treatment, medical rehabilitation, and additional health services provided without the patient being required to stay in the hospital (Kemenkes RI, 2019). This service is also known as ambulatory care, which is medical care provided to patients without the need for hospitalisation. In this context, nurses are tasked with supporting medical examinations by preparing and arranging clinical equipment, measuring weight and blood pressure, and administering medication as directed by the doctor. Although direct interaction between nurses and patients is limited to the day of the examination, outpatient nurses collaborate closely with the doctors on duty, making effective coordination crucial (Citrawati and Mariyanti, 2011).

Problems often encountered by nurses in this unit include complaints of delayed service, perceptions of unfriendliness, and administrative issues. In addition, nurses must also adapt to the dynamics of doctors' work, including unscheduled arrivals or early departures, which can affect the clinic's workflow and patient satisfaction (Citrawati and Mariyanti, 2011).

2.2.4.2 Inpatient Department

Based on the Kemenkes Decree, inpatient services involve observation, diagnosis, treatment, medical rehabilitation, and complementary health services that require patients to stay in the hospital during the treatment period (Kemenkes RI, 2019). Inpatient facilities are clinical service units that provide continuous care for patients who require observation, diagnosis, therapy, or rehabilitation for one night or more

because their medical condition prevents them from being treated at home (Putri and Sonia, 2021). Activities in the inpatient unit include patient admission, provision of medical services by doctors, implementation of nursing care, provision of medical support, distribution of medicines, provision of food, and financial administration (Nunung, 2021).

Nurses in inpatient wards interact intensively with patients who have diverse personalities and medical conditions, so they are often faced with chronic complaints that can drain their physical, emotional, and mental energy. In addition, high demands from patients' families, challenges in collaborating with colleagues who disagree, and authoritarian attitudes from doctors contribute to nurses' psychosocial workload. The combination of these factors can trigger significant burnout if not managed properly (Fatimah and Yugistyowati, 2022).

2.2.4.3 Emergency Department

According to the Kemenkes Decree, emergency services include immediate medical intervention aimed at preventing or mitigating the risk of death or disability in patients in critical condition (Kemenkes RI, 2019). Services in the Emergency Room focus on providing prompt and appropriate first aid to reduce the risk of death or disability in patients in emergency situations (Marbun et al., 2022). As the main entry point for critical patients, the ER is designed to ensure urgent initial medical intervention. Nurses in the Emergency Department are not only responsible for administering first aid, but also for recording detailed medical information in medical records, facilitating patient transfers, both from beds to wheelchairs and from the Emergency Department to inpatient units when

necessary, as well as maintaining 24-hour operational readiness (Kriswanto et al., 2022).

Emergency room nurses face a very high cognitive workload due to the need for constant vigilance in providing intensive care. The complexity of this task is exacerbated by the varying degrees of severity and types of medical conditions of patients who arrive suddenly, as well as the psychological pressure of interacting with anxious family members who often ask about the progress of their relatives' conditions. In addition, Emergency Room nurses are required to make quick clinical decisions to intervene with emergency and critical patients to prevent more serious complications. Such a workload is prone to triggering emotional and mental fatigue, thereby increasing the risk of burnout among Emergency Room nurses (Permatasari et al., 2023).

2.3 Factors Causing Burnout in Nurses

Burnout in nurses is a syndrome of emotional exhaustion, depersonalization, and reduced work performance influenced by job demands and resource availability (Maslach and Leiter, 2016).

Several recent studies have identified variations in the factors contributing to burnout across work units. One study found that 78% of emergency room nurses experienced burnout due to high work demands and constant exposure to critical situations. Meanwhile, another study reported that inpatient nurses are more prone to depersonalization due to prolonged interactions with chronic patients. In outpatient settings, the main factors contributing to burnout stem from administrative burdens and the repetitive nature of the work. These findings are consistent with the Job Demands-Resources Model, which states that the characteristics of the work unit determine the type of job demands faced (Li et al., 2023; Shah et al., 2021).

Burnout among nurses is a multidimensional phenomenon influenced by complex interactions among various factors. Research shows that the contributing factors can be grouped into three main categories: organizational, interpersonal, and individual (Maslach and Leiter, 2016).

2.3.1 Organizational Factors

Organizational factors are the primary systemic contributors to burnout. A study identified several critical aspects: (1) excessive workload, including an unfavorable nurse-to-patient ratio, particularly in the emergency department, where the ratio reaches 1:8–10 during peak hours; (2) irregular working hours with a shift system that disrupts the circadian rhythm; (3) lack of essential medical equipment; and (4) unsupportive organizational policies. A total of 78% of burnout cases among nurses were found to be directly related to organizational factors (Gomez-Garcia et al., 2022; Shirom, 2021).

