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Examine how an absence management programme can foster an attendance culture within an organisation.

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ABSTRACT

This study examined how an absence management programme can foster an attendance culture within an organisation.

Fostering an attendance culture involves the organisation sharing responsibility to its Department heads and also line managers to ensure staff continue to be committed to the organisation through the desire to attend and an expectancy of the organisation to attend work.

Emerging from the literature review, the general hypothesis is that absence is multi-faceted and 'one size doesn't fit all', which is why an absence management programme must have more than one approach and element to it, in order to create a positive shift towards an attendance culture within an organisation.

Similar conclusions are drawn from the analysis and interpretation of the qualitative and quantitative data findings of the case study. Through the implementation of the re-launch of the absence management programme within the private hospital, Management, HR and Occupational Health played a central role in absence management. Considering all these elements of the absence management programme a significant increase in attendance was realised within the private hospital.

This research contributes to the developing theories implicating absence management and cultural change. It blends elements of the practical and interpretative and shows that both these examples can be used in research.

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CHAPTER 1

RESEARCH AGENDA

1.1 Introduction

In the current economic climate, all leading organisations are now under pressure to deliver a high quality service in a timely and cost effective manner. It is all the more clear that the need for Management to deliver a meaningful and practical Absence Management Programme will initiate a higher level of attendance, improving performance which ultimately will feed into the bottom line, the profit of the organisation.

The organisation under research is one of Ireland's leading Private Hospitals. It provides specialties ranging from Cardio-thoratic and Oncology care. The organisation has commitment to high quality care and service delivery which links into its mission statement and business strategy.

One of the key concepts of the organisation's business strategy is to reduce the hospital's overheads. A drive on cost containment throughout all departments of the organisation has been conducted and the Human Resource Department has identified absenteeism as one of the areas to which if improved can contribute to the cost containment initiative.

According to IBEC's Workplace Absence Survey 2004 (IBEC 2004) only 34% of companies calculate the cost of absence. Companies that calculate the cost of absence, predominantly focus on the direct cost of absence .i.e. sick pay, overtime, replacement cost etc., and do not look at the indirect cost of absence, such as the loss of productivity and the administration costs associated with absence.

The survey also estimates the cost of absence per employee to be on average €882 per annum, which equates to a total cost of absence of around €1.5 billion.

1.2 The Need for the Study

The need for the study was to investigate whether an Absence Management Programme can foster an attendance culture within an organisation. Whether absence Management has an effect on an attendance culture and what measures are required to realise an attendance culture.

1.3 Objectives of Research

The objective of this research will examine how an absence Management system can foster an attendance culture within an organisation. This research will be carried out by using a qualitative research approach.

The research will be carried out within the researcher's place of work. It is felt there will be fewer constraints to gain access in collecting data and information when conducting this research.

Qualitative research will help deduce what impact an Absence Management Programme has on fostering an attendance culture through interviews.

1.4 Organisation of Dissertation

In chapter 2 the literature review will explore theories hypothesising reasons for absence such as psychological factors that affect behaviour of the individual and also the collective.

It will investigate what measures are needed to achieve an attendance culture through exploring the role of Management, the impact of monitoring absence, the role of Occupational Health and also the Organisations legal duty to health and safety within the workplace.

In Chapter 3, within the methodology section of this paper, through a qualitative approach through interviews will examine how an Absence Management Programme can foster an attendance culture. Quantitative data will be used to triangulate the findings of the interviews to reach findings and conclusions.

In Chapter 4, a case study within the Private Hospital will investigate through interviews and organisational data whether this organisations Absence Management Programme fosters an attendance culture.

In Chapter 5, the paper will end with a conclusion, taking into account the absence theory researched within the literature review and also the primary research conducted within the case study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Absenteeism is becoming one of the growing concerns for employers. For an organisation to impede continued rates of absence they need to encourage attendance. This literature review will explore the theories of the cause(s) of absenteeism and the models used to understand the behaviour of employees who withdraw from the workplace. It will also look at Occupational Health and Management's role in absence Management. The literature review will also review how the organisation's legal duty in health and safety has an impact in absence Management.

Findings of studies have suggested a link between the type of job an employee has and absenteeism, and that job satisfaction has an important role for an employee to be motivated to attend work (Cowling & Walters 1990). When the psychological contract of an employee to their organisation breaks down, they cease to be actively committed to the organisation. Without commitment from employees, organisations will experience high levels of absenteeism and also high levels of turnover of staff. An employee's level of commitment to their organisation determines their performance.

The most important reason why there should be a control on absenteeism for an employee, if employees are not motivated then they won't be satisfied in their jobs. (Taylor 1973:30).

A staff member's commitment to the organisation can change which can result in de-motivation and lack of performance to their assigned responsibilities and overall commitment to the organisation.

In order to be successful in promoting organisational commitment, you must focus on improving job satisfaction. (Goodman & Aitkin 1984:297) Productivity is more vulnerable when those who are absent are central to the production process.

2.2 Absence models

Many behavioural scientists have developed models to assess employees within the workplace. The models measure and evaluate an employee's motivation and job satisfaction, assessing possible reasons for absenteeism.

Individual Motivation Model

According to (Rhodes & Steers 1990) Individual Motivation Model, absence has two variables. The first variable; the ability to attend work, which deals with whether the employee is prevented from attending work e.g. has an illness. The second variable deals with the motivation to attend work; whether the employee feels pressure to attend work. The feelings of the employee and of what they think of the business and also of their job, has a huge impact on their motivation to attend work.

Rhodes & Steers also found a correlation between absenteeism trends and trends in labour turnover. If an employee is unhappy in the workplace and they want to leave, but can't, (e.g. during a recession) then absenteeism rates increase. On the otherhand, if the labour market is in favour of the employee, and they can find work easily, then trends in labour turnover increase, marking a reduced level in absence within the organisation.

The diagnostic model looks to highlight three key factors which influence employee absence; organisational practices, absence culture and employee attitudes (values and goals).

Nicholsons (1977) suggests in his attendance model an employee's motivation to attend work is attributed to the individual's traits and also their characteristics. Huczynski & Fitzpatick (1989), Rhodes & Steers (1990) identified the person's length of service, age, gender, personality, employee attitude, values and expectations, past absence behaviour to have a significant bearing on the individual's absence rates.

The individual having a long length of service showed they had a higher absence rate especially if there was an occupational paid sickness scheme within the company.

Vistnes (1997), Vandeheuvel & Wooden (1995) conducted research on absenteeism and gender. Their research revealed a higher rate of absence in women with children under the age of 6. In an older workforce the involuntary rates of absenteeism between women and men were found to have similar levels of absence.

Barmby et al (1999) also cited that gender and age have an impact on attendance, for males up to the age of 40 years of age the absence rate is at 2%, 7.5% ranging from the age of 60-65.

In comparison in females their absence rate ranges 3-4% from 16-18 to age 30 and then reaches 7% at age 60.

Within senior Management roles female absence rates were not higher than that of their male colleagues. Bekker et al (2009) concluded in their study of gender absence that women were more frequently absent than to men. This however depended on what country, their age and professional group. Women's absence also seemed to be restricted to short-term absence.

In a study on the relationship between pregnancy and sickness absence, Sydsjoe, Sydsjoe, and Alexanderson (2001) identified only 46% of all pregnancy related absent women through analysis of the companies medical certificates. These results imply sickness absence in women might partly reflect pregnancy-related illness problems rather than general illness.

Many studies show higher general rates of sickness absence among women, however, data from nine countries of the Luxembourg Employment study showed men have a higher absence rate compared to women (Barmby et al 2000).

Further studies reveal men are over-represented in long-term absence (Olsen, 1995) whereas female absences have relatively short-term occurrences of absence (Laaksonen et al 2008).

Hogan & Holland (2003) using socioanalytic theory revealed the 'Big Five' pesonality traits can predict job performance. These are; Introversion/extraversion, emotional stability, agreeableness, conscientiousness, openness to experience. The study also concluded the big five factors are also evaluations of acceptance and status. An employee's attributes can play a role in what emphasis they place their responsiblities to their work and home life.

Withdrawal Model

Withdrawal Model, Hill and Trist 1953, 1955, model suggests that absence is the result in the withdrawal from the workplace to reduce the employee's stress levels. Also employees who experience conflict within the organisation show an increase level of turnover, accidents in the workplace and absenteeism.

Turnover was described in the early phase of 'induction crisis', unsanctioned absence in the middle period of 'differential transit', and sanctioned absence in the mature phase of 'settled connection'. The model is one of organisational socialisation into the 'absence culture' of the company. Hill and Trist's study was an analysis of data of longitudinal absence trends. Data evidence revealed that sickness absence may be the product of physical conversion of stress.

The behaviour is the outcome of extreme levels of stress and is a symptom of psychological ill health. This theory deals with a relatively isolated and 'abnormal' type of absence, and is not the type of theory to explain more general theories of 'normal' absence.

Brayfield and Crockett (1955) also investigated the theory of withdrawal, indicating that employees experiencing work dissatisfaction withdrew from the workplace. Concluding absence and attendance are the behavioural outcomes of work satisfaction and dissatisfaction.

Nicholson (1977) refutes this simplified conclusion of withdrawal theory and asserts the conscious feelings of people towards their work-related behaviour most likely merits a much minor role in forces that influence an employee's actions.

Informal Contract Model

Gibson (1966) presented an absence theory, an Informal Contract Model, Social exchange theory which considers the influence of both formal and psychological contracts.

Gibson suggests that an individual's belief system has a direct impact on their attendance levels within the workplace. Within this model, absence is viewed as a concept of a contractual relationship within a social exchange framework.

The framework uses collective legitimacy and organisational attachment to explain these concepts. The framework indicates whether the individual's core perception towards their workspace is negative or positive. The type and the length of absence determines the legitimacy of absence, however the frequency of absence indicates an issue of organisational attachment.

As the negative perception (organisational attachement) intensifies, the individual's justification to withdraw from the workplace is likely to be acted upon. Gibson notes, that the size of the organisation is also a factor in the culture or perception to absenteeism within the company. Barmby and Stephan (2000), and Fenn and Ashby (2004) infer in bigger companies, there are more resources to cover absences, creating a tolerated culture of absence over a longer period of time. Green (2007) noted through a study of absence Management an increase in perception among workers to view absenteeism almost as an entitlement, using absence as another type of leave.

Bandura (1977) points out that the individual who wants to change, has sufficient incentive to change. He argues that outcomes are determined by the individuals actions and can have numerous possible effects on self efficacy and behaviour. Individuals who view the outcomes as being determind by themselves but lack the right skills would more often experience low self efficacy and view these endeavourss with a sense of futilty.

2.3 The role of Measuring Absenteeism in fostering an attendance Culture

According to the 2004 IBEC absence survey, Ireland's employers are underestimating the cost of absenteeism to their companies by 100%.

The cost of absenteeism within the workplace can be up to 40 times more a year than industrial action.

The tendency to only calculate direct costs such as sick pay, overtime and employee replacement costs, will not arrive at the real cost of absenteeism.

The survey cites that to get a real picture of the cost of absence, it would be necessary to also estimate indirect costs. Indirect costs could be broken into the effects on productivity, effect on quality of service, the administration and time spent on managing absence and the increased work pressure and increased workload on colleagues. Once the direct costs are calculated, these costs should be doubled to get the actual cost of absence (Huczynski 1989).

According to Gibson (1966) social exchange theory, an absence culture is transmitted through the social order of the organisation. For example what the employee perceives the 'norm', the collective influence of other workers' absence and what level of absence will be tolerated by the organisation.

Another example of collective influence would be that some cultures norms dictate good attendance despite how satisfied the individual is in the workplace.

Furthermore, some other cultures might see absence as a legitimate way to signal their dissatisfaction in their job. (Hill & Trist 1953,1955) The psychological contract dictates how culture is acted out. The psychological contract is a way in which collective influence converts into individual behaviour.

It is also worth highlighting there is an increase in research of sickness presenteeism. Presenteeism is when individuals attend work even though they are suffering from an illness (Chatterji & Tilley, 2002, Dew et al, 2005).

Even though there has only been limited research on this issue, there are concerns from researched evidence that presenteeism is related to future absenteeism (Bergstrom et al, 2009). Studies have also concluded that the cost of presenteeism in relation to the individual that is ill and attends work (presenteeism) may be greater than an individual that is absent from work when ill (Goetzel et al., 2004).

The monitoring of absenteeism can help an organisation ascertain the cost and also identify patterns and reasons for absence. Monitoring also can provide a view to whether an absence culture within a department is developing. With regular reporting of absence, it can have an effective approach to the Management of absence. The greater monitoring an organisation carries out, in particular firms with team production; there are significantly reduced rates of absence (Heywood et al 2008).

Throughout the study on the interrelation between teamwork, monitoring and absence found Organisations that depend on team production incur more of a cost of absence and as a result spend more on the task of monitoring absence and resourcing the Management of absence. Furthermore, organisations with teamwork incur a lower absence rate

than those that rely on productive interactions among their employees (Heywood and Jirjahn 2004) and (Heywood et al 2008).

Organisations are keen to put in place an effective and an accurate measuring system to monitor absenteeism to establish the levels of short-term and long-term absences within the organisation. Strategies such as these are the employer enforcing their side of the psychological contract, communicating their expectations of the individual's attendance to work.

Using simple numerical frameworks to calculate absence can be used to invest in profitable areas like flexible working practices, improved recruitment methods and new technology. This calculation outlines the financial implications of human resource decisions.

The Bradford Points Scheme also known as the Bradford Score is becoming the most common way to calculate and measure absence, by calculating the rate of attendance. Using the Bradford Points Scheme, one can identify any patterns of absence. In particular whether there is an issue of frequent short-term occurrences or just one single instance of absence, establishing whether there is an absence culture within the organisation. An example is illustrated below (Paul Dowling 2009).

Bradford Score is as follows; $B = S^2 \times D$

B represents the Bradford Factor Score. S is the total occurrences of absence over a period of time, normally over 52 weeks (a rolling year). D is the total number of absent days taken over the 52 weeks.

Example: An employee has a total of 14 days absence over a rolling 52-week period. (Robertsten, Jamin 2005)

One absence of 14 days is 14 points (i.e. 1 x 1 x 14)

Seven absences of two days each is 686 points (i.e. 7 x 7 x 14)

14 absences of one day each is 2,744 points (i.e. 14 x 14 x 14)

An individual's score resulting less than or equal to 49, no action is recommended. An individual's score exceeding 49, action is recommended.

In addition to calculating absence, the monitoring of absence should also involve analysing data collected to understand the reasons for absence in order for Management to take corrective action.

Taylor (1974) reported changes over time in the reasons given for illness. There was a noted reduction in stomach related illness and an increase in back ailments. These changes could have been contributed to exposure to risks. They also imply evolving social beliefs about what constitutes credible reasons for absence. Rushmore and Youngblood (1979) found that medically associated absence was related to work and non-work motives.

Employees will be prone to translate work behaviour of absence from the literal rules of the business to operational rules. If corrective action is continually not been taken by Management within an appropriate time frame, then the operational rule of absence will be perceived to be in contrast to the literal rules of the organisation, thereby creating a platform for an absence culture. This is why it is essential for Management to monitor and manage absence on a consistent basis.

Scott & Markham, (1982) suggest following a survey of 987 personnel managers that the majority of absence Management strategies are reactive and punishment-oriented. Strategies such as these are geared towards individuals who show evidence of persistent absence.

Providing appropriate training and support for Management to accurately monitor and record absenteeism, will directly contribute to an organisation adding value to their business objective of reducing their absenteeism levels in the long term.

To meet this goal, the organisation will need to involve all levels of Management of their decisions and actions that affect the relationship between the organisation and its employees (Beer 1984). By involving staff, this will empower line-Management to carry out the absence Management strategy of the business.

In 2009 an absence Management survey carried out by Chartered Institute of Personnel and Development recommended during these recessionary times, staff engagement and sickness absence should be managed. The survey also revealed as a means to reduce short-term absence, 44% of companies employed flexible working. To help reduce long-term absence 56% of companies employed flexible working (2008 Hayday Sue).

2.4 Management's role in fostering an attendance Culture

Many schools of thought on how to manage absenteeism suggest a manager's style of Management impacts on a staff member's performance and attendance.

There is a direct link on how a manager's approach to employee relations such as staff morale, staff engagement, the motivation of staff and how they manage change, to staff absenteeism. There is a theory that there are two types of Management approaches. The Unitarist sees only one level of authority, the employer. Anyone disagreeing with this authority is a trouble maker. The Pluralist seeks to find common ground to serve everyone's interest to reach the business goals and accepting difference of opinions (Fox 1968).

Others argue that other factors influence absence such as Management not accurately monitoring absence levels and avoidance to report to the top if an absence problem exists. As in the social exchange absence model, an absence culture can be created by having a high tolerance for

absence or as stated, avoiding there is an absence level at an unsatisfactory level. This leads to the organisation underestimating the real cost of absence due to the lax recording and Management of absence within the organisation (O'Kelly 1991 & Sargent 1987).

According to an IBEC absence survey carried out in 2004, 'For every 1% drop in absence rates, the company can make a saving of €250,000 on sick pay and overtime alone.'

An investigation into the cause and influences of individuals to be absent in the workplace found the causes and influences were broken down into the following categories; sickness, personality, the individual's background, their perception of their job and their responsibilities and relationships at work and inside the home (Bolton & Hughes 2001).

The reasons for absence are multifaceted, the literature and authors of theory have found there is a correlation of job satisfaction to absence. The role of the manager comes into play and how their Management style affects an employee's perception of their job and also their attachment to the organisation.

Management can use Vrooms expectancy model (1964) to predict an employee's job satisfaction. Vrooms theory suggests the employee will always decide to pursue the goal, which will receive the greatest reward for them.

Absenteeism can be associated with expectancy theory. In positive valence the employee's emotional state is driven to attend work if their extrinsic desire is met for example attendance is linked to their salary increments. Money is the motivator in this instance.

In the example of intrinsic desire, satisfaction, an employee may be driven to attend work if they feel appreciated and are satisfied within their job. On the other hand, negative valence may see the employee avoiding to attend work, for example by 'rewarding' themselves with short-term absence, perhaps in order to balance out their perceived workload compared to others.

To assess staff morale, it is recommended that organisations should carry out regular employee surveys and follow up action plans. Other tools of assessing staff morale and staff engagement can be done through conducting comprehensive staff return to work interviews. This should happen for all absences of employees, which can achieve improved levels of absence. By conducting 'return to work interviews' following staff absences, the manager can get direct and honest feedback, actively learning from successes and errors.

An absence culture is determined by the organisation's internal norms and standards. To have a direct impact on staff attendance, businesses need to improve staff motivation and engagement. This can be achieved by involving staff on a systematic basis, e.g. inviting staff ideas that may help improve the running of the organisation. The organisation in turn could pilot some of these ideas before deciding which to embed. Techniques such as positive reinforcement and recognition can empower staff, which will increase and sustain their motivation and overall morale of staff. (Dessler 2001)

Management is one of the most important roles in an organisation. Developing effective managers is a challenging task requiring views from many different perspectives.

The lifeblood of all types of managerial work and activity involves relating, understanding, cooperating, and depending on levels of consciousness. (Robert Figler 2008)

It is estimated that the annual cost to employers is more than €740 per employee who attend work while ill and do not perform.

The starting point for managing stress at work at any time is good people Management, particularly on the part of front-line managers. They can help to prevent and manage stress at work. Their behaviour can be the reason why people become stressed in the first place. Negative effects on staff can be avoided if line managers are able or learn how to behave in ways that prevent or reduce stress. (Ben Willmott 2009)

In order for the organisation to promote an attendance culture, it is increasingly more evident that proper support measures for Management be provided such as delivering training and coaching of absence Management on topics such as leading change, motivation and morale of staff. Management Training in handling absence should be provided especially if Management decide to implement disciplinary procedures. Training will ensure fair procedures are being adhered to. Fair procedures are vital to avoid any employee grievances.

2.5 The role of Occupational Health in fostering an attendance Culture

Ensuring a compliant and efficient Health and Safety programme is an integral part of realising an attendance culture within an organisation. One of the key elements to a successful Absence Management Programme is to have an Occupational Health department promoting a safe and healthy working environment for all levels of staff of its organisation. The healthier the workforce the more the workforce will perform (Persaud 2007).

The main function of an Occupational Health department is to carry out health and safety risk assessments to establish any environmental hazards within the work place that may cause harm or injury to staff thus reducing the risk of injury or illness. Implementing measures such as these will reduce occupational injury, thus reducing absence.

Part 6 of the Safety, Health and Welfare Regulations 2007 states, a risk assessment must be carried out on a person being employed as a night worker. The Occupational Health department can determine if a night worker becomes ill to request Management assign them other duties that do not involve night work (Health & Safety Authority 2007)

According to the Health and Safety Authority, Manual handling accounts for 33% of accidents reported to them from mainly industrial sectors in manufacturing and warehousing, retail, construction, agriculture and the health care sector.

