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Investigation of Quality of Life in High Risk Working Units in the Bandırma State Hospital

ABSTRACT
Quality of life of employees in high-risk units was examined in this article. Accordingly, the high-risk units' staff is working in raising the quality of life, by living and working conditions, for to eliminate the problems related to the risk of reduction any deficiencies in health care, which is important in terms of improving quality in patient care and patient satisfaction. One of the important aspects of working in health care quality management - efficient, effective and quality service delivery - is primarily proportional to the high quality of their lives.
In this article the personnel working in high-risk units was aimed to evaluate quality of life by knowledge and approach. Survey of hHealth workers' application is made. Frequency of the resulting data, percentage (%) and the chi-square (X 2) have been studied with the SPSS 19.0 software package, statistical analysis was performed in the course of tests.
Research on female health workers (65.1%), male health workers (34.9%), health workers at the ages 30-39 (39%), nurses, midwives (63.7%) showed that the rate of participation, in the past month emotional problems that reduce the time they spend on work and other activities, as a result, sometimes their residents and they feel positive but tired, despite the nurses sometimes feel happy doctors and other medical staff were found to feel happy.
As a result, the personnel working in high-risk units and concepts related to quality of life, examining factors affecting the quality of life have tried to explain the relationship between them. In the future as it is today, the sphere of health protection and quality of life must be one of the most important goals.
Key words: *Health workers, Quality of life in the health, Quality of life indicators.*

1.Introduction

In recent years due to technological changes in the healthcare industry in the world and in our country, as well, has experienced lots of changes. It is difficult to follow the best and the fastest way to health system technology that continuously adapts the technology. The main objective is to make the experience of development in health for the longest human life in a quality manner. Health workers who are treating diseases in humans, while leading them to their health, should avoid behaviors that endanger their lives. Quality of life varies from individual to individual. Hierarchy of needs is linked to the quality of life of people. If there is a significant improvement in health of patients – this is an improved quality of life for the individuals. Non-patient individual needs are what

quality of life is composed by him. As regareds improving the quality of human life, along with extension of human life, work has also been studied.

In the research related to the health sector it has been found that after taxi drivers health care workers exposed to violence of the longest-sector workers. Stress among health care workers is a result of violence, burnout, they are faced with adverse situations, such as loss of morale and motivation. Health workers reveal negative results if they reflect the problems of the business from the environment in which they live their daily lives. Sufficient efficiency can not be achieved in their work because of problems in people's private lives. From people who are not happy enough performance can not be obtained. Besides, their age (old or young people and gender affect their quality of life. Lifestyles, material and spiritual attitude also determine the quality of life. The recognition that in today's management approach human cases make the most important factor, has led to increase of the value given to human beings. Businesses with employees in management practices has become more important to ensuring harmony between businesses. Health institutions give more value to people owing to study of the human being.

In recent years development of the health sector in our country has started to compete with the world's countries. Following the integration of emerging technologies in the health system, health technologies developed in a very short time. Thanks to constructed modern hospital buildings, it is in physical conditions for health professionals to make the highest quality service delivery to patients. But despite these positive developments the desired level of quality of life of health workers failed to be achieved. The impact of the economic crisis on economies of the countries all over world, experienced social trauma did not allow to focus in full on raising the quality of life of the state health workers. Health care workers are confronting with various problems in the increasing number of patients and insufficient number of employees. The increasing trend of increasing violence in the society leads to being confronted with a variety of risks inside and outside working hours for health workers. Social life of health workers due to excessive work has reduced to almost negligible levels. Although the subject of the regulation of working environment of the employees indicate that they are not happy, psychological aspects are outweighing. They live in conflict, burnout, violence, anxiety, stress and this reduce the quality of life of employees. Raising the inpatient services, especially health professionals working in health care for their quality of life in health care institutions show more attention from other health professionals. However, there are benefits in taking into account the availability of the unique features of each unit. Health service delivery to provide a high quality of life as long as health care workers will be high quality. In this study: definition of quality of life, health and history, health in the place of quality of life, features, history are examined. In addition, health care professionals have been made to explain the quality of life.