Organizational factors are the most dominant aspect, including a high-pressure work environment, a shortage of adequate healthcare personnel, and excessive workloads, especially in crisis situations such as a pandemic. A study in the United States found that insufficient staffing and a stressful work environment were the main reasons nurses left their profession, with 68.6% of respondents directly attributing this to burnout (Shah et al., 2021). Dense work schedules that exceed normal working hours and shift systems that disrupt sleep patterns also contribute to increased physical and emotional fatigue (Sayilan et al., 2021; Shah et al., 2021). In addition, the lack of institutional support and uncertainty in internal policies further exacerbate the psychological pressure felt by nurses (Sayilan et al., 2021).

2.3.2 Interpersonal Factors

Interpersonal factors play a significant role in the development of burnout, as explained in the Job Demands-Resources theory. The study revealed three main dimensions: (1) conflict with patients and families, especially in the emergency room; (2) unhealthy team dynamics, including vertical and horizontal bullying; and (3) lack of social support from superiors and colleagues. These negative social interactions can progressively erode nurses' emotional resilience and accelerate the onset of burnout symptoms (Bakker and Demerouti, 2017).

Interpersonal factors also significantly influence the onset of burnout. Disharmonious working relationships, a lack of support from colleagues and superiors, and emotional pressure arising from the inability to freely express feelings in the workplace exacerbate the situation (Kleis and Kellogg, 2020).

2.3.3 Individual Factors

Individual factors can be classified into three main components, namely personality characteristics such as excessive perfectionism and high anxiety tendencies, maladaptive coping strategies such as avoiandce and emotional suppression, and an imbalance between work and personal life characterized by difficulty in setting healthy boundaries. These factors interact dynamically with pressures from the work environment, resulting in varying levels of vulnerability to burnout in each individual (Bakker and Demerouti, 2017; Shirom, 2021).

Age plays an important role in burnout levels, with studies in the United States reporting that nurses aged 42 are more likely to leave the profession due to burnout than those aged 48.7. Findings from China show that younger age groups tend to be more vulnerable to

emotional stress during the process of adapting to the work environment (Shah et al., 2021; Wang et al., 2025).

Gender differences have also been shown to correlate with several dimensions of burnout. A global meta-analysis shows that male nurses have higher depersonalization scores than female nurses, possibly influenced by social norms and communication styles. (Fuente et al., 2018). In addition, education level is related to the capacity to manage burnout, with nurses with a master's or doctoral degree (MSN/PhD) reported to be more resistant to burnout due to more mature stress management skills. Another study in China found that nurses with bachelor's and postgraduate degrees who have an intrinsic work value orientation may actually experience greater pressure due to professional achievement demands (Shah et al., 2021; Wang et al., 2025).

Marital status also affects nurses' emotional stability. A meta-analysis by Fuente et al. shows that single or divorced nurses are more vulnerable to burnout due to a lack of social support outside the work environment (Fuente et al., 2018). Conversely, research in Ethiopia indicates that married nurses tend to report higher levels of job satisfaction, thereby reducing the risk of burnout (Efa et al., 2024).

2.4 Differences in Burnout Scores Between Work Units

Burnout scores varied significantly across hospital departments. Comparative data showed that the prevalence of burnout tended to be highest in the emergency department (around 45–60%), followed by inpatient units (30–40%), and lowest in outpatient units (15–20%). These differences are generally influenced by differences in work stress intensity, demanding work schedules, and the emotional burden of patient care. Similar patterns were also found in studies in Indonesian hospitals, although the severity of burnout was slightly lower, which may have been influenced

by supportive collective cultural values (Alharbi et al., 2022; Chen et al., 2023; Prasetyo and Trisyani, 2023).

2.5 Previous Research

Table 2.1 Previous Research.

No	Researcher (Year)	Research Title	Method	Main Results
1.	Lisser, R. D., Lauderdale, J., Dietrich, M. S., Ramanujam, R., Stolldorf, D. P. (2024)	The Social Ecology of Burnout: A framework for research on nurse practitioner burnout	literature review	Developing a Social Ecology of Burnout framework that integrates individual, interpersonal, organizational, community, and policy factors as interactive layers determining the level of burnout among nurse practitioners, to guide further research and intervention
2.	Putra, K. R., Setyowati. (2019)	Prevalence of burnout syndrome among nurses in general hospitals in provincial East Java: Cross-sectional study	cross-sectional	The prevalence of high burnout among nurses was 34.8% for emotional exhaustion, 24.3% for depersonalization, and 24.5% for reduced personal accomplishment, with findings that marital status and work experience were significantly associated with emotional exhaustion ($p<0.05$), job status and age are related to depersonalization ($p<0.05$), and marital status affects personal accomplishment ($p<0.05$)
3.	Trisyani,Y., Emaliyawati, E., Prawesti, A., Mirwanti, R., Mediani, H. S. (2023)	Emergency Nurses' Competency in the Emergency Department Context: A Qualitative Study	qualitative method with a grounded theory approach	There are eight core competencies for emergency room nurses that are interconnected, forming two main concepts, namely the expansion of emergency room nursing practice and the demands of advanced nursing roles
4.	Ge, M., Hu, F., Jia, Y., Tang, W., Zhang, W., Chen, H. (2022)	Global prevalence of nursing burnout syndrome and temporal trends for the last 10 years: A meta-analysis of 94 studies covering over 30 countries	systematic review, meta-analysis	A meta-analysis of 94 studies from 34 countries revealed a global prevalence of burnout syndrome among nurses of 30.0% (95% CI: 26.0%–34.0%) with a significant upward trend during the decade 2012–2022 ($t=3.71$, $p=0.006$)