As a control to reduce manual handling injuries, Occupational Health delivers training to all staff, how to handle and carry a load, be it an inanimate (an object) or animate (animal or person), in accordance to manual handling regulations 2007.

In addition to training and risk assessment, Occupational Health approach of encouraging attendance in staff would be a holistic one. Linking existing reporting of absence and following up the question why the absence occurred. Using early intervention measures such as the manager referring employees absent more than two weeks to Occupational Health, and them reviewing the employee's state on health and assess the likely hood of them resuming work, can have a positive effect of the levels of attendance.

Introducing initiatives such as staff support programmes; promoting the benefits of staff care services and Occupational Health Management of staff.

Studies carried out by Konstantinos Pouliakas 2010, reviewed the effectiveness in the monitoring of absence. Indicators under investigation were Occupational Safety and Health infrastructure social security expenditure, prevention and regulations of absence.

The investigation also explored the implications of the lack of Occupational Safety and Health related to the economic and social costs involved. Revealing an average of 2-4% working hours were lost through illness cited absence. An annual 1.3 working days were lost through accidents in the work place and 2.1 days are lost due to other work-related health problems (European Communities, 2004).

Higher rates of absence were found in staff working shift work and irregular working times as there is a strong physical and mental burden on staff working these shift patterns due to the lack of adequate recuperation in between staff rest and work times (Finn, 1981).

In the interest of the employees' health and safety at work, following an Occupational Health assessment, an employee's hours of work can, for example, be recommended to be reduced or a recommendation of mandatory rest periods for staff experiencing mental or physical illness in order for the employee to receive adequate recovery. By acting on the recommendations of Occupational Health, the organisation can improve the employee's overall well being, in the hope that in the long run, the staff member's attendance level will improve.

The HSE in the UK in 2008 explored if ill health caused at work impacted a person's productivity and level of employment. The impact of bad health on a person's productivity and employment status found that an individual's health has a strong and significant impact on productivity. People in poor health earn 7-15% less than those in good health. As the person's health worsens, the likelihood of them attending work decreases (HSE 2008).

A recent study examining the effectiveness of brief behavioural interventions adapting the principles and techniques of Motivational Interviewing to four behavioural domains: substance abuse, smoking, diet and exercise, found motivational interviewing an effective intervention method in substance abuse treatment. (Dunn et al 2001)

The World Health Organisation has recognised a surge in work related pressures and stress as a problem, as the economic crisis worsens. Organisations need to implement a stress Management strategy in order to reduce its absenteeism rate. The health and safety executive have reported people in employment confirmed work-related stress has steadily increased from 820 people per 100,000 in 1974 to 1,620 people per 100,000 in 2007/8 (Michael J.Morley 2003)

A recent international study in occupational and environmental health found back injury to be the most common work-related factor affecting absenteeism among health care professionals. (Rantanen Iina & Tuominen Risto 2011)

A Danish study has reported its findings on long-term sick leave and its risk factors during pregnancy among hospital employees. It found women employed as Nurses suffered from chronic back pain. There were also risk factors for long-term sick leave whilst these women were pregnant. Other factors also recorded were long periods of walking or standing, long working days, high work level, little practical support from supervisors and colleagues, low job control, much lifting and night or shift work.

The study also revealed sick leave was more frequent in the later stage of pregnancy than in the early stage. The study concludes long-term sick leave during pregnancy was frequent and to some extent could be predicted. The findings from the questionnaire carried out in the study on staff, corroborated the association of the higher level of sick leave with the need for a change in how work tasks could be changed for pregnant staff in their first, second or third trimester, in a manner that optimised their health and well-being. (Kaerlev Linda et al 2004)

2.6 An Organisation's Legal Duty Towards Health and Safety

The cost to an organisation of not having an Occupational Health service in place to tackle absence levels can have not only economic implications to the business but also legal ones.

The UK Health and Safety Executive's 2006-07 Labour Force Survey, reported a yearly loss of 1.5 days from injury and illness caused by work. These figures are the highest since 2003-04 reported analogous statistics for self-reported illness caused or exacerbated by work. (Patton 2008)

An organisation has many pieces of legislation to adhere to. The following in discussion are those that affect Health and Safety in the workplace.

Organisation of Working Time Regulations 2001, Organisation of Working Time Act, 1997, Employment Equality Act, 1998 (Amendment Act) 2004, Safety Health Welfare Workers Act, 2005, Pregnant Employees Regulations 2007 and Manual Handling Regulations 2007

Organisation of Working time Regulation 2001

The Organisation of Working time act 2001 is an EU regulation, introduced into legislation to require all employers to keep record of all working hours of its employees. The employer also needs to keep a copy of all annual and public holiday leave granted to its employees. This is to ensure employers can produce evidence that employees are receiving paid time off and not exceeding the working time act of 1997.

Organisation of working time act 1997

Organisation of working time act 1997 regulates a maximum of hours of working, rest periods, night work, annual and public leave for employees.

The maximum for an employee to work within a working week should not exceed 48 hours.

An employee must receive a rest or break during their working day for a period of 15 minutes if they have worked 4.5 hours and 30 minutes after working 6 hours. Having worked 11 consecutive hours within 24 hours the employee must 24 hours of rest within the 7 days of working.

If night work involves a hazardous nature and or physical and psychological strain then the employee may not work more than 8 hours in 24 hours.

In February 2011, Nenagh District Court found Rac Eire Partnership, a consortium of three Portuguese companies guilty for falsifying employment records and fined them €3,000.

The National Employment Rights Authority (NERA) who took the case against the Portuguese companies, on behalf of the Minister for Enterprise, Trade and Employment following an inspection of the company in July 2008.

Employment Equality Act 1998,(Amendment Act) 2004

The Employment Equality Act 1998, amendment act 2004, under the nine grounds of discrimination one, being having a disability. An employer must provide reasonable accommodation to its employee if the employee is suffering from a disability. Under the Equality Act 2004 and Safety, Health and Welfare at Work Act, 2005, stress is cited as a disability.

Also gender discrimination is one of the nine grounds that the legislation protects against discrimination.

In 2007, the Equality Tribunal awarded Ms. Healy, a pregnant employee €50,000 against her employer for gender discrimination and victimisation (Employment Law News 2011).

Safety Health welfare workers act 2005

The Safety Health welfare workers act 2005 was introduced by the government of the day to establish a Health and safety culture amongst employers and all workers and to reduce occupational injury. This legislation applies duties to all employers and employees.

In April 2011, the High Court awarded Garda Sgt J Liston €106,400 for sustaining injuries on the job. (Employment Law News 2011)

An employer has explicit duty of care to their employees to manage a healthy and safe work environment.

They are obliged to ensure a safe place and safe systems of work and provide safety equipment and clothing where necessary. They are also required to provide training and supervision in all matters of health and safety in the work place. The employer should have a signed safety statement clearly displayed in its place of business.

In December 2009, the Roscommon Circuit Court handed down penalties against Ownercrest Properties Ltd amounting to €100K, Roscommon Building Co. Ltd €200K and to its company director Mr Doyle, €50K. The sizable penalties were awarded due to the serious breach of health and safety legislation which led to the death of an employee working for Owencrest Properties Ltd. (Health & Safety Authority 2009)

An employee has a responsibility and also a duty of care for their own health and safety and not to cause harm to themselves or others. They are obliged not to work under the influence of any intoxicants, and to submit tests for intoxicants.

The employee is required to co-operate with their employer and to use all safety equipment and clothing provided by the employer. They also have a duty to report any safety hazards, equipment in their place of work and also any unsafe work systems and practices within the work place. The employee must attend all health and safety training provided by the employer.

The introduction of the Safety Health Welfare Workers Act 2005 has improved health and safety within all industries, in particular the construction industry. There is a danger during a recession that corners are cut to save time and money.

However, the temptation of save now, pay later is a reality for many companies that are under pressure to make immediate savings, but in the long run realising hefty fines and damaging their business reputation, causing irreparable damage to the business. An element of organisation culture can be shaped by competitive environment and where the organisation is placed within its market place (Gordon 1991).

Manual handling regulations 2007

The manual handling regulation 2007 was introduced to increase the health and safety of employees and reduce hazardous work practices of carrying loads in an uncontrolled way. Training for all employees is now mandatory in organisations. This is to reduce the high statistics already cited in this literature review, of back injury being one of the highest occupational injuries being a cause for employee absenteeism.

Pregnant employees regulations 2007

Pregnant employees regulations 2007 was introduced to ensure the safety of the mother and unborn child within the workplace. A pregnant worker now must notify their employee of being pregnant in order for the employer to carry out a risk assessment to identify any hazardous tasks.

In August 2010, the Equality Tribunal awarded Ms. Blatt €100K for being victimised and discriminated against when she became pregnant. The award was so high due to the fact throughout Ms. Blatt pregnancy, she suffered from high blood pressure, which was due to work related stress, which nearly caused her to lose her baby. (Employment Law News 2010)

2.7 Discussion of Findings

As discussed in this literature review causes of absenteeism in general can be influenced not only by the inability to attend work due to health reasons but also causes of the working environment such as the individual's relationship with their manager, their attitudes to their work, commitment to the organisation and also the individual's general belief towards their own responsibility of managing their own health.

The reason for an Organisation to design and introduce an Absence Management Programme within the business is to primarily focus on the immediate reduction levels of absence, concentrating on the general cause of absence, health reasons. However, as outlined through the literature review, the reasons for an individual's absence are far more complex.

If an organisation wishes to achieve an attendance culture, the more complex reasons must be tackled, such as the individual's commitment to the organisation, their attitude to their role and what their health belief is towards managing their own health.

The literature review also explored Management's role towards fostering an attendance culture. They possess an opportunity to realise a positive impact to the individual's commitment to the organisation. Through increased staff engagement and morale, patterns of persistent absence can be reduced.

Management taking an active role of accurately monitoring absence will also have an impact and create an awareness of absence within the workplace.

Furthermore, utilising Occupational Health as a method of early intervention can highlight reasons for absence that Management and organisations may not be aware of, such as work environment i.e. workers typically working shift work, not being rostered adequate rest periods etc, which could be attributing to not only persistent absence but also presenteeism.

Sectors such as health care need to manage issues such as these, as avoiding or ignoring these, could be hazardous to patient care and also the overall reputation of the business.

The literature review also highlighted the importance of work environment attributing to factors associated with mental illness; stress. Psychological ill health according to the health and safety authority is growing particularly in the health sector due to the nature of work of health care professionals: long work hours; work load, and pressure, which allowed to go unnoticed, can lead to unhealthy levels of stress, resulting in absence.

The duty of care of both employee and employer needs to be realised, to ensure no harm comes to themselves or to others. This also includes psychological ill health. As discussed in the literature, the health & safety legislation an organisation is bound to covers stress as a disability, which needs to be accommodated and managed.

Occupational Health's role, within a correctly designed absence Management system, can devise initiatives that promote well-being and health motivation in individuals experiencing high levels of absenteeism.

2.8 Summary

Theories that have been discussed throughout the literature review accounted reasons for absence such as the individual's emotional state. It emerged within the literature review that stress is a cause of absence within organisations, in particular the health sector. Individual's motivation and desire to perform, and their attachment and commitment to the organisation were also examined, and how these contribute to absence.

The individual's health motivation was discussed. Their responsibility to home versus work life was shown to also be a factor for an organisation to consider when promoting attendance.

The theory of gender revealed it is a factor in absence, and that women who have young children are more likely to have a higher rate of absence compared to their male colleagues.

Emerging from the literature review, the general hypothesis is that absence is multi-faceted and 'one size doesn't fit all', which is why an Absence Management Programme must have more than one approach and element to it, in order to create a positive shift towards an attendance culture within an organisation.

CHAPTER 3

METHODOLOGY

3.1 Introduction

The purpose of this chapter will discuss methods used to examine how an Absence Management Programme can foster an attendance culture.

A qualitative method framework was chosen to examine the topic under research. A case study method through interview was used to gain a more in-depth understanding of how an Absence Management Programme can foster an attendance culture.

Interviews were chosen as the most appropriate tool to gain the required understanding of the participant's beliefs and opinions towards how an Absence Management Programme can foster an attendance culture. The benefit of using semi-structured interviews was appointments could be made with participants which allowed to schedule the optimum amount of time to conduct the interviews. Data was able to be gathered within the time allotted and often further opinions and beliefs were expanded upon, which added to the study. The challenges at times for interviews were that senior Management were not always able to give the time allocated or keep appointments, which slowed down the process of collecting data.

Interviews were analysed and interpreted by using grounded theory, collating overall opinions and highlighting themes that came out through interviews (Glaser 2001). The qualitative data collected was then compared against organisational quantitative data and secondary data sourced to triangulate findings and draw overall conclusions (Robson 2002).

Limitations of research were due to time constraints. The group of participants under research were confined to one particular group within the Private Hospital and to gain a better understanding of attendance culture within the Private Hospital, a more comprehensive case study would have to be carried out.

It was decided that a case study method of exploratory research using techniques such as interviews and documentary analysis will be applied in this dissertation. A Case Study is "research strategy that involves the empirical investigation of a particular contemporary phenomenon within its real-life context, using multiple sources of evidence" (Robson 2002). The phenomenon under investigation is how an Absence Management Programme can foster an attendance culture. The researcher's place of work was chosen to carry out the case study.

A Case Study Strategy is widely used to answer questions such as Why? What? and How? (Morris & Wood 1991) Documentary analysis such as secondary data using organisational data documents will be sourced and utilised.

Possible constraints to consider will be to gain permission from the Private Hospital to use this data evidence. Other documentary data will be used to draw conclusions on the research topic from gathering theories from recent publications.

Another approach for data collection being used will be interviews. These interviews will help to deduce the thoughts and opinions of how the absence Management system of the organisation under investigation can foster an attendance culture.

This primary research will be conducted through interviews, which will be a deductive research approach. Combining both methods of research, it is hoped to triangulate findings to reach final conclusions.

Yin (1994) and Stake (1995) designed protocols to conduct case studies. These protocols' purposes were to increase the validity and reliability of the case study.

This type of research is known as a triangulation (Stake 1995). Triangulation is used to confirm the validity of the investigative stage of the case study. Yin (1994) suggests this can be done by using more than one source of data in order to triangulate the evidence collected.

This way, there is a method to compare and corroborate the data and evidence collected. Allowing the researcher to corroborate the evidence gathered against the other data sources.

Triangulation increases the reliability of the data and the process of gathering it. Combining organisational data sources with interviews was viewed as an effective way to maximise the internal validity.

3.2 Participants

The researcher was conscious of selecting appropriate members of Management in order to get a valid and reliable insight and viewpoint of the topic under research. Letters was sent to the sample population inviting them to participate in the study (Appendix 3)

The sample population for the purpose of the first two interviews was taken from the HR and Nurse Management team. The sample population for the purpose of the third interview were taken from the Occupational Health Department.

The interview and case study will be based on voluntary participation and the continuous willingness for the selected participants to agree to be interviewed. Participants should be informed why they have been chosen to participate in the interview (Steane 2004).

In order to protect the participant's anonymity of the information they are providing, the interview itself will be anonymous. If at any stage these participants wish to withdraw their involvement, then this must be respected and another form of research should be adopted. When carrying out research it must be carried out in an ethical fashion.

3.3 Research Methodology

It was decided to use a qualitative approach in a form of a case study to the research. Interviews were chosen as a method to determine what opinions, beliefs and attitudes of HR, Management and Occupational Health have towards absence Management, and how it is impacting on fostering an attendance culture within the Private Hospital. Interviews will be used as a measuring instrument in order to establish the general opinion of HR, Management and Occupational Health, which exists regarding this topic under review.

The design of the interviews will determine the reliability and validity of the evidence collected. In order to increase the reliability and validity of the interview, it is recommended that a pre-testing of the interview be carried out to find any shortcomings in the design (Emory & cooper 1991).

Interviews are one of the most important sources of case study information. The interview could take one of several forms: open-ended, focused, structured or semi-structured. In an open-ended interview, the researcher could ask for opinions on events or facts. This could serve to corroborate previously gathered data. In a focused interview, the respondent is interviewed for only a short time, and the questions asked can come from the case study protocol.

The structured interview is particularly useful where a formal survey is required. The use of tape recorders during the interviews is left to the discretion of the parties involved. It has been decided to use a semi-structured interview approach. This way the interviewer hopes to be less formal and encourage responses that may not be forthcoming in a more formal, structured interview. In order to carry out conducive interviews, it is necessary to be aware of using the tools of conversation analysis. Turn taking is one of the basic tools for conversation analysis. Talk depends on shared codes; there must be codes to indicate the ends of utterances 'One speaker tends to talk at a time with little gaps between them as possible' (Hutchby and Wooffitt (1998:47)). Grounded theory will be used to analyse data gathered through interview. Collating themes that are revealed through the interview process (Glaser 2001).

There are limits to choosing interviews as a method to gather qualitative data. For instance, time is a factor to take into consideration. The time it will take, not only to transcribe interviews, but also to analyse and collate themes from each interview in order to interpret findings.

Bias is a consideration which one needs to be aware of. It is difficult to control bias and the design of an interview will not rule this out. Through a good research design, bias may not be ruled out, but it is possible to minimise it. Also misinterpretation of responses may arise during the course of the interview or collection of data. (Marshall & Rossman 1999). Other factors to consider when conducting an interview will be ethical considerations.

All academic writing must be done in an honest way. Integrity must be observed by the acknowledgement of others work, this will be done by Harvard referencing and including a bibliography, and listing publications and journals used to compile this dissertation.

3.4 Interview Design

A decision was made to design three interviews, taking into consideration the research topic and objectives. These interviews were designed to collect qualitative data. Both open and closed questions were used to collect this data. Closed questions used to quantify responses, and open questions to qualify data, allowing the researcher to establish the participants view point and perspectives beyond coded data. The time taken in completing the interviews was a factor, and also how best to analyse the data.

It is recommended that on completing the design of the interviews, one should carry out a sample to identify any amendments or changes required. Both interviews were sampled on two colleagues. From the first draft, it was clear that the questions being asked did not entirely relate to the research topic. The questions were revised, relating more to the research topic. (Appendix 1 & 2).

3.5 Research Approval

Research Approval from the Private Hospital was received from the Chief Operations Officer and Director of HR.

A letter was sent seeking approval to gain permission to carry out a case study within the Private Hospital and access to organisational data for the purpose to triangulate qualitative and quantitative findings of data collected during the research process. (Appendix 4)

For reasons of confidentiality a decision was made not to name the organisation where the case study took place, owing to the sensitive organisational data released, which was used for this study.

3.6 Limitations to Research

Due to the time limit of this research, it was decided it would be conducted at a specific population within the Private Hospital, the Nursing department.

Interviews held with Management were held with Nurse Management. A more comprehensive view could include other stakeholders such as clinical services, technical services and finance etc.

CHAPTER 4

CASE STUDY

The aim and objective of this case study is to examine how an Absence Management Programme can foster an attendance culture within an organisation. The case study was conducted within a Private Hospital.

4.1 Background

The Private Hospital employs approximately 1,200 staff. The staff comprises of varied professions within the health sector from a wide social, ethnic and economic range. The gender populous is divided approximately as 63% females and 37% males.

The HR department had a review and audit of attendance within the hospital in 2009, and this audit showed that there was an absence issue. The overall absence rate within the Private Hospital was 4.7%.

4.2 Qualitative analysis & interpretation

It was decided to use a qualitative approach to the research.

The purpose of qualitative research is to understand and gain insights. Qualitative method of research is predominantly exploratory and flexible due to the modest insight of the phenomenon, in this case study, how an Absence Management Programme can foster an attendance culture. The aim of the case study is to gain a better insight and construct explanations of the phenomenon under research. Popper (1972) described qualitative research as being particularly relevant in the 'context of discovery'. He suggests putting logic falsification in place of inductive reasoning for testing hypotheses. He believes there is a distinct difference between "the context of discovery" and "the logic of validation". A meaningful scientific statement is not that it can be verified but that it can be falsified, i.e. just because 'it' is not seen to be there, doesn't mean 'it' doesn't exist.

Three sets of interviews were carried out to determine the beliefs and opinions of HR, Nurse Management and Occupational Health and of how the re-launched Absence Management Programme could foster an attendance culture. The analysis of interviews would reveal how the Absence Management Programme is linked to HR, Nurse Management and Occupational Health and what steps they were taking to foster an attendance culture?

4.21 Human Resource Department

In 2009 the hospital re-launched the Absence Management Programme. An initial meeting with senior staff was held to consult with them on how a co-ordinated approach could improve attendance amongst staff.