2.1. Definition of Quality of Life in Health

Health is a very important aspect of the concept of quality of life. Not regarded as health law as it has value in the wide direction. These include: freedom, income, social support can be counted. Low income, lack of freedom and poor social support may be related to health. When dealing with health problems and quality of life there is a general direction of the trend of jumping. Directly focuses on functional capacity. Therefore, health-related quality of life has emerged term (Top, Özden, Sevim, 2003: 20).

Health status assessment of quality of life measures are increasingly being used to understand the health and health status are intended to optimize. The framework has changed the definition of healthy communities and individuals or groups who benefit from the services, it is spreading to evaluate the scale of the health status. Today, the research of health-related quality of life is not only for to evaluate relationship between socio-demographic characteristics and other determinants of health, but also it makes identification of priorities in health care in the country in relation to health policy, implemented programs or evaluation the costs of the programs to be implemented. Extension and new treatment of health-related quality of life concept has become one of the topics frequently studied by following the introduction of alternatives. Quality of life and health-related quality of life concepts are closely related concepts. Also determine the health-related quality of life in all dimensions of quality of life, and they think it is impossible to separate them from each other.

Multidimensional definition of health-related quality of life, by making a subjective description example, Patrick and Erickson, social opportunities, perceptions and functional status, and also diseases, injuries and shaping of corruption affected the treatment was expressed as the importance given to life by modifying (Top, Özden, Sevim, 2003: 20).

2.2. Characteristics of Quality of Life in Health

WHO health-related quality of life, multidimensional, subjective and is defined as a dynamic concept.

Multidimensionality: There are three basic dimensions closely related to each other in the context of health-related quality of life: physical, psychological and social. This size is then divided into subgroups among themselves. Health-related quality of life: physical, psychological and social are three basic sizes. Daily work by spending energy is related to the perception person physical size how much you can do. Psychological aspects of fear, anger, happiness, cover mental conditions such as depression. In the social dimension one can establish extent of their relation to the human person and is located around sharing their perception of issues with them (Savcı, 2006: 7).

Subjectivity: Subjective well-being of people is a term applicable for to describe how to evaluate their own lives. Three basic elements of subjective well-being concept of satisfaction, positive affect and negative affekt; satisfaction; marriage, leisure, can be divided into sub-groups, such as friendship; pride, joy, positive affective forgive you; sadness, guilt, shame and negative subgroups are forgiving you (Savcı, 2006: 7).

Dynamism: Subjectivity and dynamics of human kindness is the state altogether. It is of man's own world to be happy and peaceful. Psychosocial factors are integrated into person's subjective life. Here we have such subjectivity that leads to formation of different life histories in the world. Dynamism is the independence to be able to self-contained, is activated. That's why the concept of aging and quality of life is to be side by side (Savcı, 2006: 7).

2. 3. History of Quality of Life in Health

Healthstatus and clinical evaluation of physical activity per day beyond the examination, to take care of himself, and the first example of a scale that takes into

account social factors such as active business life is the recommended Karnofsky PerformanceScale to work in 1947. The health status of the patient from 0 (death) to 100 (no sign of disease) in the scoring, and clinicians are following this simple scale for evaluation

within many years; for function competence and activities of daily living evaluation (eg, Barthel Index) numerous scales has been developed. This is the first scale; still some sources if they are defined as the quality of life scales are far from evaluating compared with the scales currently in use in the state of being healthy holistically.

Sickness Impact Profile or Nottingham Health Profile as health is relatively more holistic detect and physical function, so you can see as well as stress and the beginning of development and use of scale, including life than willing to take and psychological findings are correct development. In the late 1970s, evaluation of the quality of life was conducted; functional studies in psychology are usually based on direct and indirect perception that people have about life (Bilgin, Ergenç, Timürcanday, 1989: 158).

Currently the widely used visual analogue scale is VAS (Visual Analogue Scale – VAS); for the first time it was used in 1976 and identified breast cancer patients. This scale is a thermometer like vertical line on the best and worst shows the defined health status. Marks on this scale are asked their health status of the patients. Studies mentioned above formed the basis for subsequent quality of life research, many new research scales, produced in accordance with theoretical models, have been proposed. These include quality of life, which correlates with the difference between the individual's earned with expectations from life steal expectations model, individual qualifications and requirements model which correlates levels to meet the needs of the most important theoretical basis for the decision making theory from the field of preference-based measures are considered. The common feature of the newly developed quality of life questionnaires, mood, stress level, taking into account the social role and the density of the charged subjective components such as cognitive functions and their health is associated with physical health (Fidan, Ünal, Demiral, 2003: 6).