Table 2.1 (continuation)

No	Peneliti (Tahun)	Judul Penelitian	Metode	Hasil Utama
5.	Martin, B., Kaminski-Ozturk, N., O'Hara, C., Smiley, R. (2023)	Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses	cross-sectional	High workloads and unprecedented levels of burnout during the COVID-19 pandemic, particularly among nurses with ≤10 years of experience, have triggered a 3.3% decline in the US nursing workforce through increased turnover over the past two years
6.	Li, L. Z., Yang, P., Singer, S. J., Pfeffer, J., Mathur, M. B., Shanafelt, T. (2024)	Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis	systematic review, meta-analysis	Nurse burnout is significantly correlated with decreased perceptions and scores of safety climate, increased incidence of nosocomial infections, patient falls, medication errors, adverse events, and missed care, as well as decreased patient satisfaction and quality of care
7.	Roshida, D. S., Paskarini, I., Martiana, T. (2023)	Leadership Style on Nurses' Burnout: A Systematic Review	cross-sectional, descriptive qualitative	Sincere and deep acting emotional labor significantly reduced depersonalization scores and increased personal accomplishment, while job satisfaction proved to be the main protective predictor across all three dimensions of burnout
8.	Wang, Y., Wang, X., Gao, L., Ge, Y., Xue, Y., Ji, Y. (2025)	Nurses' Work Value Patterns and Their Relatonship with Burnout: A Cross-sectional Study Based on Latent Profile Analysis	cross-sectional	There are three patterns of nursing work values, namely demand support, intrinsically driven, and overall identification. These patterns are significantly related to burnout levels, where nurses with a demand support pattern recorded the highest burnout scores and nurses with an overall identification pattern recorded the lowest scores
9.	John, R., Hill, M., Kanamori, L., Lao, R., Sayrs, L., Stottlemyre, R. L., Morphew, T. (2024)	Preventing Inpatient NP Burnout: The Power of Adequate Staffing and Leadership	cross-sectional	Burnout among pediatric inpatient nurse practitioners significantly increased at patient-provider ratios greater than 5:1 (OR=3.5–4.1; $p<0.05$), while perceptions of adequate staffing (OR=0.23; $p=0.029$) and the presence of NP practice leaders in the institution were found to protect against burnout ($p=0.012$)
10.	Galanis, P. et al. (2023)	Increase Job Burnout and Reduced Job Satisfaction for Nurses Compared to Other Healthcare Workers after the COVID-19 Pandemic	cross-sectional	Nurses showed very high levels of burnout after the pandemic (91.1% vs. 79.9% among other healthcare workers), and low job satisfaction (61.0% vs. 38.8%), with the nursing profession identified as an independent predictor of increased burnout and decreased job satisfaction

2.6 Theoretical Framework

Based on the above explanation and previous studies, the following theoretical framework can be developed.