A member of the HR department was appointed as project lead on the re-launch of the Absence Management Programme.

The mission of the re-launched Absence Management Programme in 2009 was to set a target to reduce the hospital absence rate to 3.73%.

HR Management advised prior to 2009, the senior staff team did not view themselves overall responsible for the management of absenteeism on a daily or weekly basis. There was a perception that the responsibility to manage and monitor absence should be the Human Resources Department.

HR also confirmed that the accuracy of monitoring absence was an issue, and that this needed to be improved.

Evidence of insufficient registration procedures was also discovered, such as the computerised registration of absence was partially flawed by inaccurate inputting by some members of staff.

HR calculated and measured staff with persistent absences, using the Broadford Score. It was decided that the HR project lead would accompany Management in the review meetings with staff to discuss their absenteeism.

Following the re-launch of the Absence Management Programme, HR revised the absence policy. (Appendix 5.1)

The hospital acknowledges in its absence policy that illness can occur for legitimate reasons, and in these instances practical support will be provided where possible.

The aim of the policy is to keep the level and frequency of absences to a minimum. Absence through illness is the central focus of the policy, in particular short-term frequent absence. HR hopes the absence policy will help employee's achieve regular attendance without the need to invoke the disciplinary procedure.

However, should the employee's absence continue to deteriorate following meetings, the employee should then be formally interviewed and warned. In the event of continued poor attendance, further stages of the hospital's disciplinary procedure will be invoked (Appendix 5.2). Examples of sanctions which may be taken as part of the disciplinary procedure include; medical certificates to be provided for all absences, removal/suspension from overtime roster, suspension from the sick pay scheme, deferment of an increment and dismissal.

The Absence Management Programme was communicated through information sessions held by HR and one of the main changes to the programme was that Management were being asked to take responsibility for the management of absence within their areas.

HR advised in 2009 and 2010 a 4 module Managing People Programme was delivered by IBEC and provided for all Management of the hospital. The modules covered stress/time management, understanding behaviour and its effects, motivation, communication skills and presentation skills. (Appendix 6)

The HR Training Manager confirmed that from September to December 2010, an Attendance Management Workshop was delivered by the HR Training Manager and also Project lead. Guidelines on how to conduct a return to work interview, case studies and role play exercises were the focus of this workshop (Appendix 7). A short refresher in attendance management was held in July 2011 at a Nurse Managers Workshop, due to the fact that the Nursing department absence rate continues to be high in comparison to other departments.

In early 2011, the HR Training Manager organised training sessions on time management, change management, finance for non finance managers, interview skills, I.T. training, motivating your team, performance management and presentation skills. These have been scheduled for all levels of Management throughout the hospital.

In the last two years, the hospital has increased its training. This increased training was a measure to support Management in order to increase organisational commitment from employees, staff morale and staff engagement. As discussed in the literature review, Bolton & Hughes (2001) found causes influencing absence were broken down into five categories, one of which was relationships at work. Dessler (2001) suggests through positive reinforcement, staff morale and staff engagement can be achieved.

HR revealed the Private Hospital in January 2011 launched the GAS club, in an effort to motivate and promote a healthier life style for staff. A weight loss programme with an offer for a free and confidential weigh in once a month was started. Exercise classes such as pilates and yoga were also organised. A lunchtime walking club and book swap club has also been promoted. Other classes offered in the GAS club are guitar and Italian classes. An outing to the theatre has also been arranged, for example, Greece the musical showing in July.

4.22 Nurse Management

When interviewed, Nurse Management confirmed that they record absence through a time and attendance computerised roster system. They felt this is a great tool, not only to monitor absence, but also to ensure the right amount of staff, with the right skill mix is in place, which will meet the organisations needs to provide their service delivery.

A computerised attendance system allows Management to improve the monitoring of staff absence greatly, which in turn can improve productivity, increasing decision-making and accuracy in payroll processing. (Swart 2010)

Employee fatigue has been associated with absenteeism in a recent study affecting an employee's mental and physical state and also their decision making. The study also cites that the issue of employee fatigue can cause increased rate for errors. This is quite serious for any organisation, but especially serious amongst health care professionals dealing with patient care. The computerised roster system allows managers to manage absence and to manage employee fatigue.

As outlined in the literature review there is an increase in stress related illness, particularly in the health sector. Management confirmed when interviewed, there is a staff care service in place within the Private Hospital. It is a self referral service that staff can avail of on a confidential basis. Management advised any staff that may be presenting with symptoms of personal or work related stress, and that are a cause for concern, are made aware of the staff care service and are encouraged to avail of the service (Appendix 5.4)

The job of a computerised roster system is to reduce the direct payroll cost of absenteeism, and also to allow Management provide the correct amount of rest time for staff complying with legislation (Organisation of working time act 1997, Pregnant employees regulations 2007) and also complying with the Private Hospitals health and safety polices.

Nurse Managers advised that in the last two years the hospital has provided training in areas like, IT, interview skills, performance Management. Nurse Management highlighted the benefits of the 2009-2010 Management people programme, which was delivered by IBEC. The programme covered areas such as managing stress and conflict in the work place and how good people management can prevent and manage stress at work. As discussed in the literature review, the role of the manager can have a positive as well as a negative impact on how an employee will associate themselves to their job and their attachment to the organisation.

Computerised roster training for Management is provided by IT and is carried out twice yearly. Part of this training covers how to run reports and also the recording of paid, unpaid, certified and uncertified sick leave. The current version of the computerised Nurse roster planner does not have the capability to distinguish the type of absence that has taken place.

Therefore, all reports ran from the roster system will provide hours of absence but not the reasons for absence. The reasons for absence are established through the return to work interview carried out by Management and a copy of this is forwarded to HR.

As part of the changes to the absence policy, line Management and heads of department are cited as being responsible for the accurate monitoring of absence. The absence policy clearly outlines the guidelines of reporting structure and procedure for short-term and long-term absence.

Some Management when interviewed made the point that Nursing would record their hours more meticulously to other departments due to the fact their premium payments (allowances) are paid from the hours recorded on the computerised roster system. In their opinion, this would represent a truer picture of actual attendance, while attendance in other departments may be under recorded.

Management must ensure their staff comply with the notification procedure for reporting sick leave and providing medical certificates and attend Occupational Health for an independent medical assessment when requested (Appendix 8)

19 staff within the Private Hospital have been recorded as being referred this year in compliance to the Private Hospital absence policy. Pregnancy risk assessment is carried out when a manager refers the staff member for assessment to the Occupational Health department.

The policy also includes the requirement for Management to hold 'return to work' interviews with staff for all occurrences of absence. This policy change was made with a view to increasing the awareness, firstly with Management, of the importance of investigating absenteeism at front-line level with Management, and secondly to increase the awareness of absence with the staff members in question.

Interviews revealed prior to 2009, only some of the Management team met with staff, following their return to work from absence, but this was not formalised across the hospital.

In March 2011 an Interview Skills Workshop was held for Management. This was provided by the hospital to ensure a uniformed approach in interviewing staff would be established and maintained. These interview skills are also utilised by Management during 'return to work' interviews.

One of the key features of the policy, is the principle of early intervention in the Management of sickness absence. Prior to the Absence Management Programme being re-launched, and the absence policy being revised, Management were not being proactive in the Management of absence as it was seen as a HR function. Since the review and update of the absence policy, guidelines for Management role and responsibility, are now clearly laid out in the policy.

The senior Nurse Management team are due this year to present a workshop in exploring "Practical ways to improve staff morale".

As mentioned in the literature review, Heywood and Jirjahn (2004) and Heywood et al (2008) studies on the interrelation between teamwork, monitoring and absence, found organisations that depend on team production experience a higher amount of cost of absence. They in turn spend more on monitoring absence and also spend more on the management of absence. Furthermore, organisations with teamwork incur a lower absence rate than those that rely on productive interactions among their employees.

4.23 Occupational Health Department

The Occupational Health Department is currently being used in relation to absence for pregnancy risk assessment and long-term absence.

When interviewed, Occupational Health advised that in many cases there seems to be a tendency by Management and/or HR, to involve Occupational Health in assessing staff after they have been absent for a long period of time. Occupational Health has not been informed of the absence until the staff member has been referred to assess the individual's fitness to return to work. Occupational Health feels this practice can lead to the delay in the individual's return to work. If the individual could be referred sooner, then there might be an increased chance for the individual to return to work earlier.

They also advised that they were unaware of a revised absence policy or a re-launch of the Private Hospitals Absence Management Programme in 2009. They confirmed their input was not invited into the revised absence policy in relation to managing absence for short or long-term absence. The Occupational Health Department feel communication between HR, Management and Occupational Health needs to be addressed and improved.

The Occupational Health Department found that the majority of staff being risk assessed was predominantly female. This can be accounted for by the high ratio of female population in the Private Hospital. In addition Occupational Health hold a pregnancy clinic for any pregnancies that are in need for assessment to determine whether they are under residual risk, in compliance of the Pregnant Employees Regulations 2007, Organisation Of Working Time Act, 1997 and Safety Health Welfare Workers Act, 2005.

With an increase of staff taking maternity leave there is an increase need for Occupational Health and Management to work together to ensure the staff work environment is one that does not exacerbate absenteeism during their pregnancy.

Occupational Health confirmed stress and pregnancy related illness is the two main reasons for absence. Although organisational data highlights absence greater than 5 days for 'various reasons' does not specify stress as one of the reasons for absence. It could be suggested that a percentage of the 54% (1.76% of the 3.25%) of reasons for Nurse absence in May'11 could be attributed to stress.

Fatigue, back strain and nausea are the most common causes for pregnancy related absence. Work conditions; causing fatigue for example rostering a pregnant Nurse on long periods shift work pattern (long day, night duty)

A health professional may suffer from back strain due to not adhering to the Private Hospital's manual handling policy and not calling for enough support to lift a patient (Appendix 5.3). A risk of back strain within the work place for pregnant staff could happen if the staff member in question is unable to avail of breaks to rest from standing.

Factors such as fatigue among pregnant employees may contribute to short-term and long-term absenteeism. Fatigue is ranked quite high during the first trimester and last trimester in pregnancy.

The fact that the Nurse may succumb to fatigue during long periods of standing, and being involved in patient related manual handling would be a factor contributing to increased levels of fatigue and may possibly result in short or even long periods of absenteeism.

Occupational Health when interviewed, felt that following risk assessments being carried out, that there was not the same flexibility from the Private Hospital afforded to staff, e.g. reducing hours for staff that required rest periods or deploying staff to another work area for lighter duties presenting with a pregnancy risk within their work environment.

Within the public hospital the Occupational Health recommendation to move staff in need of rest is accommodated due to the size of the public hospital, in comparison to the private. According to Occupational Health in practice this can result in a delay for the individual to return to work on a phased basis and also impedes their re-orientation to the workplace.

As discussed in the literature review, stress is cited as one of the highest reasons for absence. The withdrawal model suggests that some individuals manage their stress by withdrawing from the work place. Occupational Health plays an essential role in health assessment for health examinations to individuals for lifestyle risk factors, such as stress. Under the Equality Act 2004 and Safety, Health and Welfare at Work Act, 2005, stress is seen as a disability. The organisation is under a duty of care to manage the individual's stress and must provide them with reasonable accommodation.

When an employee is found to be in residual risk of exposure the Occupational Health department is required by law to carry out a risk assessment. They will re-evaluate work practices in order to help avoid others being similarly affected. Risk assessments, such as pregnancy risk assessment, ergonomic risk assessment, shift work risk assessment and chemical risk assessments are the types of risk evaluations that help reduce the risk of injury, which in turn reduces the risk of absence.

During the course of interviewing, Occupational Health outlined strategies that could help Management and the organisation to promote attendance. The Occupational Health department felt it could contribute to sickness

absence management by helping managers manage absence more effectively. This can be achieved through training line managers and supervisors on how to best use the Occupational Health service, when and how to refer staff for assessment, what information is required and what to expect from Occupational Health.

Developing a workable referral system that ensures medical confidentiality is maintained, and that employees under assessment are respected can result in the process being a comfortable and positive experience for the employee.

In the opinion of Occupational Health, this positive experience will help develop and maintain a close working relationship with both employees and Management, helping Occupational Health identify any risk surrounding the work environment and trends in ill health. This would help Occupational Health advise Management in how they may prevent sickness absence.

Another role of Occupational Health is to rehabilitate staff in a safe return to work, following ill health or injury. A rehabilitation programme will devise a risk assessment involving the employee and manager; this will help monitor the progress of the employee. Communication takes place with the employee, Occupational Health Doctor and manager.

Being proactive is essential in being able to apply rehabilitation strategies that can detect early changes in health which will reduce the likelihood of the condition causing absence from work.

Occupational Health advised that by improving the working ability of the employee this would be a positive cost implication to the hospital as well as the employee. Improving health improves attendance and productivity levels. Occupational Health can develop strategies that help employees maintain, and or, restore their work ability.

Vroom (1964) maintains in his expectancy model, that if an individual can visualise or see a reward at the end of the task, they will be motivated to

perform the task assigned. Also through health motivation as already outlined in the health belief model in the literature review, strategies such as health advice, and or, a planned programme of work hardening exercises before health problems arise, can achieve increased levels of attendance. The main health problem that is on the rise for businesses is a psychosocial nature, i.e. that the illness is psychological manifesting physically, emotionally, or cognitive in nature.

4.3 Quantitative Data Analysis and Interpretation

Having received organisational approval to conduct the case study within the Private Hospital, permission was granted to gain access to organisational data. The next step was to source relevant organisational data related to absence. This was required in order to compare and validate opinions gained through interview in how the re-launch of the absence Management system could foster an attendance culture within the Private Hospital.

The quantitative data sourced allowed a trend and longitudinal analysis of the levels of absence, and examine the absence policies and practices prior to the re-launch of the Absence Management Programme and also post re-launch of the Absence Management Programme.

Quantitative research tends to emphasise descriptions and testing of hypotheses and are mostly associated with numbers. Qualitative research data collection and analysis is mostly carried out simultaneously (Robson 2002). To become information the data collected must be interpreted. Having obtained permission to access the organisation's data, the reviewing of secondary data sources contained limited contents.

The period to which the analysis was been examined showed limitations as not every department captured all absences and reasons for absence. This information was pivotal in allowing a more complete analysis on such quantitative data.

The other quantitative data sourced was summary statistics of absence, which was obtained from the HR Department. These figures proved to be more reliable, as HR had manually reviewed all personnel files, and subsequently interviewed the staff directly.

4.31 Descriptive Statistics

The population of females in the Private Hospital is 63% to 37% male. The personnel analysis gender summary report below in table 1 also illustrates the female to male population ratio within the Nursing Department. The female population in Nursing is 89% in comparison to 11% of males within Nursing.

TABLE 1 - PRIVATE HOSPITAL - ANALYSIS BY GENDER REPORT - JULY 2011

	FEMALE	MALE
PRIVATE HOSPITAL GENDER POPULATION SUMMARY TOTAL	1028	611
PERCENTAGE TOTAL	63%	37%
NURSING DEPARTMENT	**FEMALE**	**MALE**
THEATRE SERVICES	102	22
CRITICAL CARE	104	7
CANCER SERVICES	61	2
MEDICAL / SURGICAL	98	4
NURSING GENERAL	124	24
SUMMARY TOTAL	489	59
PERCENTAGE TOTAL	89%	11%

Currently the highest age range in females is between 30 – 39 years which account for 351 of the female population. In comparison to the male population in the same age range is 70.

A marked increase of maternity leave in the last two years would suggest this correlates to the personnel age report as outlined in table 2, showing the highest age range of the female staff is between the age of 30 -39. This populous would be of childbearing age.

Further analysis of the personnel age report, would suggest that the second highest age range in females is aged 40-49.

One would expect to find a high percentage of staff to have children under the age of 6 within this age category.

TABLE 2 -PRIVATE HOSPITAL - ANALYSIS BY AGE REPORT - JULY 2011

AGE	<20	20-29	30-39	40-49	50-59	>60
NO. FEMALES / AVERAGE AGE	15 / 18.97	222 / 26.15	351 / 34.53	238 / 44.88	154 / 54.38	23 / 62.45
NO. MALES / AVERAGE AGE	7 / 19.09	52/ 24.63	70 / 35.19	59 / 43.75	32 / 54.72	4 / 63.73
NO. EMPLOYEES / AVERAGE AGE	22/ 19.01	52 / 24.63	70 / 35.19	297 / 44.66	186 / 54.44	27 / 62.64

SUMMARY

HIGHEST FEMALE AGE RANGE	30 - 39
HIGHEST MALE AGE RANGE	30 - 39
HIGHEST EMPLOYEE AGE RANGE	40 - 49

As discussed in the literature review, Vistnes (1997), Vandeheuvel & Wooden (1995) research on absenteeism and gender revealed a higher rate of absence within the workforce in women with children under the age of 6. In an older workforce absence rates between women and men were similar.

Since 2008 there has been a steady increase in maternity leave, which has shown a fluctuation in pregnancy related illness, resulting in absence amongst staff and in particular nursing staff.

The weekly average levels of maternity leave (paid and unpaid) in nursing in 2008 was 14 whole time equivalents (WTE), in 2009 was 24 WTE and in 2010 was also 24 WTE.

The absence weekly rates in nursing for 2008 were on an average of 14 WTE (1.85%) with an average weekly population of 326 WTE.

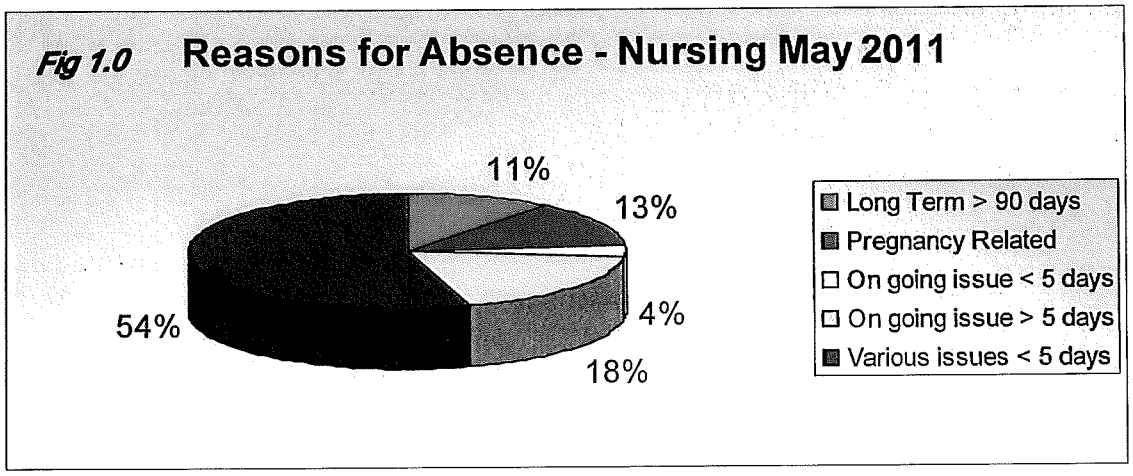
The absence weekly rates in 2009 were 12 WTE (1.37%), with an average weekly population of 324 WTE.

The absence weekly rates in 2010 were 10 WTE (1.07%) with an average weekly population of 309 WTE.

It is important to highlight that the nursing absence rates discussed above are overall absence and not just pregnancy related absence.

The current method of recording absence does not allow a breakdown of types of absenteeism and is therefore unable to analyse. Statistics relating to pregnancy illness that is available is analysed by HR from the return to work interviews.

As illustrated in fig 1.0, in May 2011 pregnancy related absence for nursing was at 13%, which is 4th in the ranking of reasons for absence. The highest at 54% is 'variours reasons', over 5 days.



These percentages when analysed against the nursing absence rate of 3.25% for May 2011, translate into pregnancy related absence being 0.42% of the nursing absence rate and 1.76% for 'various reasons' greater than 5 days of absence. This analysis would conclude long-term absence to be the current concern for nursing absence.

(Kaerlev Linda et al 2004) study concluded long-term sick leave during pregnancy was frequent and could be predicted. The findings from the study confirmed the association of the higher level of sick leave with the need for a change in how work tasks could be changed for pregnant staff that optimised their health and wellbeing.

