NURSES' PERCEIVED STRESS AND QUALITY OF LIFE ASSOCIATED WITH DEPLOYMENT TO RURAL / URBAN HEALTH FACILITIES IN ESWATINI

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ABSTRACT

Nurse Professionals are at the forefront of health service provision and play an important role in care of the people and communities. Deployment has been reported to contribute towards work-related stress and poor Quality of Life among nurses in Eswatini. The purpose of the study was to investigate the nurse's perceived stress and Quality of Life associated with being deployed to rural or urban health facilities in Eswatini. A quantitative, descriptive-correlational design was utilized. Out of 1554 nurses practicing in the public sector, 233 were selected using the multistage-cluster sampling method. Data were collected using adapted questionnaires from the Expanded Nursing Stress Scale and World Health Organization Quality of Life– BREF. Most participants were females (79.9%, n = 173). The mean age was 37.1 years with a standard deviation of 8.3 years. Most participants were deployed in settings of their preference. The overall perceived stress among the participants was rated moderate (2.33), as well as their Quality of Life (64.25%). The data did not support any relationship between overall perceived stress nor Quality of Life and deployment setting. Participants perceived workload as more stressful due to inadequate staff. Moreover, the participants regarded the physical domain as good while environmental domain was rated as poor. Nurses deployed to rural health facilities did not perceive more stress nor poorer Quality of Life compared to their urban counterparts. The study recommends establishment of wellness programmes and that nurse managers should allow subordinates time away for full engagement in wellness sessions to reduce stress, improve Quality of Life among nurses and ultimately improve patients' outcomes.

KEY WORDS: Deployment, Nurses, Perceived Stress, Quality of Life.

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INTRODUCTION

Nurse professionals are at the front line of health service provision and play an important role in the care focused on the individual, families, and communities. Much like most professionals, nurses are at risk of work-related stress interrelated to the type of location to which they are deployed. According to Sarafis, Rousaki, and Papastavrou (2016), occupational stress relates to a situation wherein job-related factors interact with an employee, changing his/her psychological and physiological condition in a way that the person is forced to deviate from normal functioning. Deployment setting contributes towards stress and poor Quality of Life. The wellbeing of nurses is important for effective functioning of the health system. High level of work–related stress can affect the wellbeing of the nurse adversely, leading to mental health problems, and burnout (Murphy & Sauter, 2003).

Moreover, Nayomi (2016) stressed that employees may create uncharacteristic errors resulting to the health system being sued billions of dollars, as a result of work -related stress. Each of these consequences experienced by the nurse can directly negatively affect the clients in the health care setting as they are at the receiving end-the consumers of the health care service. Evidence has also revealed that there is a strong negative relationship between nurse's occupational stress and job satisfaction, resulting to high staff turnover (Moustaka & Constantinidis, 2019). The stressful nature of deploying employees to an area where workers perceive stress such as intensified extended hours, could lead to burnout, job strain and emotional stress which can have a significant impact on an employee's wellbeing (Phillips, 2013)

Globally, there is a shortage of health workers especially professional nurses. According to International Labour Organization (International Labour Organization [ILO], 2017), in 2017, there were almost 4.3 million nurses and physicians shortage globally who were reported to be the result of years neglected investment in health worker welfare. Furthermore, ILO (2017) revealed that nurses from rural areas migrate to hospitals in the cities for better working conditions. It is likely that nurses deployed to rural areas are stressed by being in such settings. Most rural settings have limited resources compared to urban facilities.

Nurses in African countries are no exception to challenges experienced by nurses internationally. According to ILO (2015), it is estimated that the African healthcare system provide care to address the world most sizable disease burden (24%) with only 3% of the global health care workers and scanty financial resources. The disease burden, limited human resource and financial restraints could contribute to African nurses perceiving more stress and poor quality of life.

In 2015 over 60% of nurses revealed that they felt too tired to work while on duty and according to the study this could be linked to 70% who reported moonlighting or working overtime due to massive shortage in this under-resourced sector. Of all nurses, 10.9% indicated that they had taken sick leave when actually not sick and 5.6% had missed work without permission and 2.9% reported medico-legal incidents (Africa Health, 2019). Work-related-stress is an aspect that needs to be tackled in the region because of its unfavourable effects on the nurses' Quality of Life and nursing care rendered may become compromised.