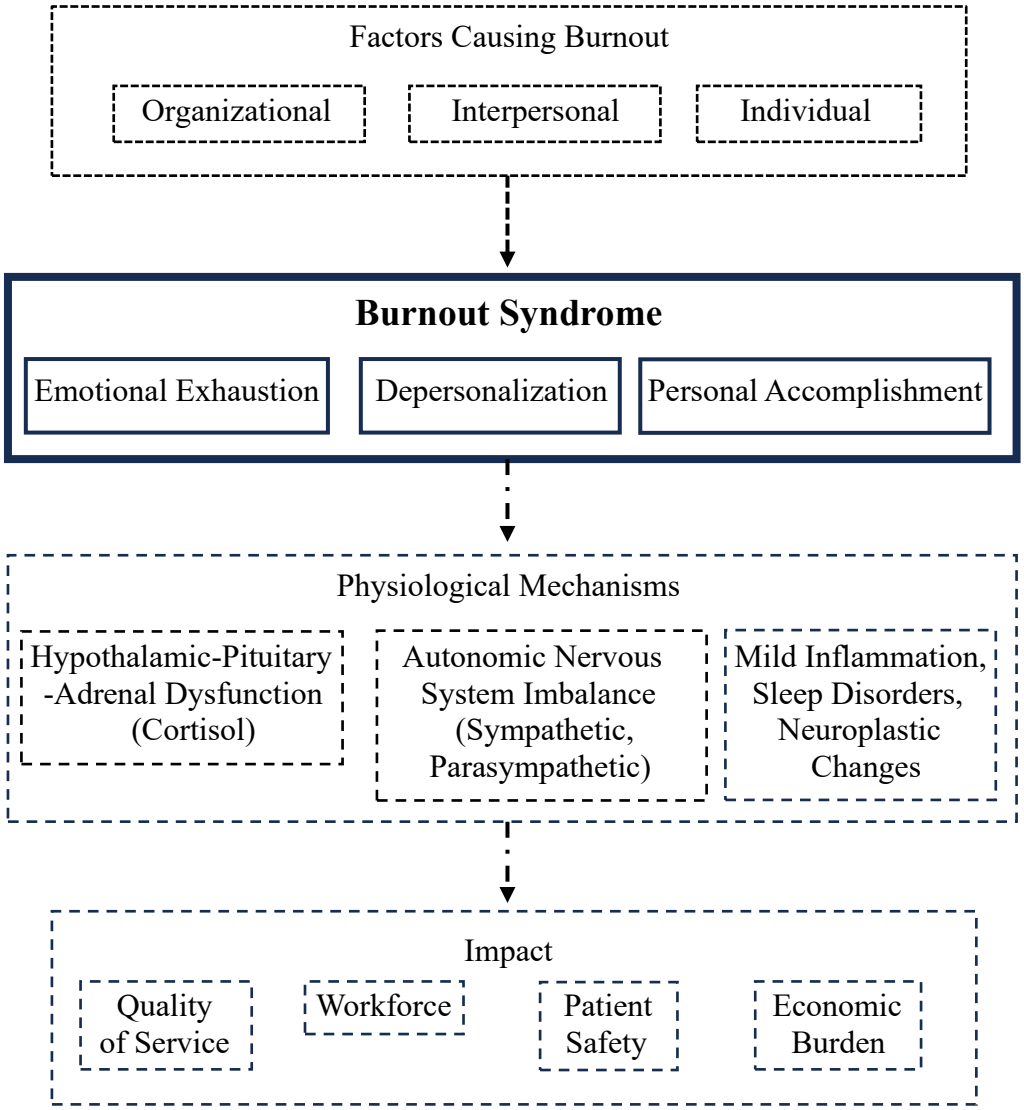

Figure 2.2 Theoretical Framework.
(Maslach and Jackson, 1986; Kany et al., 2019; Maslach and Leiter, 2019; Morera et al., 2020; Handoko, 2022; Konlan et al., 2022; Alotiby, 2024)

s

Description:

: Researched

: Not Researched

: Influences

: Causes

2.7 Conceptual Framework

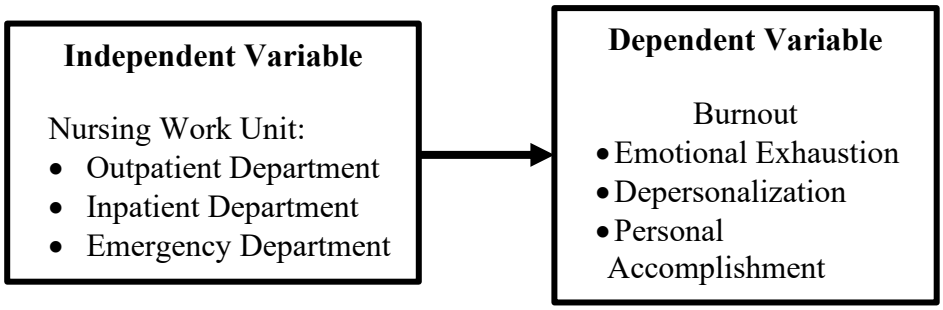

Figure 2.3 Conceptual Framework.

2.8 Hypothesis

Based on the objectives of this study, the research hypothesis is as follows:

1. H_0: There was no difference in the average burnout scores among healthcare workers in outpatient, inpatient, and emergency departments at Imanuel Way Halim Hospital in Bandar Lampung
2. H_1: There is a difference in the average burnout scores among healthcare workers in outpatient, inpatient, and emergency departments at Imanuel Way Halim Hospital in Bandar Lampung

CHAPTER III
RESEARCH METHOD

3.1 Research Method

This study is an observational analytical study with a comparative cross-sectional design. Observational analytical studies examine the relationship between two or more variables without the researcher intervening in the research subjects. Cross-sectional studies collect data from samples at a single point in time. Comparative research is a method that compares two or more phenomena, groups, or variables to identify similarities and differences.