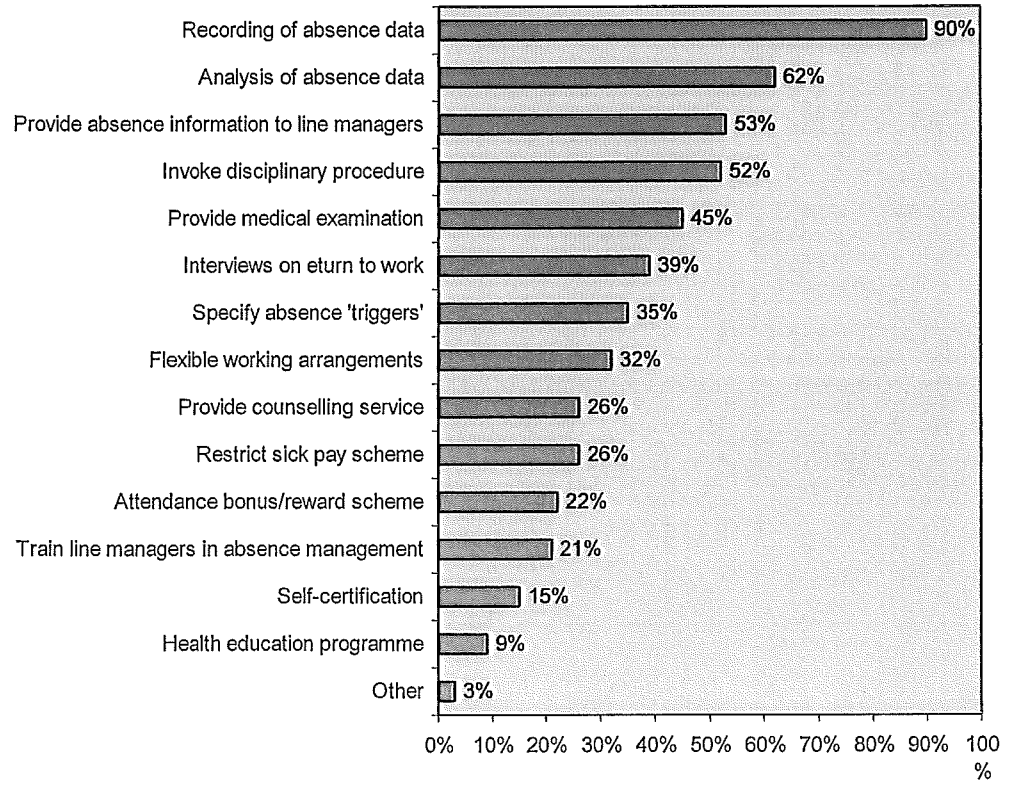
31% of employees who had been pregnant during their employment reported to be on sick leave for at least 10% of their scheduled work time during their latest pregnancy. The study also recorded 22% of the employees had been absent at least 20% of the time. These pregnant employees had an average sickness absence of 6.1 days per month. In comparison to their non-pregnant colleagues, they reported having 0.95 days sick days per month.

As indicated in the IBEC 2004 survey, one of the ways an organisation can realise an increase in attendance is for Management to have a system of absence triggers. Examples of such triggers for Management to take action would be if an employee had more than three incidents of absence within a 12 month period, also if three occurrences in six months or if the employee was absent more than 10% of the time within a 10 month rolling period.

The survey also investigated what measures organisations have in place to manage short-term absence. As illustrated below in fig 1.1, the main measures used are the recording of absence data ranked at 90%, followed at 62% by analysis of absence data. 53% of organisations provide absence information to line managers and 52% invoke disciplinary procedure.

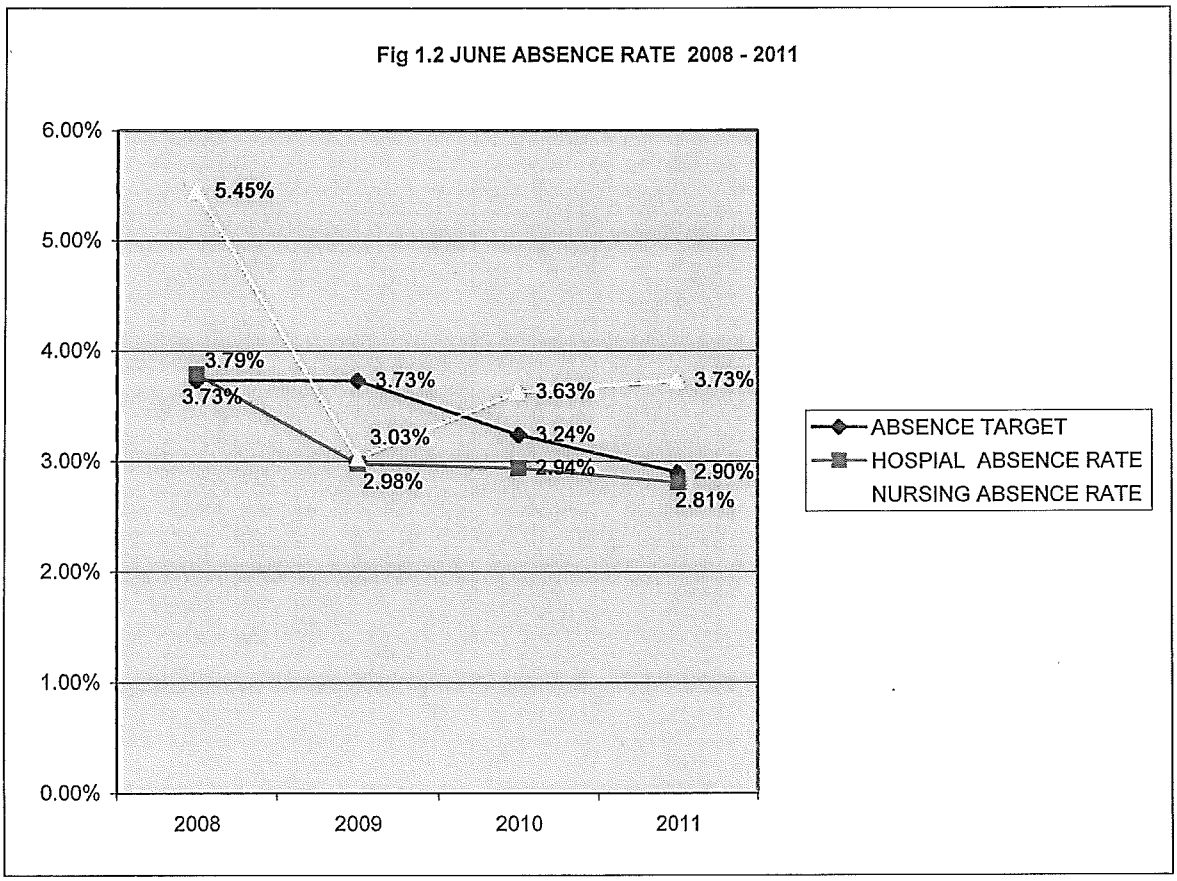
Recurring short-absence mostly may point to withdrawal from the workplace due to dissatisfaction or detachment from the organisation. In order for the organisation to hold onto staff that are worth holding onto, they need to expand the measures as outlined above. Using measures, like return to work interviews, which 39% of organisations surveyed have in place. To specify absence 'triggers' gives a clear guideline for Management to take action before a pattern of withdrawal from the employee is in effect. 35% of Organisations surveyed use this measure.

Fig 1.1 Measures used for managing short-term absence

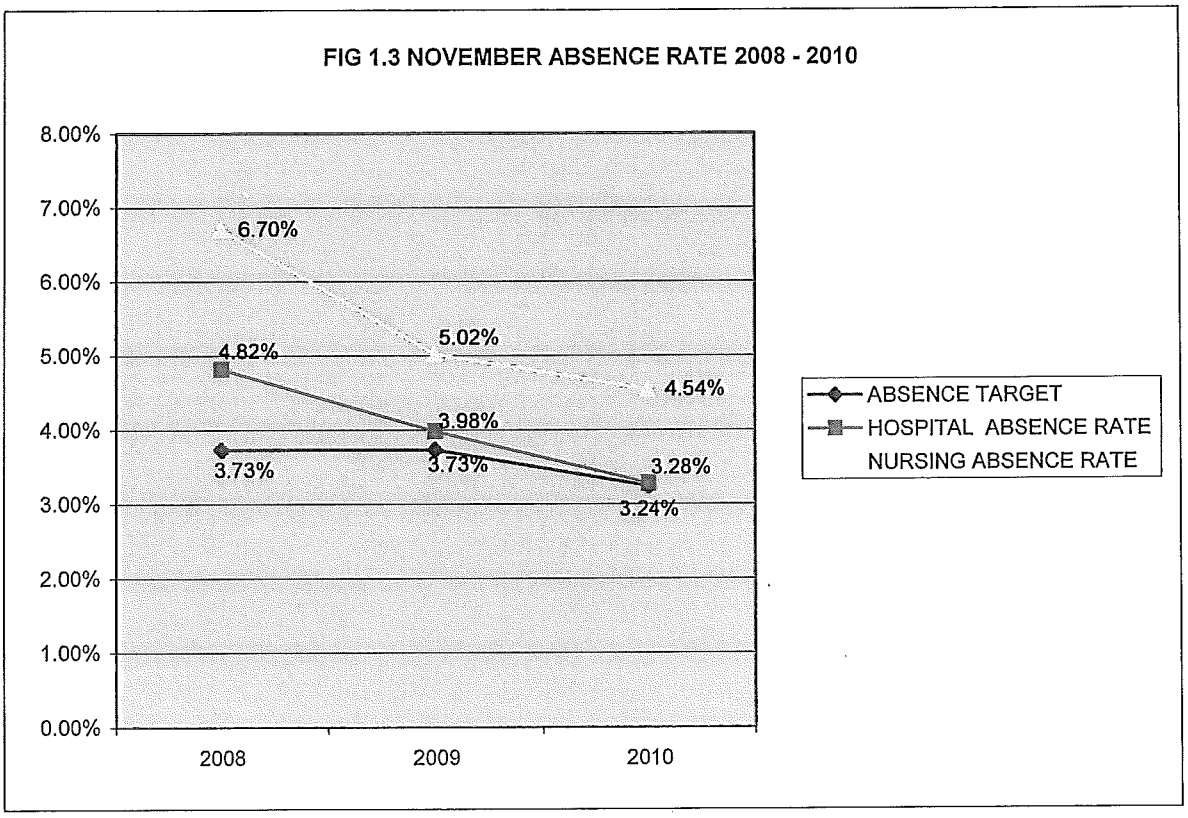


'Return to work interviews' have been carried out on a formulised basis throughout the Private Hospital. The impact of these interviews as illustrated in fig 1.2 shows an overall improvement in absence over a three year period. Prior to 2009 the absence rate was 4.7% and the absence rate for June 2011 was 2.81%.

The data of fig 1.2 also shows that in June 2009 the hospital absence rate was 2.98 %, while nursing was 3.03%, the absence rate in the hospital continued to reduce in June 2010 to 2.94%, in comparison to the Nursing department rising to 3.63%, and again in 2011 to 3.73%. The hospital overall absence rate for June 2011 was 2.81%.



The data of fig 1.3 also shows that in November 2008 the hospital absence rate was 4.82%, following the launch of return to work interviews rates of absence reduced. In November 2009 the absence rate was 3.98% and reduced again in 2010 to 3.28%. There was also a significant reduction in the Nursing department absence rate. In November 2008 the absence rate for Nursing was 6.7%. By November 2009 the absence rate in Nursing had fallen to 5.45%, steadily reducing in 2010 to 4.54%.



Analysing both June and November, there appears to be a correlation of absence rate increasing in the winter time (Fig 1.2 and 1.3).

This could correspond to, for example, an increased illness rate during the winter months and a higher rate of working hours in comparison to summer months. June being a summer month, a higher rate of annual leave could be expected.

In June 2009, a survey carried out in the UK by Harris Interactive revealed that most companies deal with absence after the event.

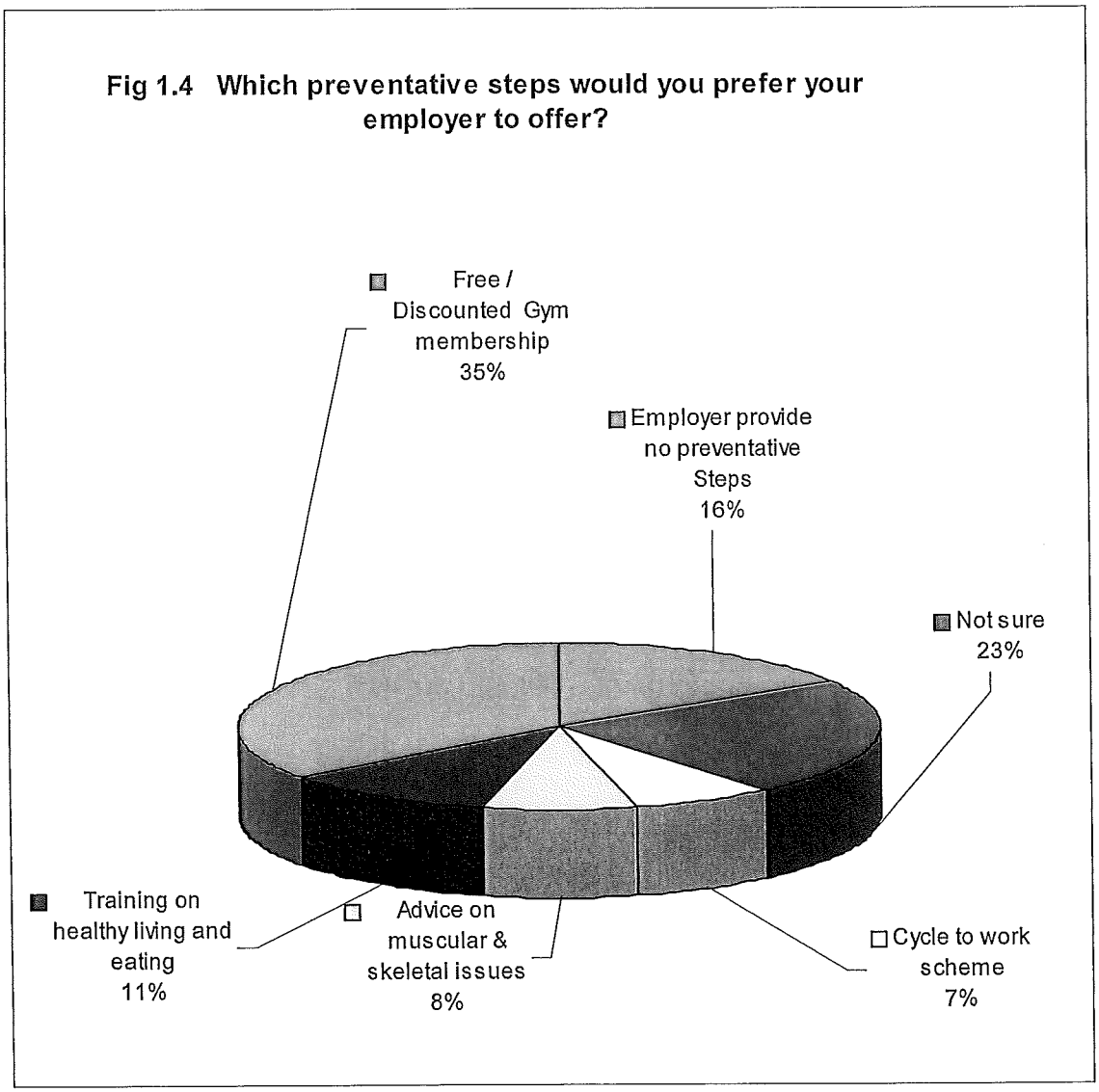
59% of employees felt policies related to absence were introduced after the event, despite 70% of employees revealing their companies had an absence Management system in place.

20% of the 1,403 sample confirmed their employer had implemented well being policies, which concentrated on the prevention of absence.

16% of employees surveyed were against their employer introducing preventative absence initiatives. 35% of respondents were interested and willing to take part in free/discounted gym membership and 11% agreed that they would welcome advice on healthy eating.

As shown in fig 1.4, interactive survey illustrates that there is a real need for Management to monitor the occurrence of absence and take preventative measures to reduce reoccurrence of absence.

Fig 1.4 Which preventative steps would you prefer your employer to offer?



4.4 Discussion of findings

Strategies such as wellbeing programmes, health checks and staff services have helped other organisations such as Temple Street Children's Hospital, Dublin (Mona Baker 2007) and Kent Police force in the UK, in promoting an attendance culture ('Occupational Health' 2007).

Their approach has been to engage staff using communication, team events and focus groups, investing into employee's wellbeing, which is seen as fundamental in engaging staff.

Temple Street Children's Hospital in 2004 introduced a 'wellbeing programme', promoting health to staff and wellbeing at work. The programme was based on the four pillars of health and wellbeing; diet, exercise, spirituality and emotional health. Being aware of the barriers for staff, and in turn taking action on their feedback, resulted in increased staff satisfaction.

As highlighted in the literature review, it is recognised that managers have a direct impact on key issues for staff performance, morale and retention. According to Mona Baker, HR Manager of Temple Street Children's Hospital, the success of these initiatives is gaining the support from top Management. 'The idea of the programme is to promote work life balance at work'. Thus ensuring staff to be "emotionally present", capable of working to the highest standard at all times (Mona Baker 2007)

Kent Police force in the UK in 2003, put in place an attendance Management programme and also used a tool called 'Asset', helping line managers identify triggers for stress and absenteeism, which achieved a collective saving of 18,600 lost days from its 6,200 staff.

Part of the attendance programme was to improve training for line managers and to also roll out health initiatives for staff such as health 'MOTs' and master classes, to advise on diet and fitness. As a result of these wellbeing initiatives, the Kent Police force reduced their absenteeism by 25%. ('Occupational Health' 2007)

Since the re-launch of the Absence Management Programme the Private Hospital has communicated to staff that its sick pay scheme is linked to all illness, including pregnancy related illness. In HR's opinion there was a perception in the Private Hospital, that being off sick throughout pregnancy would not affect their sick leave entitlement. This may be due to the fact, since 2008 the Health Service Executive put into effect a European Court of Justice ruling (case C-191/03) and Labour Court determination (LCR061) any member of staff exhausts their sick leave entitlement while experiencing a pregnancy related illness, they will continue to receive sick pay at half pay, less any social welfare benefit (Appendix 9).

As part of the hospital's revised absence policy it is now routine for the Occupational Health Department to carry out risk assessments for staff, in particular, pregnancy risk assessment. The absence policy has been updated and revised improving understanding and awareness of attendance for all staff returning from absence.

HR has planned review meetings with Management in order to support the ongoing monitoring of absence and to ensure that the momentum and focus on attendance is maintained. Cost saving is a high priority for any organisation and buy in from all staff is necessary to achieve this aim.

As discussed in the literature review, the monitoring of absenteeism, ensuring an accurate measuring system is in place to establish reasons for absenteeism such as sick leave, maternity leave etc, with regular reporting, can be an effective approach to the Management of absence.

The greater an organisation monitors absence a significant reduction of absence will be realized (Heywood et al 2008).

It is accepted that there is a deeper reason for an employee's general absenteeism. Some absences are suspected to be attributed to the secure health benefits offered by the Private Hospital, others have yet to be examined and assessed. Henrekson and Persson (2004) in Sweden examined the level of sick leave compensation affects sick leave behaviour using series data (1955--99). With several changes to the compensation level, the overall findings were that the more generous the health benefits for sick leave, the increase in sick leave, and vice versa.

In an effort to reduce costs in absence and improve levels of attendance, a change in the absence policy was made by the Private Hospital. From 2009 all new employees commencing employment must have one year's continuous satisfactory service before they benefit under the sick pay scheme (certified & uncertified sick leave).

In order for the HR department to achieve and maintain its absence target, they realise the asking 'why absence is occurring' needs to be addressed. With commitment from Management to monitor and uncover patterns that in the past were going unnoticed, may help to improve the overall working environment for staff and increase attendance, productivity and ultimately standard of service.

The training of Management has achieved a more proactive approach to the monitoring of absence and also has improved the consistency of accuracy in the recording of absence on the computerised roster system. Training such as this, allows managers to approach absence with staff, on a uniformed basis throughout the hospital.

Although the Occupational Health Department is now being utilised by Management to refer staff for risk assessments, there is still a need to encourage a more holistic and strategic approach to attendance.

Occupational Health would then be in a position to promote personal health motivation, encouraging staff to take more responsibility for their own health. They are also keen to educate Management as what occupational role is in relation to absence Management and how they can and when they should refer staff for assessment, in addition to them monitoring attendance to be more proactive in intervening in long term absence.

With continued concerns of absence rates, future plans are to continue the measures that have been put in place in order to reduce absence and encourage attendance.

HR continues to provide guidance on the monitoring of attendance and the importance of accurately recording absence. Training for Management continues in an effort to further educate and reinforce the importance to Management of their responsibility in the Management of absence.

The HR project lead is to conduct a review of attendance statistics on a quarterly basis with Management, and on a monthly basis with department heads, to ensure that the Private Hospital does not allow other issues to overshadow the priority attendance required when agreeing future business strategies.

4.5 Summary

The findings from the case study revealed the steps that HR and Nurse Management put in place since the re-launch of the Absence Management Programme have made a significant difference to the attendance culture of the Private Hospital.