Kober and Van Damme (2006) revealed that, in one hospital at Eswatini it was estimated that on average, only half of all nurses could be counted on to be able to do their full duty at any one time and half were unable. The inability of nurses to perform their duties maximally needs to be explored. Interviewed nurses in one hospital at Eswatini reported that the actual working conditions caused stress more than the issue of salaries and benefits (Kober & Van Damme, 2006).The actual working conditions for nurses in Eswatini need to be addressed, so as to reduce perceived stress among nurses and enhance the provision of quality nursing care. However, there is limited evidence on how rural or urban setting deployment influences stress and the quality of nurses' lives in Eswatini, hence this study.

Nurses are reluctant to be assigned to work in the rural health facilities in Eswatini. It has been observed that nurses from rural areas migrate to health facilities in the cities for better working conditions, resulting to rural health facilities being under-staffed and surrounding communities underserved (ILO, 2012). This creates disparities in service delivery as the Eswatini population is mostly dense in the rural areas. According to Faruk, Surajudeen-Bakinde, Abdulkarim and Oloyende (2020) more than 60% of the Sub-Saharan Africa population resides in rural areas.

The purpose of this study was to investigate the nurse's perceived stress and Quality of Life associated with being deployed to rural or urban health facilities in Eswatini. It was hypothesized that Nurses deployed to rural health facilities perceived more stress and had poor Quality of Life.

METHODOLOGY

This study used the quantitative descriptive-correlational design to study deployment, perceived stress, and Quality of Life of nurses in Eswatini. The target population for the study were professional nurses working in public clinics and hospitals in the four (4) regions of Eswatini. According to the Ministry of Health Nursing Personnel Statistics in 2019, the total number of nurses that were practicing in the public sector were 1 554. The study used a multistage-cluster sampling method to obtain study settings and participants. Two (2) from the four (4) regions of Eswatini were randomly selected, from which two (2) clinics and two (2) hospital were further selected from each region to make a total of eight (8) facilities. From these settings, all elements who met the inclusion criteria were studied.

The study power was 0.80, p-value 0.05 with an effect size of 0.5. Using these parameters the predermined sample size was 233 participants (Lipsey, 2013). Data was collected with the adapted Expanded Nursing Stress Scale [ENSS] (French, Lenton, Walters & Eyles, 2000) and World Health Organization Quality of Life–BREF [WHOQOL-BREF] (ILO, 1995)].

The ENSS demonstrated improved reliability of $\alpha = 0.96$ over the original Nurse Stress scale $\alpha = 0.89$ (Sarafis, 2016). The WHOQOL-BREF has reliability scores assessed per domain: domain one (1) physical health $\alpha = 0.82$; domain two (2) psychological $\alpha = 0.81$; domain three (3) environment $\alpha = 0.8$; and domain four (4) social relationships $\alpha = 0.68$ (Skevington, Lofty & O'Connell, 2004).

Data were analyzed using descriptive statistics, Pearson's Correlation Coefficient, and Multiple Linear Regression. Ethical clearance was sought and obtained from the Eswatini Human and Health Review Research Board. Permission was sought from management of the different health facilities, and informed consent was sought from participants. The ethical considerations observed in the study were self-determination, beneficence, and justice.

RESULTS

The response rate was 97% (N = 225) out of 100% (N = 233) targeted participants. The sequence of presenting the study findings is as follows: description of the sample, dependent variables (nurses' perceived stress and Quality of Life), independent variable (deployment) and examination of the association between the dependent and independent variables.

Socio-demographic characteristics

The age of the participants ranged between 25 and 58 years, with a mean of 37.1 years and standard deviation 8.3 years. A majority (60.4%, n= 136) of the participants were married, 32.4% (n=73) were single and 3.1%, (n=7) were cohabiting. In addition, 1.8 % (n=4) were widowed, 1.3% (n=3) were divorced and 0.9% (n=2) were on separation. Very few participants reported to be widowed, divorced or separated.

In the study there were more females compared to males. Seventy six percent (76.9%, n=173) of the participants were females and 23.1 % (n=52) were males. Most (45.8%, n=103) of the participants had a Bachelor's Degree while (24.4%, n=55) reported to have a post-diploma qualification. Moreover, 16.4 % (n=37) reported to have the certificate qualification and 13.3 % (n=30) had only the Diploma in General Nursing. The reported length of service in the nursing profession ranged from one (1) to 33 years, with a mean of 10.8 years and standard deviation of 7.2 years.