WHO individual's well-being subjective, definition and measurement of quality of life efforts began in mid-1980. Quality of life measurements in medicine, the care of nursing and health care workers; in treatment services, physicians in improving patient relationship, development of health services research, comparing the effects of treatment over time, evaluation the impact of health policies and using in the cost analysis (Eser, 2005: 23).

Publications on quality of life are experienced in development. These publications have increased since the 1990s, started in 1992, has also just published a scientific journal publishing research on health-related quality of life. The name of this magazine is International Society of Qualty of Life.

3. Materıals And Methods

This study was conducted in order to define high-risk units at the level of quality of life for employees. The following methods have been used in the study:

• Considering a shift change times of the personnel working in high-risk units and a number of staff in the department data collection days and times are determined.

• Data is collected in the form of answer of personnel in high-risk units to the questionnaire.

• In the first part of the data collection process was discussed with the head nurse and charge nurse on.

• The staff working in high-risk units made verbal description of research into each and interviewed personnel who agreed to work.

• Surveys are usually carried out in high-risk units in the workload of staff at least the rest of the staff office hours.

• Completion of the survey by personnel working in high-risk units took in average 10 minutes.

The aim of the study was to investigate whether high-risk status of the personnel working in high-risk units extent affect the quality of life. A complex structure of the health sector is structurally more than in any other sector. The reason is that the relevant sector is identical with human life. Health care workers are one of the most important sources of this sector. The economic and social development due to increased disease and the number of health workers due to illness also need to increase the variety and quality of life.

The Bandırma State Hospital 's research was carried out in February 2015, respectively. The research population, the Bandırma State Hospital's entire personnel in high-risk units (N = 214) were created. The sample size of the study of the universe reached (n = 148), respectively.

Ethics without direction; before the first stage approval of the Bandırma State Hospital ethics committee has been obtained. Data in the framework of the approval of the Ethics Committee of the hospital were collected in February 2015, respectively.

All survey questions SPSS 19 (Statistical Package for Social Science) statistical data transmitted to the environment were created. Data related to identification characteristics of employees working in high-risk units; number was assessed by percentage. P <0.05 was considered as statistically significant.

Dependent variables: Quality of life held the dependent variables of the study consisted subscales of the scale.

Independent variables: The social and demographic characteristics of arguments of the research staff working in high-risk units participating in the study (age, occupation, marital status), and raise questions about the professional lives.

4. Results

According to data obtained from the study, 65.1% of health workers are female, 34.9% – male. 14.4% are at the age range between 20-29 years, 39% – between 30-39 years, 37% – between 40-49 years, 50 years and older – 8.9%. Occupation distribution: 11% – doctors, nurses – 63.7%, other of health personnel – 24%. Distribution according to marital status: 10.3% are single, divorced – 11.6%, 77.4% – are married. Length of employment: less than 5 years – 11.6%;, 37% – between 6-15 years; 36.3% – between 16-25 years; less than 25 years – 15.1%. Weekly working time makes 35-45 hours – 26.7%; 45 hours and above – 70.5%. Duration of annual leave is less than 10 days – 2,1%; between 10-20 days – 35,6'n%; more than 20 days – 61%. Work as part of the internal medicine department – 0.7%; surgery department 28,1'n%, intensive care unit of the Emergency – 61,6'n%. Economic status between £ 0-2500 – 38.4%, £ 2501 – £ 5000 – 57.5%, more than 5000 TL – 1.4%. Residential status: distributions of itself – 52,7'n% and tenant – 42,5'n%. Children: 18.5% is depending on the situation childless, 70,5'n% – 1 or 2 children, more than 2 children 11'n%. According to the cigarette smoking status used, 53.4% and 46.6% are using cigarettes. According to the case of use of alcohol, the use is of 28.1% and of 71.9%. 19.2% with a physical illness, 80.1%-without. With any psychiatric disorder 8.9%, at 91.1% is not included. Had any surgery 44.5%; 52.7% had not. Overall health status: 6.8% – excellent, very good – 13.7%, 51.4% – moderate, poor – 25.3%. Very good health compared with 1 year ago – 2.7%, 1%, compared to the prior year 8,2'n %, same good, 61,6'n% of the first year is almost the same as before, 24,7'n% worse than before 1 year, is much worse than before 1 year: 2,7'n%.