The steps put in place such as, increasing awareness to staff of their absence, introducing the GAS club as a measure to encourage self health motivation and providing training for Management to support them in people Management and the Management of absence. Within Nursing there has been a drop in absence from 6.7% in 2008 to 3.73% in June

2011. The overall hospital absence rate was 4.7% and it is now 2.81%, which is under the national average of absence.

Although Occupational Health was not linked into the re-launch of the Absence Management Programme, their Management of health and reorientation for staff that are referred by Management, has also made a difference in the attendance of staff. With improved levels of communication from all sides, HR, Management and Occupational Health, could work together to realise further increases in the levels of attendance.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS OF RESEARCH

5.1 Introduction

The conclusion that this study has reached, from the theories and models of absence that were examined, is that without an effective Absence Management Programme, an organisation will be unable to achieve an attendance culture.

As discussed in the literature review, absence is multifaceted, and there are more reasons than just illness to account for absence.

Theories that have been discussed throughout the literature review accounted reasons for absence, such as the individual's emotional state (Huczynski & Fitzpatick 1989), (Rhodes & Steers 1990).
It emerged within the literature review that stress is a cause of absence within organisations, in particular the health sector. Individual's motivation and desire to perform, and their attachment and commitment to the organisation, was also examined on how these contribute to absence (Hill & Trist 1953, 1955), (Thompson et al 2005).

The individual's health motivation was discussed (Rosenstock & Strecher 1997), (Bandura 1977). Their responsibility to home versus work life was shown to be also a factor for an organisation to consider when promoting attendance (Bolton & Hughes 2001).

The theory of gender revealed that it is a factor in absence and that women who have young children are more likely to have a higher rate of absence compared to their male colleagues (Vistnes 1997), (Vandeheuvel & Wooden 1995)

The findings within the case study supported the notion that female absence is higher than males. In the instance of the case study, there was more absence in females than males due to the fact that within the Private Hospital the staff population of females is greater than that of the male population.

The research also found that the highest age profile for women working in the Private Hospital were of child bearing age, which was supported by data on maternity leave, being taken in the last three years (Table 1 & 2). This correlated with data collected from the HR department identifying reasons for absence in May 2011 (Fig 1.0).

The study examined some elements within an Absence Management Programme; the managers' roles, monitoring absence, Occupational Health role and an organisation's legal duty to health and safety. The paper examined what impact these had in fostering an attendance culture. Management's role and their Management style were explored within the literature review, revealing that the manager has a lot of influence on how an employee views their relationship with their job, and also their attachment to the organisation (Fox 1968). This was supported within the case study when HR collaborated with Management conducting absence review meetings and also provided Management coaching sessions in absence Management, one of the sessions being 'how to conduct a return to work interview'. Following return to work interviews being held, the absence rate within the Private Hospital, initially being 4.7%, reduced to 3.98% in 2009 and continued to fall to 2.81% in June 2011.

Supporting the premise that if Management takes corrective action in an effective intervention of absence control, for example, conduct return to work interviews, and accurately monitor and report absence, this will result in higher rates of attendance in staff.

These measures of managing absence were aimed at increasing the individual's motivation to attend, as opposed to targeting those who do not have the ability to attend. As the Private Hospital acknowledges in its absence policy, illness can occur for legitimate reasons. Its aim is to keep those levels, and frequency of absences, to a minimum (Appendix 3.1).

Accurately monitoring and recording absence was discussed throughout this study. The findings within the literature review conclude that if an organisation is not monitoring and recording absence, they will underestimate the cost of absence to the business and also will foster an absence culture. The case study also revealed that through training, monitoring and accurately recording absence, then increased attendance rates could be achieved. Absence data collected is now being used to strategise how to improve absence rates, as the organisation is now confident in its Management absence reports. The manager also can introduce early intervention measures through analysis of absence data they now record.

The other element of an Absence Management Programme, that was examined, was how the role of Occupational Health could foster an attendance culture. Within the literature review, it examined the responsibilities an Occupational Health Department has in promoting a safe and healthy working environment for all levels of staff in its organisation.

Its ethos is to identify any risks that would affect an employee within their work environment that could cause them or their colleague's injury or ill health. This is not just good practice, but also a legal requirement.

In addition to Occupational Health having legal obligations in relation to health and safety, all organisations operating in Ireland have also a legal duty to the health and safety of its staff, and also for themselves (Employment Law News 2011). The literature review examined this, and discussed what bearing health and safety legislation had on an attendance culture. Rest periods for staff to recover, health and safety equipment and for the business to provide a healthy and safe environment to work in for itself and for its staff, were discussed.

The literature found that organisations that do not adhere to health and safety legislation could not only put their staff in jeopardy, but also their business at risk. Not adhering to health and safety legislation has in the past caused occupational injury, resulting in absence or worse fatality (Health & Safety Authority 2009). Practice such as this, has put an organisation's business reputation at risk, resulting in fines from the government and bad press, which would result in the loss of business. The case study found that Management is adhering to health and safety legislation by utilising the computerised roster system to ensure adequate rest and breaks have been rostered, in order to manage absence levels.

Occupational Health departments' practice of risk assessment of staff in relation to risk of injury within their work environment, and/or assessments of an individual's persistent absence, found that these had an impact in the rate of attendance.

Findings of the re-orientation of the individual that had experienced long-term absence could be improved through a more collaborative communicative approach with Management, HR and Occupational Health, which may have a further impact on attendance.

The case study found, following the re-launch of the Absence Management Programme in 2009, that the first step to tackle the 4.7% absence rate was to revise the absence policy. Within the revised absence policy, clear procedures and guidelines were outlined for Management, on how they needed to manage long and short-term absence. Training was provided by HR as a measure to support Management in this aim, which resulted in an overall reduction in absence for the Private Hospital to a rate in June 2011 of 2.81%.

5.2 Aims and Methodology

The purpose of this study was to examine how an Absence Management Programme can foster an attendance culture.

As outlined in the methodology, the decision was made to use a qualitative approach using a case study strategy.

Interviews were used to collect data, and the opinions and beliefs of HR, Occupational Health and Nurse Management in relation to how in their opinion could an Absence Management Programme foster an attendance culture. The responses from these interviews were then analysed and discussed within the case study.

The quantitative data sourced and analysed was used to triangulate findings of the qualitative data gained through interviews (Robson 2002).

5.3 Organisations' Implications of their Absence Management Programme fostering an attendance culture.

The study would suggest that the main implication for the organisation is cost of absence, which can be saved if successful in fostering an attendance culture.

The Private Hospital has realised savings in already reducing its absence rate from 4.7% to 2.81% in two years, which equates to an overall reduction of 1.89%. As highlighted in the literature review, according to an IBEC absence survey carried out in 2004, 'For every 1% drop in absence rates, the company can make a saving of €250,000 on sick pay and overtime alone.'

In order to realise continued success, the Absence Management Programme needs continued resources. The findings suggest that until an attendance culture is inherent in the Private Hospital, the need for the HR project lead to co-ordinate the entire process is required. Training also needs to continue, such as refresher coaching sessions for Management to focus on the importance of managing attendance. The support provided by HR to Management through training and absence review meetings had a direct impact on the absence rate of the Private Hospital.

The findings of data for wellbeing initiatives would suggest that resources such as the GAS Club could develop further into a stronger brand in an attendance culture, in order to signify to staff the organisation's commitment to their well-being.

There is a risk that once a certain target of absence is reached then the focus will shift to another business strategy. To sustain and maintain an attendance culture, there must be continuous momentum from the organisation to allow Management, HR and Occupational Health work towards new levels of higher attendance.

The culture of an organisation according to Charles Handy (1985) is a set of values, which shapes attitudes and influences behaviour. The organisation's culture can have an influence on whether it has an absence or attendance culture, through expectation of attendance, as discussed in the literature review of expectancy theory, social exchange theory and health belief model.

The determination of an organisation in fostering an attendance culture will depend on whether they have measures of encouragement, support and expectation for high levels of attendance. Without these expectations being accurately communicated to staff, an absence culture can easily be cultivated within an organisation.

An Absence Management Programme must have more than one approach and element to it, in order to create a positive shift towards an attendance culture within an organisation.

5.4. Research Question

The case study was held within a Private Hospital, the researcher's place of work. It was felt that there would be fewer constraints to gain access and permission to carry out the case study within the researcher's place of work.

An Absence Management Programme can foster an attendance culture, as evidence shows in the case study, when a higher level of responsibility was adopted in recording and monitoring absence. This resulted in the reduction of absence levels.

As the quantitative data showed, following the re-launch of the Absence Management Programme within the Private Hospital, return to work interviews were put in place, the absence rate had reduced in November 2009 to 3.98% from 4.7%.

By June 2011 the absence rate had reduced to 2.81%. This result signifies the work and co-operation between Management and HR. The findings discussed in the case study would suggest that improved communication between Management, HR and Occupational Health might help increase attendance rates further. This supports the theories that formal and informal policies, such as Management intervention of absence, can have a bearing on the way an organisation operates.

A review of how the Private Hospital could implement Occupational Health's recommendations to provide lighter duties for staff when required, could have the potential to increase attendance within this group of staff. Research revealed Occupational Health is willing to provide support and training where necessary to achieve this aim.

As pointed out in the literature review, the greater monitoring an organisation carries out, in particular firms with team production, then there will be more significant reduced rates of absence (Heywood et al 2008)

5.5 Further Research

Further research in attendance and absence culture in a more comprehensive way, would be required to assess how an Absence Management Programme can foster an attendance culture.

As highlighted in the methodology there was limitations to this research, as the sample of participants were concentrated on one particular group. In order to get a broader sense of the culture within the organisation, a wider sample of all groups would be required.

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APPENDIX

1

Interview Management Questions

1. Does your organisation have any specific policy against absenteeism?
2. When are employees made aware of the absence policy?
    a. Recruitment
    b. Induction
    c. When they are absent from work
    d. Return to work interview
3. Are there any specific measures taken to discourage absenteeism within the organization? If yes, What are they?
4. Does the organization have a target absence rate? What is it?
5. Have you estimated the direct cost of pregnancy related illness resulting in absence to the organization? If yes, what is the cost?
6. Have you estimated the indirect cost of pregnancy related illness resulting in absence to the organization? If yes, what is the cost?
7. Who is primarily responsible for dealing with employees' absence?
    a. Supervisor
    b. HR
    c. Salaries
    d. Occ Health
8. How is absence recorded within the organization?
9. Does the organization provide any specific training in absence control procedures? If yes, who receives training?
10. Are absentees interviewed upon their return to work? If yes, who conducts the interviews?

11. What value does 'return to work interviews' bring to the organization?

12. Does the organisation provide a counseling service for employees who have an absence related problem?

13. Has this service helped reduce absenteeism?

14. Has the organization ever dismissed an employee due to absenteeism?

15. Is absenteeism defined within the workplace of the organization? If yes, how is this definition defined and communicated within the workplace?

16. Do you consider absence in your organization to be;

    a. A serious problem
    b. Unsatisfactory
    c. Not a real cause for concern
    d. Satisfactory
    e. Do not know

Occ Health

1. What is the most frequent reason given for pregnancy related illness by employees?

2. What are the next three most frequent?

3. Do you provide any form of health screening for pregnant employees?

4. Largely, Is there a particular stage of an employees' pregnancy that long term levels of absenteeism take place?

5. Largely, Is there a particular stage of an employees' pregnancy that short term levels of absenteeism take place?

6. In your opinion, what are the effects of absenteeism on the individual and also on the organization?

APPENDIX

2

Interview Questions

HR Management

1. Does your organisation have any specific policy against absenteeism?

2. When are employees made aware of the absence policy?
    a. Recruitment
    b. Induction
    c. When they are absent from work
    d. Return to work interview

3. Are there any specific measures taken to discourage absenteeism within the organization? If yes, What are they?

4. Does the organization have a target absence rate? What is it?

5. Have you estimated the direct cost of pregnancy related illness resulting in absence to the organization? If yes, what is the cost?

6. Have you estimated the indirect cost of pregnancy related illness resulting in absence to the organization? If yes, what is the cost?

7. Who is primarily responsible for dealing with employees' absence?
    a. Supervisor
    b. HR
    c. Salaries
    d. Occ Health

8. How is absence recorded within the organization?
9. What training has the hospital provided, if any, to support management in increasing attendance?

10. Does the organization provide any specific training in absence control procedures? If yes, who receives training?

11. Are absentees interviewed upon their return to work? If yes, who conducts the interviews?

12. What value does 'return to work interviews' bring to the organization?

13. Does the organisation provide a counselling service for employees who have an absence related problem?

14. Has this service helped reduce absenteeism?

15. Has the organization ever dismissed an employee due to absenteeism?

16. Is absenteeism defined within the workplace of the organization? If yes, how is this definition defined and communicated within the workplace?

17. Do you consider absence in your organization to be;
    a. A serious problem
    b. Unsatisfactory
    c. Not a real cause for concern
    d. Satisfactory
    e. Do not know

18. Do you think absenteeism was always a problem or just in recent times?

19. Can you describe how the organisation traditionally handled absenteeism?

20. Were Medical Certs required?

21. If medical certs were not received, were employees still paid?

22. When the manager speaks to the employee regarding their absence, are they required to ask the nature of the illness?

23. Why do you think absence is an issue?

24. Do you think the business did anything to make it worse?

25. Do you think the organisation lost any business because of absence?

26. Following the re-launch of the absence management programme, how would you describe the absence process now?

27. Are employees still being paid regardless if they do not submit medical certs?

28. What difference has the re-launch absence policy in 2009 made, if any to staff and the hospital?

29. Do you think absenteeism is still a problem for the hospital?

Nurse Management Interview Questions

1. Does the hospital have any specific policy against absenteeism?

2. When are employees made aware of the absence policy?
    a. Recruitment
    b. Induction
    c. When they are absent from work
    d. Return to work interview

3. Are there any specific measures taken to discourage absenteeism within the organization? If yes, What are they?

4. Does the organization have a target absence rate? What is it?

5. Do you know the estimated direct and indirect cost of pregnancy related illness resulting in absence to the hospital? If yes, what is the cost?

6. Do you know the estimated direct and indirect cost of general illness resulting in absence to the hospital? If yes, what is the cost?

7. Who is primarily responsible for dealing with employees' absence?
    a. Supervisor
    b. HR
    c. Salaries
    d. Occ Health

8. How is absence recorded within the hospital?

9. What training has the hospital provided, if any, to support management in increasing attendance?

10. Did you avail of this training?

11. If yes, what benefits did it have in the management of increasing attendance?

12. If No, why did you not avail of the training?

13. Are absentees interviewed upon their return to work? If yes, who conducts the interviews?

14. What value does 'return to work interviews' bring to the hospital?

15. Does the hospital provide a counselling service for employees who have an absence related problem?

16. In your opinion, has this service helped reduce absenteeism?

17. Is absenteeism defined within the workplace of the organization? If yes, how is this definition defined and communicated within the workplace?

18. Do you consider absence in the hospital to be;

a. A serious problem
b. Unsatisfactory
c. Not a real cause for concern
d. Satisfactory
e. Do not know

19. Do you think absenteeism was always a problem or just in recent times?

20. Can you describe how the hospital traditionally handled absenteeism?

21. Were Medical Certs required?

22. If medical certs were not received, were employees still paid?

23. When the manager speaks to the employee regarding their absence, are they required to ask the nature of the illness?

24. Why do you think absence is an issue?

25. Do you think the hospital did anything to make it worse?

26. Do you think the hospital lost any business because of absence?

27. Following the re-launch of the absence management programme in 2009, how would you describe the absence process now?

28. Are employees still being paid regardless if they do not submit medical certs?

29. What difference has the re-launch absence policy in 2009 made, if any to staff and the hospital?

30. Do you think absenteeism is still a problem for the hospital?

Occ Health

1. Who is primarily responsible for dealing with employees' absence?
    a. Supervisor
    b. HR
    c. Salaries
    d. Occ Health

2. Are there any specific measures taken by Occupational Health to discourage absenteeism within the private hospital? If yes, what are they?

3. How are staff referred to Occupational Health?

4. What level of contact does Occupational Health have with line management, in relation to staff under assessment?

5. What measures does Occupational Health have in place to consult supervisors and senior management to help them with prevention action regarding absenteeism?

6. Are absentees interviewed upon their return to work? If yes, who conducts the interviews?

7. What value does 'return to work interviews' bring to the hospital?

8. Does the organisation provide a counselling service for employees who have an absence related problem?

9. Has this service helped reduce absenteeism?

10. Do you consider absence in your organization to be;
    a. A serious problem
    b. Unsatisfactory
    c. Not a real cause for concern
    d. Satisfactory
    e. Do not know

11. What is the most frequent reason given for illness by staff?

12. What are the next three most frequent?

13. Do you provide any form of health screening for pregnant employees?

14. What is the most frequent reason given for pregnancy related illness by employees?

15. Largely, Is there a particular stage of an employees' pregnancy that short term and long term levels of absenteeism take place?

16. Largely, Is there a particular stage of an employees' career that short term levels and long term levels of absenteeism take place?

17. In your opinion, what are the effects of absenteeism on the individual and also on the hospital?

APPENDIX

3

Date

Re: Participation in Interviews for dissertation research

Dear Manager

I would like to invite you to participate in an interview for my dissertation research.

The topic of research is to examine how an absence management programme can foster an attendance culture.

I am conducting a case study within the private hospital and would welcome your opinions and insights into the research topic.

Please note your participation in this interview is voluntary and any information provided will remain anonymous.

Should you wish to withdraw from the case study at any time, this will be respected and any data collected from interview, will not be used.

Yours faithfully

Eileen Courtney

APPENDIX

4

Date

Director

Private Hospital

Dear Name

RE: Seeking permission to carry out a case study within the hospital

I have undertaken to study towards a BA (hons) in Human Resource Management. As part of my course, I have a dissertation to write. The topic I have chosen is to examine how an absence management programme can foster an attendance culture within an organisation.

I wish to apply for permission to carry out a case study within the hospital as part of my research for my dissertation.

All primary data sourced will be gathered through interviewing members of Nurse Management, HR and Occupational Health. All participants will be invited to take part of these interviews on a voluntary and on an anonymous basis.

I wish also to request permission to gain access to organisational data relating to absence statistics and permission to use the hospitals computerised roster system to analyse data from its database for my study.

Should you have any queries regarding the above, please feel free to contact me.

I trust you will look favourably on my application and I look forward to your decision in due course.

Yours faithfully

Eileen Courtney

APPENDIX

5

APPENDIX

5.1

PRIVATE HOSPITAL – HUMAN RESOURCES

Owner / Date:, Director of Human Resources, 18/05/2009

Document No.: POL-HRM-006

Reviewed by / Date: HR

Administrator, 18/05/2009

Date of issue: 18/05/2009

Authorised by: Quality Dept., 18/05/2009 Edition No.: 005

(Review Date: 18/05/2012)

THE ABOVE IS FOR COMPLETION BY THE QUALITY DEPARTMENT

POLICY AND PROCEDURE FOR MONITORING ANDMANAGING ABSENCE AT WORK

1.0 POLICY STATEMENT

1.1 The Hospital considers the contribution of its staff to be of paramount importance in delivering excellent service to its patients. Attendance at work is a primary requirement, as high absence rates reduce the resources available to the Hospital and place colleagues under undue pressure.

1.2 The Hospital recognises and accepts its responsibility to employees to ensure a safe working environment and conditions of employment that are conducive to good health and well being. The Hospital acknowledges that absence due to illness can occur for legitimate reasons and in such instances, where possible, every practical support will be provided. However, the aim is to keep the level and frequency of absences to a minimum by adopting good management practices.

2.0 AIM OF POLICY

2.1 This policy is designed to promote good practice and to provide a framework for effective management of sickness absence. One of the key features of this policy is the principle of early intervention i.e. if there can be early and successful addressing of issues affecting individuals which may otherwise lead to them having problems with their attendance.

2.2 The aim of this Policy is to ensure a fair, consistent, and proactive approach in the management of sickness absence. The Hospital expects and encourages a high rate of attendance from its employees and the policy aims to:

- Minimise absence levels across the hospital, while also providing reasonable support to those absent for legitimate reasons, with the aim of assisting their return to work at the earliest opportunity.
- Provide appropriate support to members of staff suffering ill health. Identify members of staff who may require support in order to undertake their duties, and identify any changes which may be necessary to their working environment or practices.
- To provide practical guidance for line managers in promoting a positive culture of attendance in the work place and in dealing with absenteeism.
- Protect confidentiality of the employee.
- Ensure the hospital complies with all relevant legislation.

3.0 SCOPE OF POLICY

3.1 Absence through illness is the central focus of this policy and in

particular short term, frequent absence.