Most of the participants were registered nurses. A majority (68.4%, n=154) of the participants, reported that they were registered nurses, followed by 17.3% (n=39) who were nursing assistants. Furthermore, 12.9% (n=29) reported that they were supervisors (nursing sisters) and only 1.3% (n=3) were in the matron rank. A majority of participants worked with more than one group of clients. Most (45.3%, n=102) participants reported that they worked with more than one group of clients, and 20.9% (n=47) worked with all the groups of clients (new-born, children, adolescents , elderly and old people , community , labor and delivery clients, palliative clients, mental health). Likewise, 9.8% (n=22) worked with clients who had mental health disorders, 8% (n=18) worked with children, while 7.6% (n=17) were working with the elderly and old-aged clients, while 4.9% (n=11) were working with the community. Furthermore, 4.9% (n=4) of the participants reported that they were working with clients in the maternity (labor and delivery). An equivalent proportion (0.9%, n=2) of participants reported that they were engaged with palliative and new-born clients respectively. The sample socio-demographic description of the sample is summarized in *Table 1*.

Table 1: Study sample socio-demographic characteristics (N=225)

Characteristic	Frequently / Mean	Percentage (%) / SD
Age (years)	37.1	8.3
Marital status		
Single	73	32.4
Married	136	60.4
Cohabiting	7	3.3
Widowed	4	1.8
Divorced	3	1.3
Separated	2	0.9
Gender		
Female	173	76.9
Male	52	23.1
Length of service in the nursing profession (years)	10.8	7.2
Position		
Nursing assistant	39	17.3
Registered nurse	154	68.4
Clinic supervisor	29	12.9
Matron	3	1.3
Current setting		
Rural	72	32.0
Urban	153	68.0
Most preferred setting		
Rural	105	46.7
Urban	120	53.3

DESCRIPTION OF DEPENDENT VARIABLES

There were two (2) dependent variables in the study, perceived stress and Quality of Life of the respondents. The first dependent variable to be described was perceived stress.

PERCEIVED STRESS

Perceived stress on criticism by physician: A majority of participants reported to be stressed by criticism from physicians. Eighty percent 80.0% (n=180) of the participants reported that they were stressed by criticism from the physician. Moreover, 20.0% (n=45) reported that they were not stressed by criticism from the physician.

Perceived stress on feeling inadequately prepared to help with the emotional needs of the patient's family: A majority of the participants were stressed by feeling inadequately prepared to help with the emotional needs of the patient's family. Of the participants 87.6% (n=197) reported that they were stressed by feeling inadequately prepared to help with the emotional needs of the patient's family. Only 12.4% (n=28) reported that they were never stressed by feeling inadequately prepared to help with the emotional needs of the patient's family.

Perceives stress from conflict with the supervisor: A majority of participant's perceived stress from conflict with the supervisor. Sixty five percent (65.3%, n=147) of the participants reported that they were stressed by having a conflict with the supervisor, and only 34.7 % (n=78) reported that they were not stressed by having conflicts with the supervisor.

Perceived stress from inadequate information from a physician regarding the medical condition of a patient: A large amount of the participants reported that they were stressed by having inadequate information from a physician regarding the medical condition of a patient. Eighty two percent (82.2%, n =185) revealed that they were stressed by having inadequate information from the physician regarding the medical condition of a patient. However, 17.8% (n=40) of the participants reported that they were not stressed by having inadequate information from a physician regarding the medical condition of a patient.

Perceived stress from patient making unreasonable demands: A majority of participants were stressed by receiving unreasonable demands from patients. Almost all (91.5%, n =205) participants reported that they were stressed from unreasonable demands from patients. Merely 8.5% (n=20) reported that they were not stressed by unreasonable demands from patients.

Perceived stress from being sexually harassed: Most participants reported that they were stressed by sexual harassment in their settings. Of the participants 57.0% (n=128) reported that they were stressed by sexual harassment at the work place while 43.1% (n=97) were never stressed by sexual harassment in their settings.

Perceived stress from floating to other units that are short staffed: Floating to other units stressed a majority of the participants. Most (74.2%, n=166) participants reported to be extremely stressed and only 25.8 % (n=59) were not stressed from floating to other units that were short staffed.

Perceived stress from unpredictable staffing and scheduling: Most participants were stressed by unpredictable staffing and scheduling. Eighty four percent (84.9%, n=191) were stressed by unpredictable staffing and scheduling whereas 15.1% (n=34) reported that they were not stressed from unpredictable staffing and scheduling.