Table 1.
Distribution of the Demographics of Health Professionals

		n	%
Gender	Woman	95	65,1
	Male	51	34,9
	Total	146	100,0
Age	20-29	21	14,4
	30-39	57	39,0
	40-49	54	37,0
	50 and up	13	8,9
	Total	145	99,3
	Missing data	1	,7
	Total	146	100,0
Marital status	Single	15	10,3
	Divorced	17	11,6
	Married	113	77,4
	Total	145	99,3
	Missing data	1	,7
	Total	146	100,0
Profession	Doctor	16	11,0
	Nurse / Midwife-Medical Officer	93	63,7
	Other medical staff	35	24,0
	Total	144	98,6
	Missing data	2	1,4
	Total	146	100,0
Working time	Less than 5 years	17	11,6
	6-15 years	54	37,0
	16-25 years	53	36,3
	25 years	22	15,1
	Total	146	100,0
Weekly working time	35-45 hours	39	26,7
	45+ hours	103	70,5
	Total	142	97,3
	Missing data	4	2,7
	Total	146	100,0

Table 1.1.
Distribution of the Demographics of Health Professionals

		n	%
Annual leave time	Less than 10 days	3	2,1
	10-20	52	35,6
	Over 20 days	89	61,0
	Total	144	98,6
	Missing data	2	1,4
	Total	146	100,0
Worked part	Internal section	1	,7
	Surgery department	41	28,1
	Emergency-intensive look-Operating	90	61,6
	Other	11	7,5
	Total	143	97,9
	Missing data	3	2,1
	Total	146	100,0
The economic situation	0-2500 TL	56	38,4
	2501-5000 TL	84	57,5
	More than 5000TL	2	1,4
	Total	142	97,3
	Missing data	4	2,7
	Total	146	100,0
Home situation	İtself	77	52,7
	Rent	62	42,5
	Other	7	4,8
	Total	146	100,0
Child Status	No	27	18,5
	1-2	103	70,5
	More than 2	16	11,0
	Total	146	100,0
Do you smoke?	Yes	78	53,4
	No	68	46,6
	Total	146	100,0
Do you use alcohol?	Yes	41	28,1
	No	105	71,9
	Total	146	100,0

Table 1.2.
Distribution of the Demographics of Health Professionals

		n	%
Do you have a physical illness?	Yes	28	19,2
	No	117	80,1
	Total	145	99,3
	Missing data	1	,7
	Total	146	100,0
Do you have a psychiatric disorder?	Yes	13	8,9
	No	133	91,1
	Total	146	100,0
Have you ever had surgery?	Yes	65	44,5
	No	77	52,7
	Total	142	97,3
	Missing data	4	2,7
	Total	146	100,0
In general, you can tell which one to your health	Perfect	10	6,8
	Very good	20	13,7
	Medium	75	51,4
	Bad	37	25,3
	Total	142	97,3
	Missing data	4	2,7
	Total	146	100,0
How would you rate your health when you compare the 1 year ago	Much better than before 1 year	4	2,7
	A little better than before 1 year	12	8,2
	Almost the same as 1 year ago	90	61,6
	Worse than 1 year ago	36	24,7
	Much worse than before 1 year	4	2,7
	Total	146	100,0

On the gender of the participants: The question was – "Did you reduce the time you spend on your work and other activities as a result of emotional problems in the past month?" As a result it was the comparison of expression. As a result of emotional problems in the last month, the female health workers reduced the time they spend on work and other activities: 78% (n = 32), No– 59.8% (n = 61); as a result of emotional problems in the past month, the male health workers reduced the time they spend on work and other activities 22% (n = 9), reduction of those 40.2% (n = 41), respectively. Male and female health workers as a result of emotional problems in the last month on work and the time they spend on and other activities noted the reduction of time: P <0.05 (0.39 <0.05). There was a significant relationship by gender between them because it reduced the time spent by health professionals for business and other activities as a result of emotional problems in the past month (Table 2).