3.2 This policy will not apply to employee's with a terminal illness.

3.3 Any new employee who commences employment from 1 January 2009 will have to have one years continuous, satisfactory service with the hospital before they are entitled to benefit under the sick pay scheme.

This applies to both certified and uncertified sick leave. However, all employees must comply with the notification procedure for reporting sick leave and providing medical certificates.

3.4 All categories of employees are covered by this policy.

3.5 Payment of sick pay is at the discretion of the hospital.

4.0 DEFINITIONS

4.1 Unscheduled absence can be:

- Certified and uncertified sick leave.
- Absence due to occupational injury.
- Any other unscheduled and unauthorised/unexplained absence.

5.0 RESPONSIBILITIES

5.1 Responsibilities of Employees:

Employees must comply with Departmental procedures for:

- Attendance at work
- Informing Dept Head/Manager of absence
- Submission of medical certificates
- Application for and submission of Social Welfare Monies

(See Appendix 1)

- Attendance at Occupational Health/independent medical

assessment when requested (Appendix 2).

5.2 Responsibilities of Department Head/Ward Manager

- Ensure employees are familiar with this policy and departmental procedure for reporting absence as part of their first day induction
- Promote high levels of attendance and advise employees when their attendance record is a cause for concern and to advise of necessary improvements.
- Interviewing all employees on their return-to-work following illness – (see Appendix 3)

• Assessing the validity of explanations for absences and recommending appropriate follow-up action as required.

• Ensuring employees comply with procedure for obtaining Social Welfare during sick leave.

• Monitoring the overtime of employees who recently had unscheduled absences. Overtime should not be allowed to become a substitute for earnings lost through unscheduled absence.

• Advising employees of the availability of the Staff Care Programme if appropriate.

• Recording of all absences on Core Attendance/Rostering system.

5.3 Responsibilities of Human Resources (Nursing and Non-Nursing):

• Provide Department Heads/Managers with statistical information on a monthly basis.

• Assist Dept Heads/Managers with advice and support in managing absenteeism.

• Liaise as required with Occupational Health Department re: unscheduled absence due to medical reasons.

• Ensure Occupational Health is provided with all relevant information on referrals (including employment medical screening assessments).

• Advise staff of availability of the Staff Care Programme if appropriate.

• Advise staff of Social Welfare procedure during sick leave (Appendix 1).

• Monitoring and reviewing the implementation of this policy.

5.4 Role of the Occupational Health Department

• To provide an independent, confidential advisory service to both the employer and employee. At the request of the Hospital will be responsible for:

□ Evaluation of staff with recurrent unscheduled absences.

□ Evaluation of staff returning after long-term illness or other circumstances to ensure fitness.

□ Liaising with GPs as required.

□ Providing advice, recommendations and written assessments to HR and Department Heads on staff who are referred to Occupational Health.

6.0 PROCEDURE FOR REPORTING ABSENCE DUE TO ILLNESS:

6.1 Employees are required to inform their manager when they will be absent from work owing to illness, injury, compassionate leave or force majeure leave or for any other reason **in line with the relevant departmental procedure for reporting absence.** Employees are responsible for ensuring that they are aware of their departments/wards procedure for reporting absence.

6.2 When notifying of sick leave, the employee must indicate the nature of the illness and the likely duration of the illness (insofar as possible) so that alternative arrangements for cover can be made.

6.3 If notification is not received, or is received late, the staff member concerned will be deemed to be on unauthorised absence and will not be paid. Responsibility for ensuring that the **Formatted:** Bullets and Numbering notification requirement is complied with rests solely with the employee.

6.4 Where a employee is absent for more than two **consecutive** days1, a medical certificate must be submitted on the third day, to their Head of Department/Manager or nominee, as per departmental procedure**.**

6.5 Medical certificates should be signed by a licensed registered Medical Practitioner / General Practitioner, be legible and contain the following information:

- Employee's full name and address
- Doctor's name and address
- Date cert issued
- Dates effective from and to
- Nature and duration of illness
- State if the cert is final i.e. return to work date

6.6 Medical certificates which do not conform to these requirements will not be accepted, will be returned to the employee and may result in withdrawal of the sick pay scheme, if not corrected.

6.7 When an employee is resuming duty after a period of illness the Hospital reserves the right to request a medical certificate certifying them fit to resume duty.

6.8 Medical certificates should be submitted on a weekly basis unless otherwise agreed with Department Head/Manager.

6.9 Medical certificates will not be accepted retrospectively

6.10 All employee's on certified sick leave for more than 3 days and who are part of the Hospitals Sick Pay Scheme are required to make a claim to Department of Social Welfare for illness benefit and any monies/cheque received should be forwarded to Salaries Department – (see Appendix 1)

6.11 Uncertified sick leave, unless circumstances are exceptional, may not be immediately preceded or followed by

- Annual leave
- Rest periods – when a pattern of absence is identified the

hospital reserves the right to request a medical certificate

6.12 Resumption of Duty: an employee returning from sick leave should inform his/her Department Head/Manager one day in advance of the expected return-to-work date - **or as per departmental procedure**

6.13 If an employee is unable to resume duty on the expiry of the original medical certificate the line manager must be informed a minimum of 24 hours prior to the expiry date that the absence is continuing (**or as per departmental procedure)**. The reason and duration of the absence must be given.

6.14 A return-to-work interview will be carried out with the employee, as soon as possible, following their return to work. (See Appendix 3)

1 ***For staff normally working 39 hour working week, two days = 15.6 hours. Staff working 35 hour***

working week two days = 14 hours. Staff working 37.5 hours = 15 hours.

7.0 PROCEDURE FOR MANAGEMENT OF SHORT TERM ABSENCE

7.1 In conjunction with Human Resources Dept – Nursing and Non-nursing

the following process should take place for each Department/Ward/Area:

• HR in conjunction with Department Heads/Managers will examine all employees' sick leave records (certified and uncertified for a period of 12 months or longer if deemed necessary). The instances and reasons for the absences will be examined..

• Any employee who has a sick leave record that is a cause for concern will be required to attend a meeting to discuss their attendance levels. (Note: the absence may be filtered out if it is of a non-recurring nature i.e. broken limb, pregnancy related illness.)

• The Hospital aims to ensure that appropriate support and advice is provided to employees and will take into consideration the individual circumstances surrounding the absenteeism.

• This initial meeting will be non-disciplinary and the purpose will be to:

□ Review and agree dates of illness absence to ensure the records are accurate.

□ Establish the reasons for illness and determine what actions need to be taken by the employee and by the Hospital to improve the attendance i.e. referral to occupational health, staff care programme.

□ Advising the employee that whilst the recorded illnesses may be genuine a sustained improvement is expected.

• An agreed action plan will be confirmed in writing to the employee and details of the meeting will be recorded.

• If any medical condition is identified at this stage that is likely to have an effect on job suitability a referral will be arranged with

Occupational Health.

7.2 The aim of the policy is to help employee's achieve regular attendance without the need to invoke the disciplinary procedure.

However, should the employees absence continue or deteriorate following the initial meeting the employee should be formally interviewed and warned. As this is stage 1 of the Hospital's disciplinary procedure i.e. counselling stage, the employee should be advised that they are entitled to be represented by a fellow staff member, shop steward or union representative.

The purpose of the meeting will be to

• continue to discuss the unscheduled absence and reasons

• continue to try and identify any underlying reasons for absence

• Refer the employee to Occupational Health (if not already attending) if fitness to carry out the normal range of duties emerges as an issue.

• Inform the employee that if there is not a substantial and sustained improvement their employment may be terminated on the grounds of their inability to maintain an acceptable attendance level.

• The outcome of this meeting should be confirmed in writing.

In the event of continuing poor attendance, further stages of the Hospitals disciplinary procedure will be invoked.

• Examples of Sanctions which may be taken as part of the disciplinary procedure include:

□ Medical certificates to be provided for all absences

□ Medical certificates to be provided either side of rest days

□ Removal / Suspension from overtime roster

□ Suspension from the sick pay scheme

□ Deferment of an increment

□ Dismissal

8.0 PROCEDURE TO BE FOLLOWED IN THE CASE OF LONG TERM ABSENCE

When employees are unfit to attend work their absence should be managed in a sympathetic manner and reasonable steps taken to facilitate the individuals return to work as soon as possible.

Long term absence can be defined as periods of sickness absence that are continuous for more than 3 months or frequent absences of a related manner.

In cases of terminal illness, this procedure will not apply. Where the employee is absent from work due to long term sickness the department head will maintain contact with the employee and offer any appropriate assistance.

Depending on the nature of the illness an individual may be referred to Occupational Health for a medical opinion to advise of the likely length of time of absence and any implications for the employee's fitness for work.

Following the report from Occupational Health the head of department and HR will determine a strategy for monitoring and managing the absence.

In order to facilitate the earliest possible return to work, the hospital, in conjunction with advice from Occupational Health may consider the following options:

• seeking specialist advice

• further reassessment by Occupational Health over a defined period

• phased return to work

• alteration/restriction/limitation of certain tasks

• redeployment

Any employee who is due to return to work following a significant period of absence will be referred to Occupational Health for an assessment before they are allowed to return to work.

In circumstances where Occupational Health deem it unlikely that an employee will return to work the department head, HR and the employee will meet to discuss possible options.

APPENDIX 1

SOCIAL WELFARE PAYMENTS DURING SICK LEAVE

HOW DO I CLAIM FOR ILLNESS BENEFIT?

POLICY STATEMENT

The Sick Pay Scheme is a benefit to staff who are eligible, that makes payments available to staff during sick leave. These are detailed in 'Sick Pay Scheme' section of the Staff Handbook. To comply with the rules of theSick Pay Scheme, staff who are on certified sick leave for a period of more than 3 days (including Saturdays) must apply to the Department of Social and Family Affairs for Illness Benefit and submit details to Salaries. If an employee works part time and/or shift work illness benefit must be claimed for greater than three calendar days of illness even if not rostered to work all of the days. If an employee is absent Thursday, Friday and Monday a claim must still be made for social welfare, irrespective of whether an employee is normally rostered to work Saturdays or not.

It is the employees own responsibility to make a claim for illness benefit within 7 days of becoming ill. A delay of more than 7 days may cause you to lose some of your payment.

STAFF WHO ARE A MEMBER OF THE SICK PAY SCHEME

1. When your GP/doctor certifies you sick for greater than 3 days, ask for a Social Welfare Medical Certificate (known as MC1). Complete this form (ensure your doctor puts an end date for your illness on the form) and hand it in to your local social welfare office or post it to: Department of Social and Family Affairs, P.O. Box 1650, Dublin 1

2. If an employee works part time and/or shift work illness benefit must be claimed for greater than three calendar days of illness even if not rostered to work all the days. For example, if an employee works 2 days per week but has been certified sick for the week a claim for illness benefit must be made. If an employee works full time, is certified sick for one week and they are rostered to work Monday, Wednesday and Friday they must claim illness benefit.

3. Upon receipt of Illness Benefit a copy of the cheque should be forwarded to the Salaries Department for deduction from your salary.

4. Employees who fail to return copies of the Social Welfare cheques to the hospital are in breach of the rules of the sick pay scheme and payment of salary will be withheld and/or the employee may be removed from the Sick Pay Scheme.

5. If salaries do not receive a copy of the Social Welfare cheque(s) within two months from the date of illness monies owed will be deducted from the employees salary.

PROCEDURE FOR COLLECTION OF SOCIAL WELFARE BENEFITS:

□ It is the employee's own responsibility to make a claim to Department of Social Welfare and submit cheques to salaries department.

□ To try to ensure that cheques are submitted, the following procedure is undertaken by HR and Salaries.

RESPONSIBILITIES HR (Nursing & Non-Nursing) & SALARIES

1. HR runs Pay Code Occurrence report on a monthly basis. (Selection Criteria : Work Groups = All, Pay Codes 8, 11, 12, 13, 20, 21 and 22).

2. HR submits Report to Salaries (as close to 10th of following month as possible).

3. Salaries remind relevant HODs by email of outstanding cheques.

4. If Salaries does not receive cheques from employee or notifications from Social Welfare within two months from date of illness, any monies owed is deducted from the employees salary.

APPENDIX 2

OCCUPATIONAL HEALTH - STAFF REFERRAL FORM

Sections 1-4 should be completed by the Department Head / Supervisor and forwarded to HR (nursing or non-nursing).

1. Employees Details:

Name (Print): _____Employee number: _____

Date of birth: _____ Male / Female: _____

Contact Address: _____

_____ Tel No: _____

Job Title: _____ Department: _____

Hospital / Organisation: _____

2. Manager's Details:

Name (Print): _____ Job Title: _____

Department: _____ Contact Tel No: _____

Manager's Signature: _____ Date of referral: _____

Countersigned: _____(Service / Nurse Manager) where applicable

3.Reason for Referral:

☐ Absence attributed to ill health Certified ☐ Uncertified ☐

☐ Fitness for return to work / Likely date of return to work

☐ Accident at work

☐ Assessment of fitness to undertake full duties

☐ Possible work related health problem

☐ Health related performance issues

☐ Other (Please state).....

4. Management Queries:

Please state / list any questions you would like to be addressed by OH Department.

.....

.....

5.Sickness Absence Record:

Please list below or attach all episodes of sickness absence during the last 48 months (if possible) Give dates and durations of absences and reasons for absence (where known).

First day of
sickness absence

Last day of
sickness absence

Total number
of days

Reason for absence

(If they are not at work, the employee must be informed of the referral in writing and a copy of this form sent to the employee) If they are at work, the employee must be informed of the reasons for referral to Occupational Health and in any event, consent to a confidential report being sent to the person referring.

Form sent to Occ. Health on _____ Copy of Form sent to Employee on_____

Signed: _____(for relevant HR Dept).

I understand a confidential report will be sent to the manager stated above about my Occupational Health referral.

Signed: _____(employee being referred)

Note: Appointments for staff will only be made on receipt of a fully completed referral form in Occupational Health.

APPENDIX 3

PRIVATE HOSPITAL RETURN-TO-WORK INTERVIEW

GUIDELINES

1. Return-to-work interview should always be conducted after an unscheduled work absence and recorded on this form at department/ward level.

2. When a employee's attendance is generally very good, an informal enquiry about the employee's health should suffice. In the main, the 'return-to-work' interview has a number of functions:

2.1. shows concern with regard to the employee's wellbeing and fitness to return to work, and offer any support if necessary

2.2. reinforce with the employee the importance of good attendance

2.3. conveys the message that all absence are noted,

2.4. allows for corrective action to be taken to reduce the level of unscheduled absence as appropriate

3. The interview should be conducted in a timely fashion – as soon as possible after returning to work.

4. The return-to-work interview is not part of the hospital's disciplinary procedure.

Ward/Unit/Department:

Employee Name:

Post Held:

Absence Dates: From Date To Date

Reason for Absence:

Was absence medically certified? o **Yes** o **No**

Social Welfare Claimed (>3 days) ? o **Yes** o **No**

Interview Notes:

Recommendations / Comments:

Signed:

_____

DEPT HEAD/MANAGER

Date:

Completed form should be filed at Dept/Ward level.

APPENDIX 4

CRITERIA FOR ELIGBILITY TO BENEFIT UNDER THE SICK PAY SCHEME NON-OFFICER GRADES

All non-officer grades (household staff, catering assistants, porters, CSSD, ward attendants, lab assistants, Imaging assistants may be granted up to 60 working days (twelve weeks) paid sick leave in any continuous 12-month period i.e. the twelve months up to the first day of the current illness plus the current illness.

Uncertified Sick Leave

A maximum of seven (or 54.6 hours based on a 39 hour week) uncertified sick leave days may be granted in any calendar year.

Notes:

1. Only working days are counted.

2. 54.6 hours is pro-rata for a part time employee

3. Medical certificates are not accepted retrospectively.

4. No payment of salary will be made for uncertified sick days in excess of 7 days (54.6 hours) in a calendar year

OFFICER GRADES

All officer grades may be granted up to six months full pay and six months half-pay subject to the following conditions:

1. No salary is payable where an officer has exceeded 365 days in any continuous four-year period i.e. the four years up to the first day of the current illness.

2. Full salary is payable where an officer has not exceeded 183 days in any twelve months i.e. the twelve months up to the first day of the illness plus the current illness.

3. Half salary is payable where the 365 days condition '1' above has not been exceeded but the 183 days in condition '2' has been exceeded.

Uncertified Sick Leave

A maximum of seven (or 49 hours based on a 35 week and 52.5 hours based on a 37.5 hour week) uncertified sick leave days may be granted in any continuous twelve-month period.

Notes:

1. Rest days e.g. Saturdays and Sundays are counted for the purposes of the calculations. Unpaid leave is not counted.

2. 49 / 52.5 hours is pro-rata for part time employees

3. No payment of salary will be made for uncertified sick days in excess of 7 days (49 hours / 52.5 hours) in a continuous twelve month period.

APPENDIX

5.2

PRIVATE HOSPITAL - HUMAN RESOURCES
Owner / Date: Director of Human Resources, 15/03/2011
Document No.: POL-HRM-008 Reviewed by / Date: HR Administrator, 15/03/2011 Date of issue: 15/03/2011
Authorised by: Quality Dept.,15/03/2011 Edition No.: 003
(Review Date: 15/03/2014)
THE ABOVE IS FOR COMPLETION BY THE QUALITY DEPARTMENT

DISCIPLINARY POLICY AND PROCEDURE

1.0 POLICY STATEMENT

1.1 The Hospital management acknowledges the need to establish a procedure that will ensure fair treatment for employees who become liable to disciplinary action because of failure to meet standards with regard to conduct and performance. The primary aim of this procedure is to help the individual whose performance falls below the Hospital requirements to achieve the necessary improvements.

2.0 POLICY PURPOSE

2.1 The purpose of the policy is to make all staff and managers aware of the disciplinary procedure.

3.0 SCOPE OF POLICY

3.1 This document applies to all employees of the hospital.

4.0 RESPONSIBILITIES

4.1 It is the responsibility of HR to ensure that the procedure is adhered to in a fair and consistent manner.

5.0 PROCEDURE

Stage 1: Counselling

The employee will be put on notice as to the particular aspect of his/her work performance, conduct or ability that has fallen below standard and advised of the improvement required.

Stage 2: Written Warning

The employee will be given a written warning of the specific aspect of the work, conduct and/or ability which is below standard, stating clearly that this is the first warning and he/she will be advised of the improvements which must be made. This incident will be recorded in writing and a copy of the warning will be given to the employee and the employee's trade union/representative as appropriate.

Stage 3: Written Warning

In the event of a further offence or a failure to achieve the required improvements after Stage 2, the employee will be issued with a second warning.

This warning will be recorded in writing and will be issued to the employee concerned and a copy to his/her representative as appropriate.

Stage 4: Final Written Warning

In the event of a further offence or failure to achieve the required improvements after Stage 3, the employee will receive a final written warning and/or possible suspension without pay. It will be made clear to the employee that his/her employment may be terminated if the conduct or work performance does not improve. This will be confirmed in writing to the employee concerned and a copy to his/her representative as appropriate.

Stage 5: Dismissal

In the event of a further offence or failure to achieve the required improvements after Stage 4, the employee may be dismissed. Before any decision is taken to dismiss an employee, he/she will be informed again of the reason(s) for the proposed dismissal and will be given the opportunity to state his/her case.

Note: The life span of any one stage of the Disciplinary Procedure will be one year.

Representation

At all stages the employee will be given the right to be accompanied by a fellow employee of his/her choice or his/her Shop Steward or his/her Union Representative, as appropriate.

Rights of Appeal

In the event of a dismissal an employee has the right to appeal his/her case to the Chief Operations Officer. The appeal must be lodged by the employee, in writing, within five days of the dismissal. If no appeal is received within this time frame, the decision will be deemed to have been accepted by the employee.

Serious Misconduct

If management considers that an employee has committed one of the offences listed below under 'Serious Misconduct' (or an offence of a similar gravity) they will arrange for the suspension with pay of that employee pending an investigation of the incident. A thorough investigation will be conducted. As part of this investigation, the employee will be invited to a meeting and advised of the charge(s) against him/her and afforded the opportunity of having a representation made on his/her behalf. Management's conclusion based on the outcome of this investigation, including the meeting, will be notified to the employee and to his/her employee representative together with details of proposed disciplinary action.