Perceived stress from the patient's family making unreasonable demands: Among the participants 83.6% (n=188) perceived stress from the patient's family that made unreasonable demands while only 16.4% (n=37) were not stressed by the patient's family which made unreasonable demands.

Perceived stress from death of a patient: Most participants were stressed by the death of a patient. Among the participants 82.3% (n=185) reported that the death of a patient was stressful. At the same time, 17.7% (n=40) did not report any stress that occurred as a result of the death of a patient.

Perceived stress from lack of support from immediate supervisor: A majority of participants were stressed by lack of supervision from the supervisor. Eighty three percent (83.1%, n=187) of the participants reported stress from lack of support from the immediate supervisors. However, 16.9 % (n=38) reported that they had no stress from lack of support from the immediate supervisors.

Perceived stress from criticism by the supervisor: Sixty five percent (65.7%, n=148) of the participants perceived stress from criticism by the supervisor. Although 34.3% (n=77) reported that they had no stress from criticism by the supervisor.

Perceived stress from not having enough time to complete all my nursing tasks: Of the participants 84.9 % (n=191) reported stress from not having enough time to complete all their nursing tasks and only 15.1%(n=34) reported that they never experienced stress from not having enough time to complete all their nursing tasks.

Perceived stress from lack of support from other administrators: Most participants were stressed by lack of support from other administrators. Seventy three (73.8%, n=166) of the participants reported that they were stressed by lack of support from other administrators. Yet, 26.2 % (n=59) reported no stress from lack of support from other administrators.

Perceived stress from criticism by nurse administrators: Of the participants 74.3% (n=167) reported that they were stressed by criticism from nurse administrators while 25.7% (n=58) did not perceived stress from criticism by nurse administrators.

Perceived stress from placement in rural/urban setting: Of the participants84.4% (n=190) reported that they were not stressed by placement in the current setting and only 15.6% (n=35) were stressed by placement in the setting.

Overall perceived stress mean value of study parameters
French at al. (2000) categorized the overall mean score for expanded nursing stress scale as follows: means between 1.00 - 1.99 as low level of stress, 2.00 - 2.99 as moderate and 3.0- 4.00 as high level of stress. In

this study, the overall stress was moderate (2.33) ,while workload stressors had the highest mean score (mean= 2.58, SD=1.15) and ranked moderate: death and dying (mean=2.56, SD=1.21) was the second highest, followed by problems with supervisors stressors (mean=2.49, SD=1.30), patient and family stressors (mean=2.48, SD=1.15), inadequate emotional preparations (mean=2.38,SD=1.06), uncertainty concerning treatment stressors (mean= 2.35,SD=1.20), conflict with physician stressors (mean=2.30, SD=1.37) , problems with peers (mean=2.14,SD=1.17) all these were rated moderate. Discrimination (mean=1.77, SD=1.61) was the least parameter that was perceived as causing stress on participants and interpreted as low. The overall perceived stress mean values of study participants are illustrated in *Table 2.*

Table 2: Overall level of stress among participants (N=225)

Parameter	Mean value	SD	Interpretation
Death and dying	2.56	1.21	Moderate
Patient and family stressors	2.48	1.15	Moderate
Problems with supervisors	2.49	1.30	Moderate
Uncertainty concerning treatment stressors	2.35	1.20	Moderate
Conflict with physician stressors	2.30	1.37	Moderate
Workload stressors	2.58	1.15	Moderate
Inadequate emotional preparations	2.38	1.06	Moderate
Problems with peers	2.14	1.17	Moderate
Discrimination	1.77	1.61	Low
Total	**2.33**	**1.25**	**Moderate**

Stressful categories

The top most stressful categories for participants in this study were: workload (M=2.57), death and dying (M=2.56) and problems with supervisors while the least perceived stressful categories were discrimination (M=1.76), problems with peers (M=2.14) and conflict with physicians (M=2.29).

Quality of Life

The second dependent variable in the study was Quality of Life. This section describes the findings obtained in each of the asked questions.

Rating of one's quality of life: Most participants rated their quality of life as good. Of the participants 60.8 % (n=137) rated their quality of life as good, while 27.6% (n=62) reported that it was neither good nor poor. Only39.2% (n=88) of the participants reported that their quality of life was poor.

Satisfaction with health status: In the study most (57.3%, n=129) participants were satisfied with their health status while only 42.7 % (n=96) reported that they were dissatisfied with their health status.