3.2 Time and Place of Research

3.2.1 Research Time

This research was conducted from August to December 2025.

3.2.2 Place of Research

This study was conducted in the outpatient, inpatient, and emergency departments of Imanuel Way Halim Hospital in Bandar Lampung.

3.3 Research Population and Sample

3.3.1 Research Population

The population is the entire research object being studied. The population in this study is all nurses actively working in the Outpatient, Inpatient, and Emergency Departments at Imanuel Way Halim Hospital in Bandar Lampung, from August to December 2025.

Table 3.1 Distribution of Nurses at Imanuel Way Halim Hospital, Bandar Lampung (n=161).

Department / Subunit	Number of Nurses
Outpatient Department	40 people
- Dialysis Room	11 people
- Polyclinic Room	24 people
- Aesthetic Clinic	3 people
- MCU Room	2 people
Inpatient Department	98 people
- Onycha	15 people
- Tulip	7 people
- Mawar	20 people
- Narwastu	9 people
- Perinatology	14 people
- Anggrek	15 people
- Lavender	18 people
Emergency Department	23 people

Based on the above data, the total number of nurses to be studied at Imanuel Way Halim Hospital in Bandar Lampung is 161, comprising 40 outpatient nurses, 98 inpatient nurses, and 23 emergency room nurses.

3.3.2 Research Sample

A sample is a portion of the research objects taken from the entire population under study and is considered representative of that population. In this study, the minimum sample size required was calculated using the Slovin formula, which is used to determine sample size in quantitative research. The Slovin formula is as follows:

$$n = \frac{N}{1 + N \times e^2}$$

Description :

n = sample size

N = total population

e = error rate in the study is 5% = 0,05

With the following results:

$$n = \frac{N}{1 + N \times e^2}$$

$$n = \frac{161}{1 + 161 \times (0{,}05)^2}$$

$$n = 114{,}79 = 115 \text{ people}$$

A total of 137 nurses completed the questionnaire and met the inclusion criteria. Five respondents were excluded because they met the exclusion criteria, namely having less than 6 months of work experience in the relevant unit, leaving 132 nurses. From this number, 115 respondents were randomly selected using a random number generator in Microsoft Excel to obtain the sample size that had been determined in accordance with the research allocation.

3.3.3 Sample Criteria

3.3.3.1 Inclusion Criteria

1. Nurses who are actively working at Imanuel Way Halim Hospital in Bandar Lampung during the research period.
2. Nurses working in one of three units, namely Outpatient, Inpatient, and Emergency.
3. Expressing willingness to become respondents by agreeing to the informed consent form submitted as consent to participate voluntarily.

3.3.3.2 Exclusion Criteria

1. Nurses who are on leave (annual leave, sick leave, or maternity leave) during the data collection period.
2. Respondents who filled out the questionnaire incompletely or did not follow the instructions, resulting in data that could not be further analysed.

3. Less than six months of work experience in the unit where they are assigned, to ensure adequate exposure to the work environment and related unit stressors.

3.3.4 Sampling Techniques

Sampling in this study was carried out using the proportional random sampling technique, which randomly selects units proportional to their sizes within each installation, using Microsoft Excel. The study population consisted of all nurses who met the inclusion criteria in the Outpatient, Inpatient, and Emergency Departments of Imanuel Way Halim Hospital in Bandar Lampung. After calculating the total population N and determining the total sample size n, the sample allocation for each subunit was calculated using the formula:

$$n_h = \frac{N_h}{N} \times n$$

Description :

N_h = population size in stratum/subunit h

N = total population

n = total sample size before/after non-response adjustment

The value of n_h is then rounded to the nearest integer using the largest remainder method to keep the aggregate proportion equal to n.

The calculation results are as follows:

$$n_{Dialysis} = \frac{N_h}{N} \times n$$

$$n_{Dialysis} = \frac{11}{161} \times 115$$

$$n_{Dialysis} = 7{,}8 = 8 \text{ people}$$

The above calculation was applied to each subunit, and the results are shown in Table 3.2.

Table 3.2 Proportional Sample Allocation by Department and Subunit.