Table 2.
With Sex "as a Result of Emotional Problems in the Past Month you Spend on Your Work and Other Activities did you Reduce the Time?" Expression Comparison

Did you reduce the time you spend on your work and other activities as a result of emotional problems in the past month?		Gender		Total	Two-tailed significance	
		Woman	Male		X^2	p
Yes	n	32	9	41	4,281	,039
	%	78,0	22,0	100,0		
No	n	61	41	102		
	%	59,8	40,2	100,0		
Total	n	93	50	143		
	%	65,0	35,0	100,0		

The gender of the participants; "to target as a result of your emotional problems in the past month, did you manage less?" As a result of the comparison of expression; they are targeted as a result of emotional problems in the last month of the female health workers who accomplished less than 50.9% (n = 28), who managed more than 74.7% (n = 65), they are targeted as a result of emotional problems in the past month than male health workers who accomplished less than 49.1% (n = 27), who managed more than 25.3% (n = 22), respectively. Female health workers accomplished more than they targeted as a result of emotional problems in the past month, it revealed that the man failed.

P <0.05 (0.04 <0.05) considering the gender of health workers with more than they targeted as a result of emotional problems in the last month there was a significant relationship between health workers to be unable to succeed (Table 3).

Table 3.

Gender "To Target as a Result of Your Emotional Problems in the Past Month did You Manage Less?" Expression Comparison

To target as a result of your emotional problems in the past month did you manage less?		Gender		Total	Two-tailed significance	
		Woman	Male		X^2	p
Yes	n	28	27	55	8,448	,004
	%	50,9	49,1	100,0		
No	n	65	22	87		
	%	74,7	25,3	100,0		
Total	n	93	49	142		
	%	65,5	34,5	100,0		

6.Conclusıons and Recommendatıons

This study has been carried out in February 2015 among The Bandırma State Hospital's staff in high-risk units for to determine the level of quality of life;

- 65.1% of (95 people) were women,
- 39% (from 57 people) were 30-39 years old,
- 77.4% (113 people) were married,
- 63.7% (93 people) were nurses, midwives and health officers,
- 37% (54 people) had 6-15 years of total work time,
- 70,5'n% (103 people) had weekly working time of 45 hours or more,
- 61'n% (89 people) had more than 20 days of annual leave,
- 61.6% (90 people) work in emergency, intensive care and in the operating room,
- 57,5'n% (84 people) had income between 2501 TL and 5000 TL,
- 52,7'n% (77 people) had their own house,
- 70,5'n% (103 people) has 2 children,
- 53.4% (78 people) are smokers,
- 71.9% (105 people) do not use alcohol,
- 80,1'n% of (117 people) do not have a physical illness,
- 91,1'n% of (133 people) have no psychological discomfort,
- 52.7% of (77 people) had no surgery,
- 51,4'n% (75 people) are in moderate health,
- 61,6'n% of (90 people) had almost the same state of health compared with one year ago.

The comparison is made according to gender;

- As a result of emotional problems in the past month that reduced the time spent by male and female workers for business and other activities,
- Women accomplished more than they targeted as a result of emotional problems in the past month, the men failed,
- Similar in the past month, sometimes they feel calm and positive,
- Similar in the past month, sometimes they felt tired in the last month,

The comparison made by the profession;

- As a result, during the last 4 weeks of physical health
- Doctors, they have difficulty in doing business and other activities, nurses, midwives, health officers and other personnel have some difficulties,
- Emotional problems in the past month affected work or other activities that doctors, nurses, midwives, health officers and other staff if they do care, can not always be so careful,
- Doctors in the past month they felt themselves quite calm and positive, nurses, midwives, health officers and other staff – sometimes they feel calm and positive,
- Doctors and other staff feel that they were quite happy in the past month, nurses, midwives, and health officials say that sometimes they feel happy,
- Doctors they know they do not get sick more easily than other people get sick, nurses, midwives, health officials think that they rarely get sick easier than other people, other staff – if they are ill, so never easier than other people,
- Doctors think of health, it would definitely get worse, nurses, midwives, health officials rarely think that their health will worsen, they do not know if other personnel may not go worse health,
- They do not know whether the doctor nurses, midwives, health officers and other personnel of the mostly understood excellent health.

The vast majority of female health workers, married, with a ***nuclear*** family structure was found to be homeowners. Although the number of alcohol users is very low, smoking continues to reduce the quality of life. Although nurses and midwives continue to work, a lot of the influence of emotional problems, although they are positive and calm, they installed stress of work and quality of life; these problems were found to be normal.

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