Presence of physical pain that prevented one from doing what he/she needed to do: Most participants reported that physical pain prevented them from performing what they needed to do. Eighty eight percent (88.9%, n = 200)of the participants revealed that physical pain prevented them from doing what you needed to do, and only 11.1% (n=25)reported that they were not affected by physical pain in performing what they had to.

Medical treatment needed to function in life: A majority of participants needed medical treatment to function. Eighty three percent (83.6%, n = 188) reported that they needed medical treatment to function in their daily lives, and only16.4 % (n=37) did not need any medical treatment to function.

Finding life enjoyable: A majority of participants enjoyed life. Eighty six percent (86.2% n=197) revealed that they enjoyed life very much. A low proportion (13.8%, n=31) of the participants reported that they did not enjoy life at all.

Finding meaningful life: Most participants perceived their lives as meaningful. Ninety one percent (91.7%, n=204) reported that their lives were meaningful while only 9.3% (n=21) reported that their lives were not at all meaningful.

Ability to concentrate: Almost all (93.8%, n=211) the participants reported that they were able to concentrate well, and only 6.2 % (n=14) had challenges in concentrating.

Evaluation of safety in daily life: A majority of the participants felt safe in their daily lives. Ninety-one percent (91.6%, n =206) of the participants reported that they felt safe in their daily lives. Nonetheless, 8.4% (n = 19) reported that they did not feel safe in their daily lives.

Perception of healthy physical environment: In general the participants felt that their physical environment was healthy. Most (96.9%, n = 218) participants reported that their physical environment was healthy, and only 3.1% (n=7) revealed that their physical environment was not healthy.

Having enough energy for everyday life: A majority of participants had enough energy for everyday life. Preponderance (93.3%, n = 210) of the participants reported that they had enough energy for everyday life. Although 6.7% (n=15) revealed that they did not have enough energy for everyday life.

Having of enough money to meet needs: A majority of participants reported that they did not to have enough money to meet their needs. Almost all (94.7%, n = 213) the participants revealed that they did not possess enough money to meet their needs. Merely 5.3% (n=12) reported that they had sufficient money to meet their needs.

Satisfaction with condition of ones living place: Half (50.7%, n= 114) of the participants were satisfied with their living place. However, (49.3% (n=111) of the participants reported that they were not satisfied with the places in which they lived.

Satisfaction with access to health services: A majority (56.9%, n =128) of participants were not satisfied with access to health services. However, 43.1%, (n=97) reported that they were satisfied with access to health services.

Overall Quality of Life score of study domains

When scoring quality of life using the WHOQOL-BREF a mean score of items within each domain is used then multiplied by four (4), scores are then interpreted as follows: 45 or less indicate a low Quality of Life, 46 – 65 indicate moderate QOL and 66 -100 indicate high Quality of Life (WHO, 1995). In the current study in the physical domain the participants had a Mean =3.76 and Standard Deviation =0.95; psychological domain Mean =3.73 with Standard Deviation =0.89; environmental domain Mean =3.11 and Standard Deviation =0.96) and social relationships had a Mean =3.52 and Standard Deviation = 0.96. The overall Quality of Life of the participants was 56.48 which was interpreted as moderate. Based on the mean scores, the physical domain was rated high while the environmental domain was rated least. The participants' overall Quality of Life scores are summarized in *Table 3*.

Table 3: Participants' overall Quality of Life scores (N = 233)

Domains	Mean value/ score	SD
Physical	3.76 x 4= 15.04	0.95
Psychological	3.73 x 4= 14.92	0.89
Environmental	3.11 x 4= 12.44	0.96
Social relationships	3.52 x 4= 14.08	0.96
Overall QOL	**56.48**	**0.94**