Department / Subunit	Population (N_h)	Sample Allocation (n_h)
Outpatient Department	**40**	**28** (subtotal)
- Dialysis Room	11	8
- Polyclinic Room	24	17
- Aesthetic Clinic	3	2
- MCU Room	2	1
Inpatient Department	**98**	**70** (subtotal)
- Onycha	15	11
- Tulip	7	5
- Mawar	20	14
- Narwastu	9	6
- Perinatology	14	10
- Anggrek	15	11
- Lavender	18	13
Emergency Department	**23**	**17**
TOTAL	**161**	**115**

Next, the researchers assigned a unique code to each nurse in each subunit, then randomly selected samples from each facility using random number generator software until the allocated number of samples was obtained. This approach ensured that the proportion of respondents from each subunit within each facility reflected the population composition, thereby increasing the representativeness of the sample and minimising selection bias in the study.

3.4 Identification of Research Variables

3.4.1 Independent Variable

The independent variable in this study was the nurses' work unit. Nurses' work units were categorised based on their assignment location at Imanuel Way Halim Hospital in Bandar Lampung, including:

1. Outpatient Department
2. Inpatient Department
3. Emergency Department

3.4.2 Dependent Variable

The dependent variable in this study was the level of burnout among nurses, which was measured based on three dimensions in the Maslach Burnout Inventory - Human Services Survey (MBI-HSS) instrument, namely:

1. Emotional Exhaustion
2. Depersonalization
3. Personal Accomplishment

3.5 Operational Definition

Table 3.3 Operational Definition.

Variable	Operational Definition	Measuring Instrument	Measurement results	Measuring Scale
Independent: Outpatient Department	Assignment of nurses tasked with providing nursing care in outpatient facilities	Questionnaire	0 = Outpatient	Nominal
Inpatient Department	Assignment of nurses tasked with providing nursing care in inpatient facilities	Questionnaire	1 = Inpatient	Nominal
Emergency Department	Assignment of nurses tasked with providing nursing care in the emergency room	Questionnaire	2 = Emergency	Nominal
Dependent: Burnout (MBI-HSS)	Burnout is a condition of physical, mental, and emotional exhaustion caused by high and prolonged work demands, resulting in a feeling of disharmony between oneself and one's work. Burnout consists of the dimensions of Emotional Exhaustion, Depersonalization, and Personal Accomplishment	MBI-HSS Questionnaire	Total Score (0-132)	Ratio
Emotional Exhaustion	Perceptions arising from fatigue caused by work activities	MBI-HSS Questionnaire	Score 0-54	Ratio
Depersonalization	Perceptions of withdrawal tendencies within the work environment	MBI-HSS Questionnaire	Score 0-30	Ratio
Personal Accomplishment	Perceptions of this tendency give rise to feelings of inadequacy and powerlessness to develop oneself	MBI-HSS Questionnaire	Score 0-30	Ratio

3.6 Research Instrument and Materials

3.6.1 Informed Consent and Respondent Identity

Informed consent in this study involves obtaining written consent from respondents prior to participation, including detailed information about the objectives, benefits, and rights and obligations of participants during the research process, to protect ethical principles. Informed consent is explained directly and is also included in the Google Form. The demographic questionnaire attached to the Gform collects data on respondent characteristics, including age, gender, education level, marital status, and work unit, which will then be used in descriptive analysis and as covariate variables to evaluate factors that may influence burnout levels.

3.6.2 Maslach Burnout Inventory - Human Services Survey (MBI-HSS) Questionnaire

The instrument used in this study was the Maslach Burnout Inventory - Human Services Survey (MBI-HSS), a widely used tool for assessing burnout in healthcare workers, particularly nurses. This instrument was developed by Christina Maslach and Susan E. Jackson, and consists of three main dimensions, namely: Emotional Exhaustion, which measures emotional fatigue due to continuous work pressure; Depersonalization, which measures the tendency to be negative or indifferent towards patients; Personal Accomplishment, which assesses individuals' perceptions of their personal competence and work success (Maslach and Leiter, 2016). The instrument was distributed via GForm to nurses.

The MBI-HSS instrument measures the level of burnout based on three main dimensions, namely:

1. **Emotional Exhaustion**

   This dimension describes the emotional exhaustion experienced and the feeling that emotional capacity has been completely depleted in carrying out professional duties (Purnamasari, 2021).

The items on Emotional Exhaustion measure the core of emotional and physical exhaustion, namely the feeling of being emotionally drained and the depletion of energy that reduces the ability to cope with work demands (items 1, 2, 8), recovery impairment reflected in feeling tired at the start of the workday (item 3), and fatigue due to repetitive interpersonal interactions that deplete affective resources (items 4, 6). In addition, several items assess the decline in meaning/work results that exacerbates fatigue (item 9) (Maslach and Jackson, 1981; Purnamasari, 2021).