Examples of **misconduct**, which may lead to the setting in motion of the Disciplinary Procedure:

□ Bad time-keeping □ Insubordination

□ Poor Work Performance □ Unauthorised Absence from work

□ Not clocking-in □ Lack of cooperation

□ Breach of Rules & Regulations (which does not warrant a more serious penalty applying)

Examples of **serious misconduct:**

□ Physical Assault or Violence □ Breach of confidentiality

□ Theft □ Abuse or destruction of hospital property

□ Conviction of criminal offences which result in prison sentences, whether the offence was committed on or outside the hospital premises

□ Intoxication or being under the influence of alcohol

□ Unprescribed drug usage or misuse of prescribed medicines

□ Falsification of any reports or records

□ Non-compliance with the requirements within the Safety Statement and Fire Regulations within the hospital

□ Unofficial industrial action

□ Gambling, betting, money lending or the distribution of unauthorised literature or goods on the premises

□ Unauthorised removal of hospital or personal property

□ Fraud

□ Serious breach of hospital rules

□ Obscene behaviour

□ Failure to follow a reasonable instruction

□ Possession of firearms or explosives

□ Sexual misconduct at work

□ Breach of hospital information technology regulations

Note: The above lists are not exhaustive lists Summary dismissal on foot of gross misconduct will be without notice.

Examples of Disciplinary Action:

□ Suspension without pay for a period

□ Dismissal

□ Deferral of an increment

□ Demotion

□ Implementation of the Disciplinary Procedure at a level higher than Stage 1 and appropriate to the offence.

APPENDIX

5.3

PRI VATE HOSPI TAL

Owner / Date: Development & Health & Safety

Manager, 12 / 12 / 2007

Document No.: POL-GEN- 033

Review ed by / Date: Director of HR, CEO, 12 / 12 / 07

Date of issue: 14 / 12 / 2007

Authorised by: Quality Dept.,14 / 12 / 2007 Edit ion No.: 001

(Review Date: 14 / 12 / 2010)

THE ABOVE IS FOR COMPLETION BY THE QUALITY DEPT.

POLI CY ON MANUAL HANDLI NG

1 .0 POLI CY STATEMENT

1.1 Manual Handling is a significant risk to many staff who work in the Mater Private Hospital, part icularly Nursing, Portering, Allied Health Professionals and Stores staff.

2 .0 AI M OF POLI CY

2.1 The object ive of this policy is to ensure that the hazards associated with manual handling in the hospital are managed so as to minimise the risk of injury or ill health.

2.2 The policy aims as a minimum to comply with the relevant laws on manual handling as set out in the Safety, Health and Welfare at Work (General Applicat ion) Regulat ions (SI 299 of 2007) .

3 .0 SCOPE OF POLI CY

3.1 The policy is directed at all employees of the hospital. All employees will receive manual handling training as soon as possible after commencing work unless they have documented evidence of having received appropriate training within the previous two years.

3.2 The key object ives of the Manual Handling Policy are

(a) to prevent manual handling injuries from occurring with the Hospital's staff;

(b) to make sure that yearly risk assessments are carried out regarding manual handling risks in the Hospital;

(c) to make sure that mechanical aids are available at all t times to staff who require them;

(d) to make sure that manual handling training is provided to all staff and also that all staff are fully compliant with manual handling training requirements;

(e) when a manual handling incident occurs then a proper investigation takes place to establish what was the cause and what can be done to prevent its reoccurrence and

(g) to make sure that follow ups take place where improvements are required.

4 .0 DEFI NI TI ONS (if any)

5 .0 RESPONSI BI LI TY

5.1 The ultimate responsibility for implementation of this policy rests with the Chief Executive.

5.2 Training records will be maintained by the Health and Safety Department who will advise each department of the expiry dates of training for their staff.

5.3 I t will be the responsibility of each Department Head to ensure that their staff have received the appropriate training within the specified t time.

5.4 Training will be arranged and provided by the Manual Handling Coordinator.

6 .0 RI SK ASSESSMENT

6.1 This policy takes a risk assessment based approach. A risk assessment of all manual handling tasks will be carried out on an annual basis. Where it is practicable the manual handling task will be eliminated. I f this is not possible the task will be reduced by the use of mechanical aids or re design of the task. Where this cannot be achieved training will be provided and controls put in place to minimise the risk of injury.

(A) Procurement of New Equipment

Before new equipment is ordered, a risk assessment will be carried out to evaluate any manual handling risks which the new equipment may introduce. This risk assessment will be carried out by the Head of Department and the Health and Safety Manager and will be documented. In so far as is practicable, the procurement of new equipment will be used as an opportunity to eliminate or reduce manual handling risks

(B) Patient Risk Assessment

A risk assessment will be carried out for each patient on admission to the hospital. This will establish the capability of the patient in relate ion walking, moving in the bed, showering etc. The risk assessment will establish how many staff and what special equipment is required for the various tasks. I t will be revised as required subject to changes in the patient's conditions.

7 .0 MANUAL HANDLI NG TRAI NI NG

7.1 Training will be provided to all staff at maximum intervals of three years. Initial training for patient handling will be of one day duration and refresher will take four hours. Initial training for static manual handling will be of four hours drat ion and refresher training of two hours. All new employees will be asked to produce documentary evidence of having received manual handling training relevant to their work and if this is not available they will be required to at tend manual handling training on recruitment .

7.2 Training sessions will be provided at the required frequency and at suitable times to ensure that all staff have adequate not ice and opportunity to at tend initial and refresher training.

7.3 The training will reflect the work environment . Case studies will be used to emphasise the importance of applying the training in the course of work with particular emphasis on employees carrying out their own risk assessment

8 .0 MANAGEMENT OF TRAI NI NG RECORDS TO ENSURE COMPLI ANCE:

8.1 Manual Handling training records will be closely managed The records will be maintained by the Health and Safety Department in a manner that will highlight the month in which each employee falls due for training. The system will then generate a note to the employee and their immediate supervisor/manager informing them that they must take MH training in the next 6 months. This note will be repeated three months later. When employees get to within one month of expiry of their training, a final not ice will be issued, copied to the CEO and Safety Manager.

9 .0 I NCI DENT I NVESTI GATI ON

9.1 All incidents and accidents including near misses regarding manual handling will be reported and investigated. The time spent on the investigation will reflect the seriousness of the incident . The investigation will be carried out by the Department Head or by a senior person in the Department and by the Health and Safety Manager. The investigation will establish the root cause of each incident . Remedial act ion will be implemented where possible to prevent a recurrence of the incident . The results of the investigation will be fed back into the relevant departments risk assessment and also to the manual handling training programme. I fan investigation shows that the original risk assessment in the Safety Statement needs revising, then this revision will be implemented.

APPENDIX

5.4

PRIVATE HOSPITAL

STAFF CARE PROGRAMME

STATEMENT

The Staff Care Service is to facilitate staff to address areas of personal stress through the provision of a Counseling Service and to pro-actively support staff in the event of a hospital based incident , through the Critical Incident Care Program.

PROCEDURE

Management and staff will be encouraged to have a positive view of the Service and to view utilization of the service as a positive and pro-active step in a staff member's
own health care.
This will be achieved through:
x A promotional/ awareness t raining program which will precede the official start -up of the program.
x On-going presentations on subjects significant and pertinent to one's psychological and emotional health.
The service has two main elements:
1. **The Counseling Service** will provide staff with the facility to have a consultation with a counselor within days and then to proceed to treatment / care/ support or guidance with the problem.

2. **The Critical Incident Care Program** will pro-actively care for staff that experience incidents at work, which can be particularly stressful for them. This will be provided through telephone support and/ or individual/ group debriefings as required.

WHO PROVI DES THE SERVI CE?

An external provider called Stephanie Regan & Associates. This organization is an established provider of Staff Care and Critical Incident Care in Ireland. Stephanie is a Clinical Psychotherapist as are all her Associates.

ELI GI Bl LI TY

x The Counseling Service will be available to all hospital employees and where appropriate to members of their immediate family.
x Inclusion of family members will be at the discretion of the provider. Decisions regarding inclusion will be based on the relevance of the family member's problem to the clinical well being of the staff member.
x The Critical Incident Care Program will be available to all staff that is involved in a Critical Incident at the hospital, regardless of their employment status.

PRI NCI PLES OF UTI LI SATI ON

x The Counseling Service and the Critical Incident Care Program will be strictly voluntary and confidential and on a self- referral basis.
x A colleague or manager may suggest or encourage a staff member to avail of the service if they feel that they would benefit from it .
x I t is envisaged that the counseling service will be used on a per problem basis and generally once. Any re-use of the service will be at the discretion of the provider.

ATTENDANCE

x Attendance at counseling sessions will be on the staff member's own time.
x Attendance using sick leave or annual leave must be in accordance with current hospital policy.1
x Appointments will be made direct ly with The Provider and individual needs will be accommodated.
In the instance of a **Critical Incident** the hospital will facilitate Attendance at debriefings whether in-house or at an off- site locat ion and these may be conducted on duty time.

Page 1 of 2

PAYMENT
The hospital will meet the costs of up to four counseling sessions per event . The staff member will cover all further costs except : *At the discret ion of the provider, with the approval/ agreement of the coordinator, who can decide to provide a further session/ s to a maximum of six in total. Such decisions would be made on the basis of financial need only.*

Drug & Alcohol Treatment Programmes
x Where a staff member is referred to an Alcohol Treatment Cent re, the costs of t reatment will be covered by the hospital if required (e.g. staff member has inadequate or no private health insurance cover) . This will apply for one t reatment only.
x I f there is a clinical requirement for a psychiat ric review before t reatment can begin, cost s will be met by the hospital if required.

1 Ref: MPH Employee Handbook: Section 7 Leave Arrangements

Page 3 of 4

CRI TI CAL I NCI DENT PROGRAMME
Should a Crit ical Incident occur at the hospital the following is the line of communicat ion and act ions to be followed.
2

2 Ref: Hospital Safety Statement

Critical Incident, On Duty Person in Charge, Executive H&S Committee, Director of Nursing/ Deputy

PROVI DER
1. After the incident , the on-duty supervisor/ person in charge should immediately not ify either:
x The Director of Nursing/Night Superintendent ,
x Staff Care Service Coordinator, or
x Any member of the Execut ive Health & Safety Commit tee.
2. An Incident / Accident form should be completed by the on-duty supervisor/ person in charge and sent to the Chairperson of the Health and Safety Commit tee.
3. The provider will then act ivate a system of support init ially by telephone to each staff member involved. This may require the release of home telephone numbers of staff.
4. The provider will then liaise with the contact person in '1' above on the need for a CISD and any arrangements associated with that .
5. Feedback will be given on a st rict ly 'need to know basis' as follows:
x Psychological fitness to return to work
x Special leave requirements
x Special considerat ions which would assist the staff members return to work
x Feedback from the group on mat ters they wished to be conveyed on their behalf but did not wish to convey personally and which would be beneficial to management to be aware of.

CONFI DENTI ALI TY
All case notes are kept at the external Provider's offices and will only be discussed, released, or reported upon **w ith the express w r it ten permission of the staff member .**
In the instance of a Crit ical Incident the hospital can seek from the Provider a report , which will indicate the clinical intervent ions, made on their behalf to assist staff following the Incident .
This will include the names of staff members who at tended CISD and general observations about the incident and react ions but will not include any details of any individual staff member's react ion.

APPENDIX

6

IBEC

Managing People Skills Programme

Duration: 4 Days

Course Purpose:
The Managing People Skills Programme is designed to assist managers in developing their management and interpersonal skills and to build on many of the core skills introduced in our earlier Managing People Programme. Participants will gain a greater understanding of their communication and management style and its impact on those they manage.

Programme Outcomes:
On completion of the programme, participants will be able to:

Gain an insight into their own behavioural style and approach to others by carrying out a detailed personality profile

Develop the key communications skills and the confidence to use them

Improve personal presentational skills through practice and feedback

Develop and improve key management skills in communication, motivation, managing meetings, team building and time management

Develop a greater understanding of their own preferred interactive style and recognise the dynamics of interpersonal relationships.

Programme Schedule:

Day One
The Role of the manager

Managing Vs operating

Identifying vital management skills

Your leadership style

Personality testing

Understanding behaviour and its effects

Communication skills

Skills of communication

Personal style

What are the key skills?

How to become a more effective communicator

Day Two
Managing performance

Target setting

Giving feedback

Influencing others

Taking corrective action

Dealing with conflict

Presentation skills

Designing an effective presentation

How to make a powerful presentation

Practice skills

Communicate with confidence

Day Three
Motivation

Theories and Practice

Your own interactive style

Styles to develop

Delegation

Case examples

Day Four
Time management / stress management

Components of an effective time management system

Identifying time wasters/ stressors

How you can manage your time more effectively

Gaining control

APPENDIX

7

Guidelines on conducting return to work interview with staff.

- The return to work interview should take place after *every* episode of sick absence.
- The meeting should take place as soon as possible after staff member returns to work (if possible same day).

Purpose:

- Welcome staff member back to work.
- Advise staff member that they have been missed.
- Let the staff member know how their absence has been covered.
- Find out cause of the absence.
- Be aware of any ongoing health problems and possible future impact.

Preparation:

- Ensure you have the right information available – sick leave record, certificates etc.
- Check records for both current and previous absences.
- Be prepared to discuss any trends or patterns of recent absences.
- Ensure you have private room/space/area to carry out the meeting.

Discussion: (Remember the HELLO model)

- Begin the discussion by welcoming the employee back to work. **(H)**
- Enquire how they are feeling/fit to resume duty. **(E)**
- Confirm the reason for the sickness absence (check it same as on doctor's cert if medical certificate provided).
- If appropriate and if staff member is willing to discuss the steps they are taken to recover e.g. .medication, receiving treatment etc. **(L)**
- If there is an underlying absence pattern, a sensitive discussion about what might be causing this may follow.
- Bring the staff member up to date on what has been happening while they were away and how their work was covered. **(L)**
- Listen to the staff member and give them an opportunity to discuss any concerns that they may have.
- Discuss and agree any steps/follow up actions that may be required after the meeting. **(O)**
- End the meeting positively, reinforcing the importance of the staff member's contribution to the team.

Possible questions:

- What is the reason for your absence/have they recovered/resume normal duties/how are you feeling now?
- Was medical advice sought/was medication prescribed/is there a medical certificate for this absence?
- Is there anything the Hospital can do to help?
- Is there anything relating to the absence that the Hospital should be aware of for the future?

Remember:

- Check doctor's cert is accurate and covered the absence period.
- Remind staff member to claim sickness disability benefit.
- Complete the return to work interview form.
- Return to work interview is not a disciplinary meeting.
- Staff Care Services is available to staff.

APPENDIX

8

OCCUPATIONAL HEALTH - STAFF REFERRAL FORM

Sections 1-4 should be completed by the Department Head / Supervisor and forwarded to HR Administration, HR Department,
(In the case of Nursing and Medical Staff, it should be forwarded to Nursing HR and Medical HR respectively).

1. Employees Details:

Name (Print): _____ Employee number: _____

Date of birth: _____ Male / Female: _____

Contact Address: _____

_____ Tel No: _____

Job Title: _____ Department: _____

Hospital / Organisation: _____

2. Manager's Details:

Name (Print): _____ Job Title: _____

Department: _____ Contact Tel No: _____

Manager's Signature: _____ Date of referral: _____

Countersigned: _____ (Service / Nurse Manager) where applicable

3.Reason for Referral:

☐ Absence attributed to ill health Certified ☐ Uncertified ☐

☐ Fitness for return to work / Likely date of return to work

☐ Accident at work

☐ Assessment of fitness to undertake full duties

☐ Possible work related health problem

☐ Health related performance issues

☐ Other (Please state).....

4. Management Queries:

Please state / list any questions you would like to be addressed by OH Department.

.....

.....

5.Sickness Absence Record:

Please list below or attach all episodes of sickness absence during the last 48 months (if possible) Give dates and durations of absences and reasons for absence (where known).

First day of sickness absence	Last day of sickness absence	Total number of days	Reason for absence

(If they are not at work, the employee must be informed of the referral in writing and a copy of this form sent to the staff member) If they are at work, the staff member must be informed of the reasons for referral to Occupational Health and in any event, consent to a confidential report being sent to the person referring.

Form sent to Occ. Health on _____ Copy of Form sent to Staff Member on_____

Signed: _____(for relevant HR Dept).

I understand a confidential report will be sent to the manager stated above about my Occupational Health referral.

Signed: _____(employee being referred)

Note: Appointments for staff will only be made on receipt of a fully completed referral form in Occupational Health.

APPENDIX

9

Guidelines on HSE Circular re Pregnancy-Related Illness

HSE HR Circular 25/2008 gives effect to a European Court of Justice ruling (case C-191/03) and Labour Court determination (LCR061) on a case taken by a HSE employee in relation to the application of sick leave regulations to employees who are absent on pregnancy related sick leave.

While the ruling/determination upheld the HSE's position it also provided as follows:

(i) during pregnancy-related illness "the amount of payment made is not so low as to undermine the objective of protecting pregnant workers"; and

(ii) if the officer is absent due to ill-health following maternity leave, the effect of offsetting absences due to pregnancy-related illness must not result in her receiving an amount "that is lower than the minimum amount to which she was entitled during the illness which arose while she was pregnant".

In view of the ruling of the European Court of Justice and the Labour Court determination the HSE agreed to the following sick leave arrangements for health service employees who are absent as a result of pregnancy related illness. ***These revised arrangements apply to both officer grades and general support staff.***

While the sick pay scheme for support staff does not provide for payment at half pay[1], for the purposes of pregnancy-related illness the extension to sick pay as provided for in HSE Circular 25/2008 will be **at half pay** (less any social welfare benefit to which the employee may be entitled on foot of their social welfare contributions).

[1] Support staff may be granted up to a maximum of 12 weeks' full pay in any period of 12 months, commencing on the first day of illness.

Pregnancy-related illness occurring before maternity leave commences

An employee who is medically certified as unfit for work *due to pregnancy-related illness* prior to the commencement of maternity leave and who has exhausted her entitlement to sick pay in accordance with the normal sick pay rules will continue to receive sick pay at **half pay** (less any social welfare benefit to which the employee may be entitled on foot of their social welfare contributions) for the duration of her illness until maternity leave commences.

Illness occurring post maternity leave[2]

If an employee is unfit for work following maternity leave[3], her entitlement to sick leave at half-pay will be extended by the period of absence due to pregnancy-related illness on sick leave at half-pay which occurred prior to maternity leave. This extension only relates to a pregnancy-related illness which arose prior to the employee's confinement.

However, the period on half-pay will not be extended by any period of pregnancy-related illness which occurred before maternity leave commenced, during which the employee benefited from extended pregnancy-related sick leave at half-pay.

Example 1 Officer Grades

An employee who is absent from work due to pregnancy-related illness exhausts her entitlement to sick leave at full pay on 31 March. She goes on sick leave at half pay from 1 April to 31 May (a total of 61 days) until she commences maternity leave on 1 June. As the employee did not exhaust her normal sick pay entitlements during pregnancy-related illness prior to going on maternity leave, the extension does not apply to her.

During maternity leave she receives maternity pay under the maternity pay scheme.[4]

[2] The illness occurring post maternity leave *does not* have to be related to pregnancy or childbirth
[3] Reference to maternity leave also includes additional (unpaid) maternity leave
[4] The rules governing the grant of maternity pay are set out in Department of Health and Children 8/98

The employee returns to work following maternity leave. She subsequently goes on sick leave and eventually exhausts her entitlement to half pay in accordance with the normal sick leave rules. However, her entitlement to sick leave at half pay is extended for the length of time she was absent due to pregnancy-related illness and in receipt of sick leave at half pay i.e. a total of 61 days. Following this extension, the normal rules governing sick pay apply.

Example 2 Officer Grades

An employee goes on sick leave due to pregnancy related illness at half pay from 1 January until 31 March (a total of 90 days). At this stage, under normal sick leave rules, she would be due to go off pay on 1 April. However, due to the extension she continues to receive sick leave at half-pay until she goes on maternity leave on 1 June.

During maternity leave she receives maternity pay.

Following maternity leave, the employee goes on sick leave. Her entitlement to sick leave at half-pay is extended by the length of time for which she received sick leave at half pay in accordance with the normal sick leave rules i.e. a total of 90 days. Following this extension, the normal rules governing sick pay apply

It is important to note that the extension to sick leave for illness occurring after maternity leave **does not apply** in respect of the period during which the employee benefited from an extension to sick leave prior to going on maternity leave (i.e. from 1 April to 1 June).

Example 3 General Support Staff

An employee goes on sick leave due to pregnancy-related illness on 1st January. From 1st January to 19th February the employee receives sick leave at full pay in accordance with the sick pay scheme for general support staff. On 19th February the employee exhausts her sick pay entitlements. However, as her sick leave is pregnancy-related, the employee is entitled to sick leave at **half-pay** from 20th February until she goes on maternity leave on 1st April.

Following maternity leave, the employee goes on sick leave. As she had exhausted her sick leave entitlement at full pay, she will be entitled to **sick leave at half pay.** This entitlement is for a period equivalent to the length of time for which she was absent on full pay during her pregnancy related illness i.e. the period from 1st January to 19th February. Following this extension, the normal rules governing sick pay will apply.