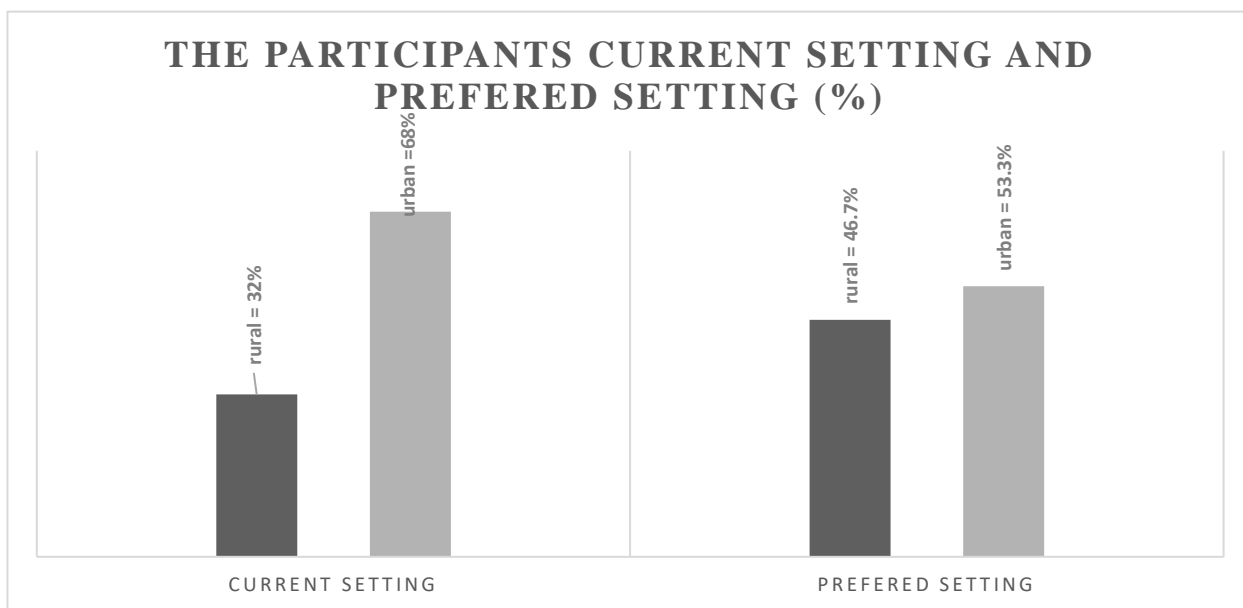**DESCRIPTION OF THE INDEPENDENT VARIABLE (SETTING)**

The independent variable in the study was setting of deployment which was either rural or urban. The findings on deployment (rural / urban) are described in this section.

Participants' facility setting: Most participants were from the urban setting. The largest proportion (68.0% n= 153) of the participants reported that they were working in the urban setting and only 32.0% (n= 72) were deployed to rural health facilities.

Participants' most preferred setting: A majority of participants preferred to be deployed to urban setting facilities. A greater proportion (53.3%, n=120) of the participants preferred to work in urban setting, while 46.7% (n=105) preferred working in rural settings.

Figure 4: Illustration of participant current setting and preferred setting

REGRESSION ANALYSIS OF DEPENDENT VARIABLES AND THE INDEPENDENT VARIABLE

The multiple linear regression analysis done assess the relationship between the independent variable, setting and dependent variables, perceived stress and Quality of Life.

Setting (rural / urban) and perceived stress: The data did not support a significant relationship between setting and perceived stress (F=1.876, p=0.172). This means that the deployment setting (rural / urban) was not a good predictor of perceived stress.

Setting (rural / urban) and Quality of Life: There was no association between setting and Quality of Life (F=1.876, p=0.172). This means that the setting (rural / urban) is not a good predictor of Quality of Life (F=0.231, p=0.631), reflecting that setting (rural / urban) was not a good predictor of Quality of Life.

DISCUSSION

Sexual harassment is a violation of human rights which could cost the organization millions and be detrimental to the psychological wellbeing of the victims. It is worth noting that the study has picked element of sexual harassment from nurses which should be prioritized, as sexual harassment is usually not disclosed because victims may fear victimization and discrimination. According to World Employment and social outlook-Trends (2020) sexual harassment includes a wide range of behaviors: gazes, rude jocks, demeaning comments based on gender and sexual assault. The current study findings are in harmony with the United States Bureau of Labor Statistic (2020) which reported that 52% of workplace-related sexual violence occurred against health care workers and two thirds of the victims were nurses working in hospitals.

Noteworthy is that, sexual harassment tends to be overlooked and some managers feel that nurses should deal with privately, hence it is often unreported or under-reported in the U.S. (Bureau of Labor Statistic, (2020). Those who are sexually harassed report a wide range of negative outcomes, lower job satisfaction, poorer psychological and physical health consequence, higher absenteeism, reduced self-esteem, and decline in productivity (World Employment and social outlook-Trends (2020). This reflects that sexual harassment in the work place needs to be addressed and each organization needs to establish a structure to be followed by employees in reporting it.