2. **Depersonalization**

This dimension reflects emotional detachment and treating patients as mere objects, accompanied by cynicism toward coworkers and the organisation where one works (Purnamasari, 2021). The items on Depersonalization assess affective and behavioral changes toward service recipients, namely emotional hardening and a tendency to keep one's distance or be cynical toward patients (items 10–11), negative affective symptoms such as frustration or irritability that encourage cynicism (item 13), and manifestations of withdrawal from interpersonal involvement that can arise from excessive workload (item 14). Some items also include counter-directional energy indicators (item 12) to show low depersonalization when energy is maintained (Maslach and Jackson, 1981; Aguayo et al., 2011; Bakker and Demerouti, 2017).

3. **Personal Accomplishment**

This dimension is demonstrated through a tendency to evaluate oneself negatively, including perceptions of a decline in work competence, performance, and the quality of interactions with others (Purnamasari, 2021). The Personal Accomplishment items measure feelings of competence and professional achievement, including perceptions of task effectiveness and meaningful

contributions to patients (items 19, 17), the capacity to maintain a therapeutic atmosphere and interpersonal skills that characterize professional efficacy (items 17, 21), restorative experiences or satisfaction after intense work that supports a sense of accomplishment (item 18), and indicators of severe disturbances that reduce self-esteem, such as feeling "on the edge" or being frequently blamed by service recipients (items 20, 22). Several items also assess decreased involvement/empathy that is inversely associated with PA (items 15–16) (Maslach and Jackson, 1981; Aguayo et al., 2011; Maslach and Leiter, 2016; Putra and Setyowati, 2019).

Each MBI-HSS statement is rated using a seven-point Likert scale ranging from 0 = never, 1 = a few times a year, 2 = once a month, 3 = several times a month, 4 = once a week, 5 = several times a week, to 6 = every day. Fourteen items are negative, so that the response "every day" receives the highest score (6) and "never" the lowest score (0), while eight positive items are scored in reverse. This tool is effective in evaluating the emotional aspects, interpersonal attitudes, and perceptions of self-achievement that are the main indicators of burnout syndrome in the nursing profession (Maslach and Jackson, 1981). In this research instrument, the Emotional Exhaustion dimension is measured through the questions in section 1 of the questionnaire, the Depersonalization dimension by section 2, and the Personal Accomplishment dimension by section 3.

The classification of burnout levels in MBI-HSS is generally based on the score of each subscale. For Emotional Exhaustion, a score of < 19 is categorised as low, a score of 19–26 is considered moderate, and a score of > 26 indicates a high level. For Depersonalization, < 6 indicates a low level, a score of 6–9 indicates a moderate level, and a score of > 9 indicates a high level. Meanwhile, in the Personal Accomplishment dimension, scores < 34 are low, 34–39 are moderate,

and> 39 indicate a high level. Thus, the scores in each dimension determine whether a nurse is in the low, moderate, or high burnout category (Maslach and Jackson, 1981).

3.6.3 Validity and Reliability Test

The MBI-HSS has undergone rigorous psychometric testing and has demonstrated good internal reliability and construct validity in the healthcare population. The validity test of the MBI-HSS was reported by Rusca and Setyowati in nurses at a public hospital in East Java Province in 2019. The validity analysis of the MBI-HSS was conducted on 35 respondents with a table r of 0.27, indicating that all items in each dimension met the validity criteria. In the emotional exhaustion dimension, all items had an r value > 0.53; in the depersonalization dimension, r > 0.64; and in the personal accomplishment dimension, r > 0.64. Thus, the 22 items on the MBI-HSS were declared valid (Rusca and Setyowati, 2019). The reliability test was reported by Putra in 2019 on a sample of 485 nurses in public hospitals in East Java Province. The MBI-HSS has good reliability in all dimensions, namely emotional exhaustion (α = 0.845), depersonalization (α = 0.732), and personal accomplishment (α = 0.858), above the minimum Cronbach's Alpha limit of 0.60, so it is considered reliable (Putra, 2019).

3.7 Research Process

3.7.1 Research Procedures

The steps taken in this study are as follows:

1. Conducting a pre-survey at Imanuel Way Halim Hospital in August 2025 to understand the field conditions and readiness of the research location.
2. Preparing a research proposal and presenting it in a proposal seminar to obtain approval from the supervisor.

3. Submitting a research cover letter to Imanuel Way Halim Hospital in Bandar Lampung after the proposal was approved by the supervisor, then coordinating with the management of Imanuel Way Halim Hospital to obtain permission to conduct the research.
4. Submitting the approved proposal to the Health Research Ethics Committee of Imanuel Way Halim Hospital in Bandar Lampung and waiting for the issuance of an ethics permit.
5. Approach potential respondents who meet the inclusion and exclusion criteria, and request their consent through an explanation of informed consent.
6. Distribute a Google Form containing the respondents' identities and characteristics, as well as the Maslach Burnout Inventory - Human Services Survey (MBI-HSS) questionnaire to the respondents.
7. Collect questionnaires completed by respondents into Microsoft Excel for data processing purposes.
8. Perform data management, including editing, coding, entry, cleaning, validation, and consistency checks.
9. Analyze data univariately and bivariately according to the established statistical methods, then compile a final report and present the research results.