The findings from the current study is consistent with Sarafis et al. (2016) revealed that dealing with death and dying resulted in higher stress among participants compared to other stressors. The most stressful dimension stated was related to coping with the reality of human suffering before, more than the dying process (Sarafis et al., 2016). Sarafis et al. (2016) reported the stress resulted from nurses feeling inadequately prepared to nurse dying patients. Death is one of the realities that each one of us have to undergo. Thus observing the patient progressing and reaching the ultimate end - death, might leave each of the nurses wondering that one will have to go through before actually dying, hence the stress. Nonetheless, the pre-service curriculum may need to be reviewed and the component on death and dying be strengthened.

Consistent with Bratt, Broome, Kelber, and Lostocco (2000) the current study showed that participants were stressed by lack of support from immediate supervisors. Bratt et al. (2000) reported that there was a significant association between supervisor's leadership behaviors with perceived stress among intensive care unit nurses in the United States of America and Canada. Lack of support from the immediate supervisor is likely to compromise the quality of nursing care and strain the relationship between the subordinates and supervisors. The nurse managers need to be capacitated on how they can effectively support their subordinates.

Maintaining appropriate nurses staffing level promotes quality nursing care and improved patient outcomes because nurses can complete all their nursing tasks as required. The estimated nurse-patient-ratio in Eswatini is estimated to be 1:1000 instead of the recommended World Health Organization ratio of 1:5

(Clottey, 2016). According to Sarafis et al. (2016) nurses omit necessary nursing care because of time pressure and this is usually associated with worse patient's outcomes. In a study that examined the nature and prevalence of care left undone by nurses in a hospital in England hospital, the findings showed that more than 86% reported that one or more care activities were left undone due to lack of time (Ball, Murrrels, Raffery, Marrow, & Griffiths, 2012).

There researchers further reported the type of nursing tasks which were left undone and they included: comforting or talking to patients (66%), updating nursing care plans (47%) and educating patients (52%). These tasks are critical nursing tasks as opposed to clerical work which nurses find themselves prioritizing because of pressure from funding organizations. There is therefore a need to investigate the nurse's tasks that are left undone in Eswatini. The Ministry of Health needs to consider recruiting more nurses so as to reduce the nurse-patient-ratio and improve patient outcomes.

Violence which can be verbal or physical attacks by patients and may be attributed to: patient's poor coping mechanisms, distress from underlying pathology or effects from medication (Jacobson, 2011).The current study findings are in harmony with Pitts and Schalller (2019) who followed 213 health care providers for nine (9) months. The findings revealed that a total of 827 violent cases were reported and of the participants 78% from the health workers were nurses. Furthermore, the study also revealed that female participants were twice as likely to be violated (Pitts & Schalller, 2019). There is therefore a need for organizations to identify root causes of patient violence and work collaboratively with relevant stakeholders to address those challenges to protect the lives of nurses.

Perceived stress from staff shortage could result in negative effects on both the nurses and clients outcomes. According to Kamal et al. (2012) caring for clients, individuals, families, groups, populations or entire communities with complex and distressing problems could be very stressful to even highly experienced nurses. The stress could be worsened by staff shortage. Furthermore, Kamal et al. (2012), reported that nurses compared to other general and professional services were more likely to be loaded excessively with work, thus liable to lowered quality of life.

Health status is an individual relative level of wellness and illness which is usually subjectively rated the individual: some people perceive themselves healthy despite suffering from one or more chronic diseases (WHO, 2016). When individuals are not satisfied with their health status negative outcome increase. In a descriptive survey by Tharkar (2019), 54% of then nurses reported poor physical and mental health. The study also revealed that nurses with poor health were more likely to commit medical errors (26%).

Employers can prioritize the wellbeing of nurses in the work place through establishing wellness units. Developing health and wellness programs and strategies at health facilities can help establish an environment that provides the support, resources and incentives for employees (Arena et al., 2013).Early

diagnosis with good prognosis can also be achieved through the health and wellness programmes in the work place.

Concentration is a crucial aspect in nursing which relates to the ability to think critically, learn, good memory, and ability to make logical decisions. Concentration in cooperates the speed of thinking and clarity thought. Some people with cognitive difficulties may have no insight into their difficulties hence the use of this indicator to assess their cognitive ability (WHO, 2019). Inability to concentrate may lead to medical errors which are a serious public health problem and leading cause of death in the U.S. (Rodziewicz, Houseman, & Hipskind, 2023).

The two types of medical errors include commission and omission mistakes. Medical errors are reported to typically occur from a convergence of multiple contributing factors (Rodziewicz, Houseman, & Hipskind, 2023). Thus medical institutions are encouraged to work collaboratively to remove the culture of blame while retaining account ability and regularly assess the concentration ability of nurses to minimize medical errors and improve patient outcomes.