3.7.2 Research Process

Figure 3.1 Research Process.

3.8 Data Management

3.8.1 Data Processing

The data obtained from the collection stage is then processed using computer software. The data processing stage in the software involves a series of steps, including:

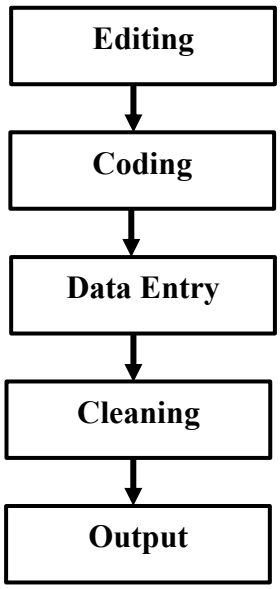

Figure 3.2 Data Processing Flow.

1. **Editing**

   The data processing began with data editing to address missing values, correct inconsistencies, and standardize responses on the questionnaire. At this stage, the completeness of demographic variables, including age, gender, education level, marital status, and occupation based on work unit, was checked and adjusted to meet the criteria for further analysis (Dahlan, 2014).

2. **Coding**

   The next activity was data coding, which involved assigning alphabetic codes to each research variable to facilitate further analysis. The coded data was then imported into Microsoft Excel and organized based on the predetermined variable codes (Dahlan, 2014).

The coding for burnout syndrome is as follows:

a) Positive Questions
   1) Every day : 0
   2) Several times a week : 1
   3) Once a week : 2
   4) Several times a month : 3
   5) Once a month : 4
   6) Several times : 5
   7) Never : 6

b) Negative Questions
   1) Every day : 6
   2) Several times a week : 5
   3) Once a week : 4
   4) Several times a month : 3
   5) Once a month : 2
   6) Several times : 1
   7) Never : 0

The scores obtained from the data collection sheets filled out by respondents will be totaled, and conclusions will be drawn in the form of burnout scores based on the dimensions of each individual. Then, these scores will be analyzed to obtain average scores and determine the level of burnout experienced by nurses in each work unit.

3. Data Entry

The next step is to enter the data into statistical software for analysis. The data that has been coded and organized in Microsoft Excel is exported to SPSS and imported into the software for statistical analysis (Dahlan, 2014).

4. **Cleaning**

   The next step involves verifying the data after analysis to ensure the accuracy and consistency of the results. Once the analysis process is complete, the dataset is reviewed in the software to validate the suitability and correctness of the values before further interpretation (Dahlan, 2014).

5. **Output**

   The research results are presented in the form of outputs from the data analysis process using computer software, which are then printed and attached as part of the research document. After the data is analyzed, the findings are processed and presented as the final results of the study (Dahlan, 2014).

3.8.2 Data Analysis

Statistical analysis in data management uses statistical software programs that incorporate two types of data analysis, namely univariate and bivariate analysis, by first conducting a normality test.

3.8.2.1 Normality Test

The normality of the distribution of total burnout scores and scores for each dimension was tested using the Kolmogorov-Smirnov test when the sample size was < 50 and the Shapiro-Wilk test when the sample size was ≥ 50. The test was conducted per work unit group, namely outpatient care, inpatient care, and emergency room. The normality test results ($p > 0.05$) showed that the normality assumption was met.

3.8.2.2 Univariate Analysis

Univariate analysis aims to describe the characteristics of each research variable. For numerical variables, including total burnout scores and scores on each dimension, descriptive statistics are used in the form of median values, interquartile

range (IQR), and minimum and maximum values. Meanwhile, categorical variables such as work unit, gender, and burnout category are presented in frequency distribution and percentages.

3.8.2.3 Bivariate Analysis

Bivariate analysis is used to test differences and relationships between two variables. The comparison of burnout scores between the three work units (outpatient, inpatient, emergency room) will be analyzed using One-Way ANOVA if the assumptions of normality and homogeneity are met. If not, Kruskal-Wallis with post-hoc tests will be used.

3.9 Research Ethics

This study has been submitted for research permission and implementation to the Health Research Ethics Committee of Imanuel Way Halim Hospital and has received ethical approval under letter number 2008/SDM/RSIM/XI/2025. Before collecting data, respondents were informed about the study's informed consent and then given a Google Form to complete the questionnaire. Primary data were obtained from the questionnaires completed by respondents, namely nurses in the outpatient, inpatient, and emergency departments of Imanuel Way Halim Hospital.

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