There is an outcry for nurses who do not appreciate their current work setting. The findings from the present study are contrary to Sveinsdottir (2010) who reported that nurses working in hospital settings among Islamic nurses wanted to change to rural health facilities. The nurses reported that they wanted to change because they were exposed to strenuous working conditions in the hospital which increased their total score of occupational stress (M=2.26) as opposed to the other nurses (M=2.21). Notable, both groups of nurses were working in the public sector.

Being deployed to a preferred setting does not only benefit the worker but also the employer because when the worker is happy he or she becomes productive and successful. A study that was conducted by Kakyo and Xiao (2018) in Uganda to understand nurse managers perceived challenges in the rural health care settings in Uganda. The findings revealed that managers deployed to rural settings perceived stress from low staff-patient-ratio and high level of workload, lack of essential medicines and equipment, low salaries, and delayed payment. The current study reflected that the deployment setting did not lead to perceived stress among the participants. This could be because most participants were deployed to their preferred setting. Moreover, perceived stress is a consequence of multiple factors and not only deployment setting.

The findings on the Quality of Life scores of the participants in the present study were consistent with a study conducted by Jothanna and D'Silva (2016) which found that the overall Quality of Life among nurses in the State of Karnataka was moderate. This reflected that the participants were moderately happy in their work environment and at the same time it was presumed they that they were working under stress. Moreover, studies (Ladani et al., 2017) which also assessed the Quality of Life of nurses reported moderate overall Quality of Life among nurse participants. Ladani et al. (2017) rated high the physical domain and the least rated was the environmental domain. Probably nurse administrators should develop strategies to improve

the other domains of nurses' quality of life, so as to minimize the nurses' stress and maximize their Quality of Life in the work setting.

It was hypothesized that nurses deployed to rural health facilities perceived more stress and had poor quality of life. However, the findings showed that nurses deployed to rural health facilities did not perceive more stress nor poorer Quality of Life compared to their urban counterparts.

CONCLUSION

The respondents were more stressed by workload especially due to shortage of staff. Moreover, Quality of Life, in the physical domain was rated as good and environmental domain was least regarded. The study demonstrated that nurse's perceived stress as well as Quality of Life was moderate. The data did not support a significant relationship between the independent variable, deployment (rural /urban) and the dependent variables, perceived stress and quality of life (p ≥0.05)

RECOMMENDATIONS

On the other hand, tertiary nursing institutions need to review and strengthen the pre-service curriculum. Special focus should be components of death and dying and emotional health. Nurse Managers need to encourage nursing assistants to engage in professional advancement, so that their work-related stress could be minimized.

Health facilities administrators need to develop or strengthen structures through which abused nurses could report abuse from patients and families. Wellness programme need to be supported through nursing sisters allowing unit time away for nurses so that they can be fully engaged in wellness sessions for early diagnosis and good prognosis. Support groups may need to be established by nurse administrators to support nursing assistant and nurses assigned to specialty settings so that their work-related stress could be minimized through sharing of experiences and coping strategies. Regular assessment of nurse's concentration ability need to be implemented by the nurse mangers to minimize medical errors and improve patient outcomes. Medication quality assurance endeavors for prescription errors need to be done by facility teams, senior medical officers and quality improvement done by ward teams to close gaps.

There is a need for a research to explore nursing tasks that are left unfinished as well as to assess the causes of such and implications. Future research can explore: workload effects on nurses in Eswatini, root causes of patient violence and sexual harassment. The Eswatini Ministry of Health needs to put in place policies addressing sexual harassment in the work place, structures to be followed by employees in reporting it and supports systems for victims need to be in place. Ministry of Health should ensure that information on harassment is conveyed during orientation of staff.

LIMITATIONS

The study adapted WHOQOL-BREF and the ENSS to assess perceived stress and Quality of Life among nurses in Eswatini. Both of the tools are valid and reliable. However, they were used probably for the first time among the nursing cadre in Eswatini. Hence replicating the study in the same population could help validate findings from the current study.

Nevertheless, the sample size was representable for the findings to be generalized to the nursing population in Eswatini. The findings could be generalized beyond the Eswatini populace, however, with caution.

Administration of the tool might have caused some limitations because information collected was from verbal reports of the participants. Verbal reports could make participants overestimate or underestimate the phenomena under study. Probably future studies could use of physiological measures to prospectively assess perceived stress and Quality of Life among nurses in Eswatini.

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