Figure 1.0 - REASONS FOR ABSENCE – NUSING MAY 2011

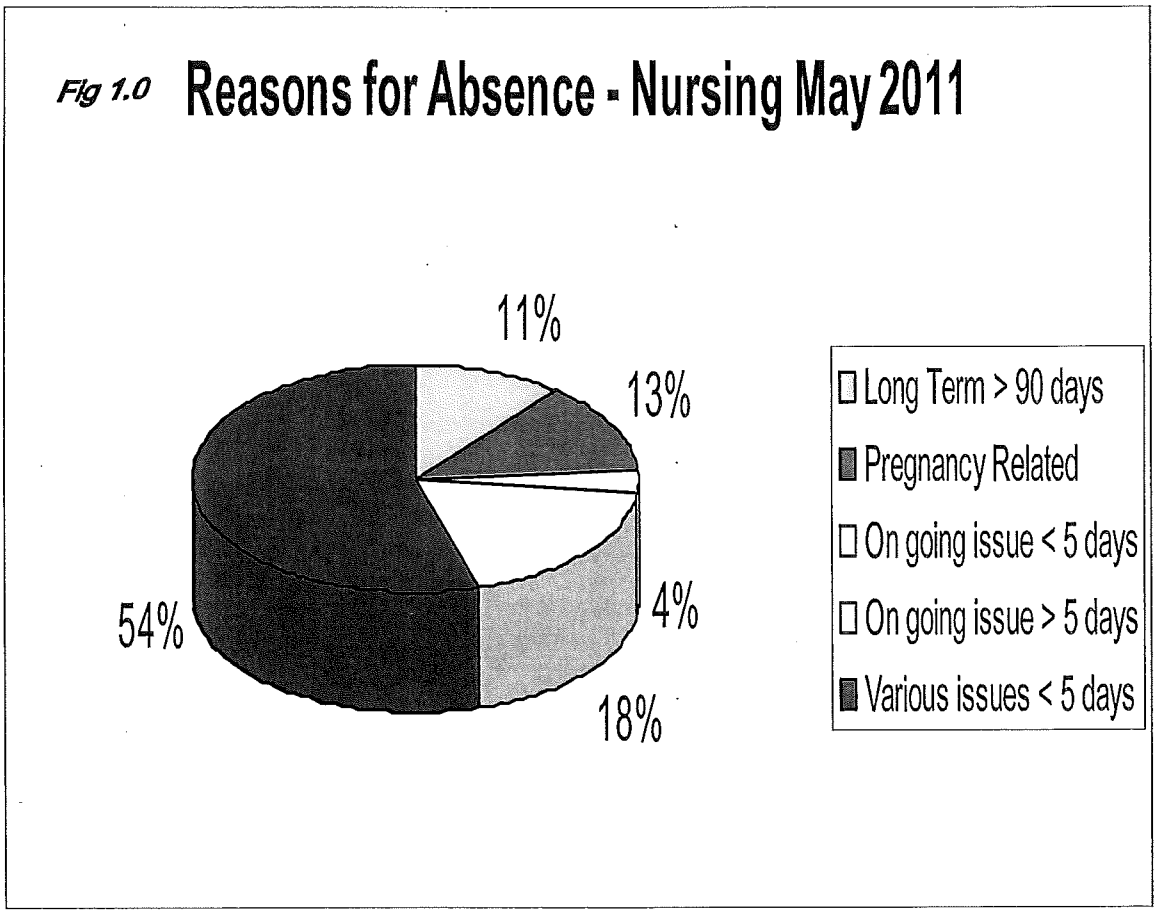
NURSING - MAY 2011

	Jan	Feb	March	April	May
Actual	3.94%	3.66%	4.44%	3.77%	3.25%
Target	2.9%	2.9%	2.9&	2.9%	2.9%
Variance from Target	↑ 1.04%	↑0.76%	↑1.54%	↑0.87	0.35%

Reasons for Absence - May 2011

Nursing sick leave has decreased for the second consecutive month.

The chart below reveals the reasons behind the absences for May.



Measures used for managing short-term absence

Other	3%
Health education programme	9%
Self-certification	15%
Train line managers in absence management	21%
Attendance bonus/reward scheme	22%
Restrict sick pay scheme	26%
Provide counselling service	26%
Flexible working arrangements	32%
Specify absence 'triggers'	35%
Interviews on eturn to work	39%
Provide medical examination	45%
Invoke disciplinary procedure	52%
Provide absence information to line managers	53%
Analysis of absence data	62%
Recording of absence data	90%

Fig 1.1 Measures used for managing short-term absence

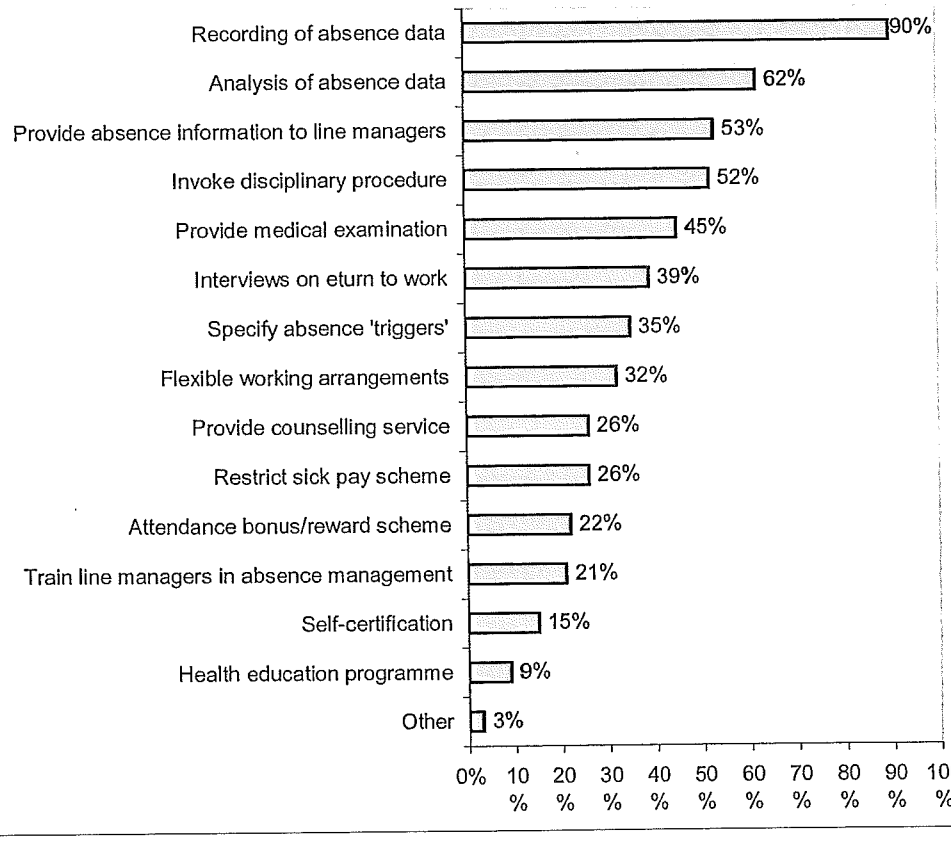


Fig 1.2 JUNE ABSENCE RATE 2008 - 2011

	ABSENCE TARGET	HOSPIAL ABSENCE RATE	NURSING ABSENCE RATE
Jun-11	2.90%	2.81%	3.73%
Jun-10	3.24%	2.94%	3.63%
Jun-09	3.73%	2.98%	3.03%
Jun-08	3.73%	3.79%	5.45%

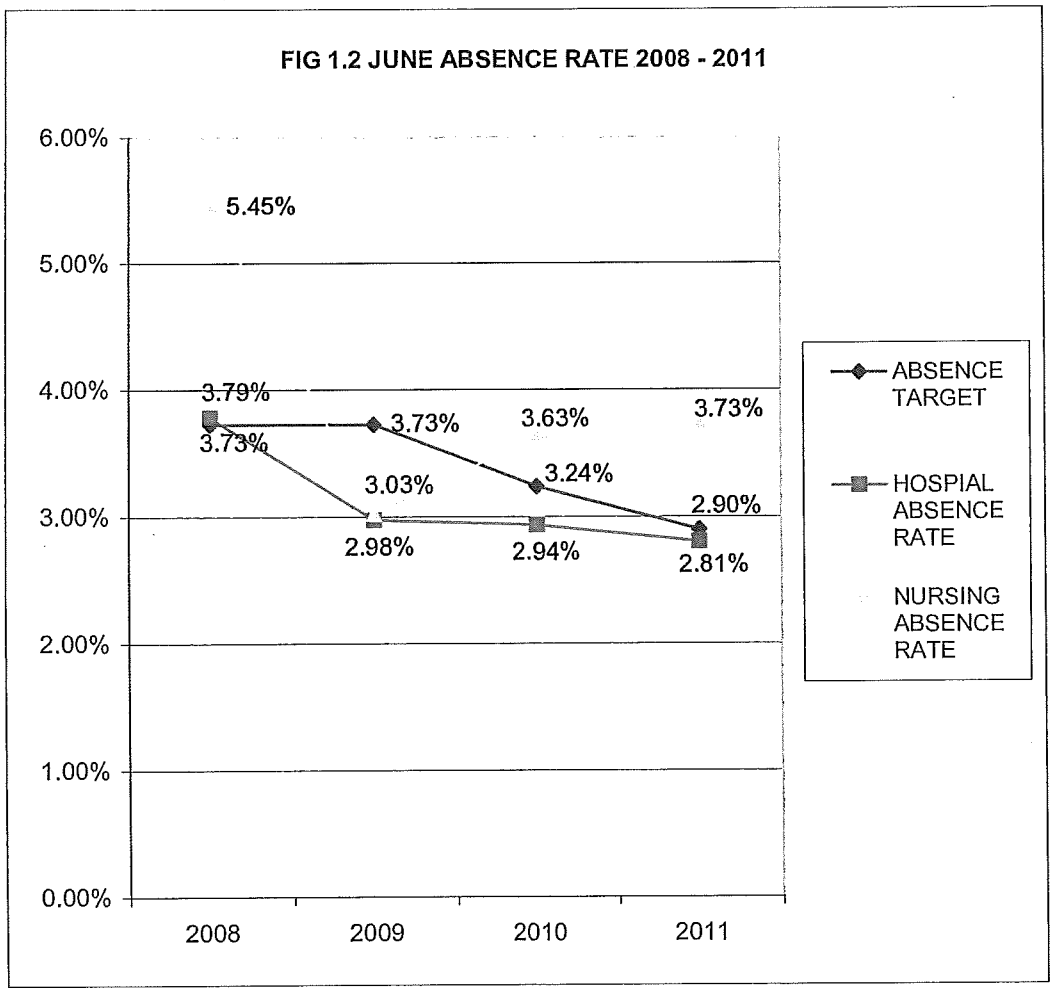
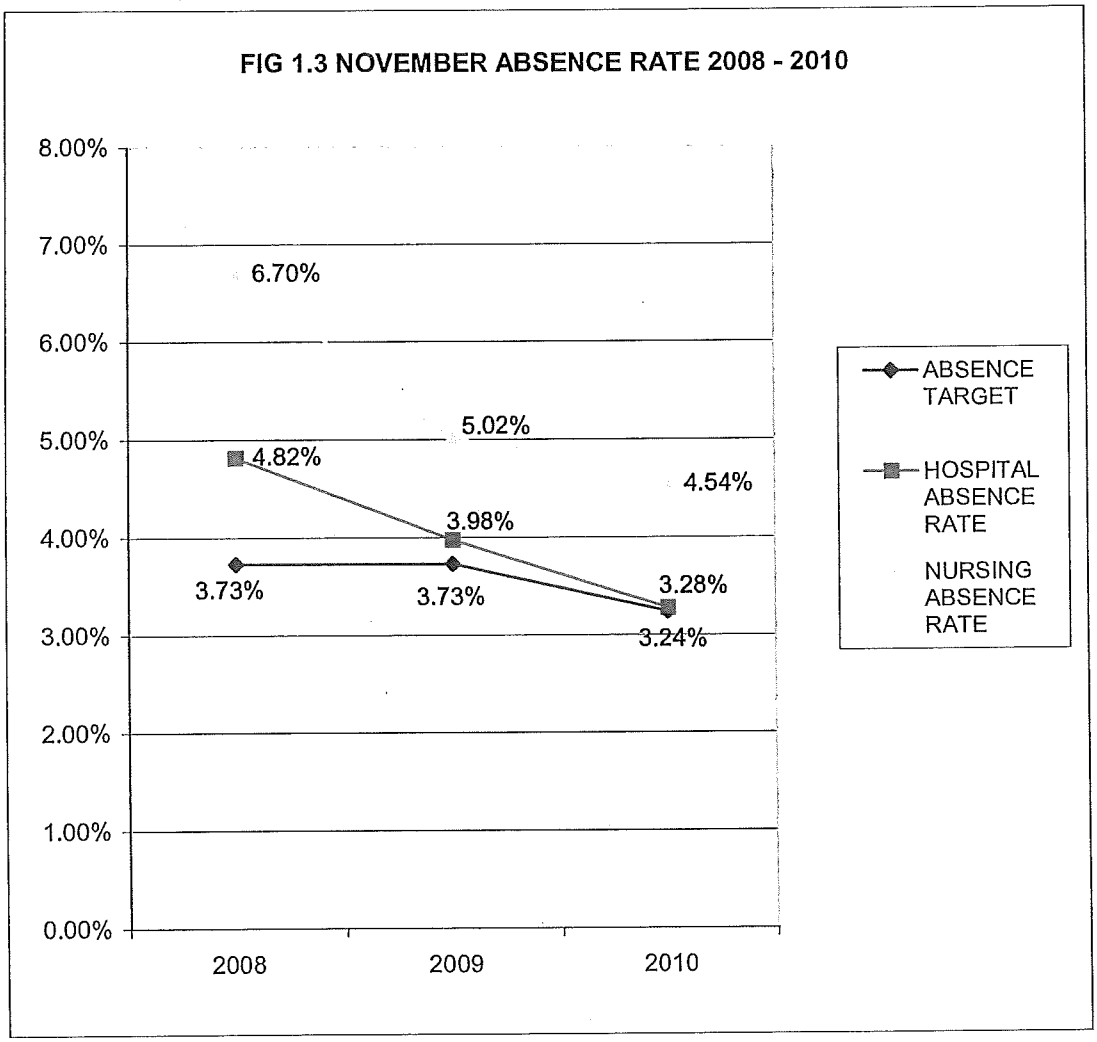


FIG 1.3 NOVEMBER ABSENCE RATE 2008 - 2010

	ABSENCE TARGET	HOSPITAL ABSENCE RATE	NURSING ABSENCE RATE
Nov-08	3.73%	4.82%	6.70%
Nov-09	3.73%	3.98%	5.02%
Nov-10	3.24%	3.28%	4.54%



Which preventative steps would you prefer your employer to offer?

Employer provide no preventative Steps	16%
Not sure	23%
Cycle to work scheme	7%
Advice on muscular & skeletal issues	8%
Training on healthy living and eating	11%
Free / Discounted Gym membership	35%

Fig 1.4 Which preventative steps would you prefer your employer to offer?

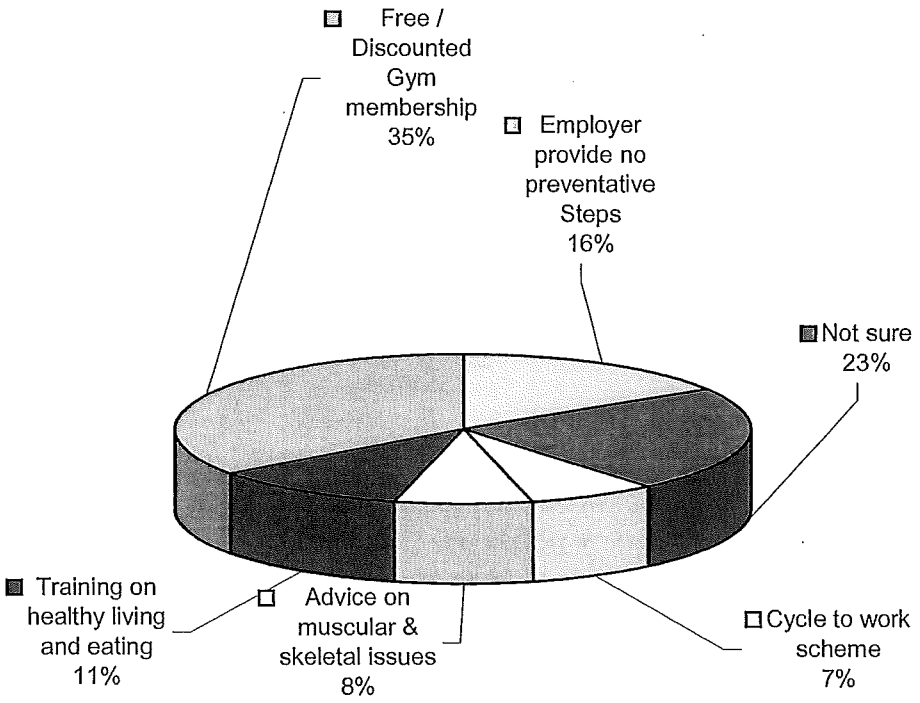


TABLE 1 - PERSONNEL ANALYSIS BY GENDER - JULY 2011

PRIVATE HOSPITAL - ANALYSIS BY GENDER REPORT - JULY 2011

	FEMALE	MALE
PRIVATE HOSPITAL GENDER POPULATION SUMMARY TOTAL	1028	611
PERCENTAGE TOTAL	**63%**	**37%**

NURSING DEPARTMENT	**FEMALE**	**MALE**
THEATRE SERVICES	102	22
CRITICAL CARE	104	7
CANCER SERVICES	61	2
MEDICAL / SURGICAL	98	4
NURSING GENERAL	124	24
SUMMARY TOTAL	489	59
PERCENTAGE TOTAL	89%	11%

Department		No. Females	%	No. Males	%	Total
1	DIAGNOSTIC IMAGING	66	89	8	11	74
02	PATHOLOGY	40	78	11	22	51
03	OPERATING THEATRE	1	25	3	75	4
4	CARDIOLOGY	28	82	6	18	34
5	PULMONARY	4	100	0	0	4
08	PHARMACY	19	95	1	5	20
09	NURSING SERVICES	93	80	23	20	116
1	PHYSIOTHERAPY	11	79	3	21	14
12	MATERIALS	0	0	8	100	8
13	H&S AND PROJECTS	1	33	2	67	3
4	CATERING	84	78	24	22	108
5	ADMINISTRATION	21	81	5	19	26
17	CONSULTANTS STAFF/INCOME CONTINUAI	82	88	11	12	93
18	DIETETICS	5	100	0	0	5
9	OTHER SERVICES	0	0	3	100	3
2	RADIOTHERAPY	22	81	5	19	27
25	MEDICAL	9	36	16	64	25
26	PERFUSION	0	0	5	100	5
7	RT PHYSICS	5	100	0	0	5
31	RT LIMERICK	20	87	3	13	23
CS	CLINICAL SERVICES	3	100	0	0	3
C	HEALTHCHECK	15	100	0	0	15
R	HUMAN RESOURCES	7	78	2	22	9
IT	INFORMATION TECH	3	33	6	67	9
OR	O.R. SERVICES	102	82	22	18	124
A	QUALITY	10	83	2	17	12
S	SUPPORT SERVICES	1	100	0	0	1
SW	SOCIAL WORKERS	2	100	0	0	2
S	TECHNICAL SERVICES	0	0	7	100	7
IN	FINANCE	27	71	11	29	38
HRT	HEART CENTRE	2	100	0	0	2
MCG	MATER CARDIOLOGY GROUP	22	92	2	8	24
NC	ONCOLOGY SERVICES	61	97	2	3	63
TH	OTHER (SECURITY)	0	0	113	100	113
POR	PORTERING	2	7	28	93	30
ERO	AEROMEDICAL CENTRE	2	100	0	0	2
CAR	CRITICAL CARE	102	94	7	6	109
NCR	CANCER CENTRE	0	0	1	100	1
CONS	CONSULTANTS (SECURITY)	14	7	187	93	201
EDS	MEDICAL/SURGICAL	96	96	4	4	100
XTG	MARKETING	2	40	3	60	5
NOON	NOONANS (SECURITY)	1	1	76	99	77
URG	GENERAL NURSING	39	98	1	3	40
Overall Totals		1024	63	611	37	1635

***** End Of Report *****

TABLE 2 - PERSONNEL ANALYSIS BY AGE - JULY 2011

PRIVATE HOSPITAL - ANALYSIS BY AGE REPORT - JULY 2011

AGE	<20	20-29	30-39	40-49	50-59	>60
NO. FEMALES / AVERAGE AGE	15 / 18.97	222 / 26.15	351 / 34.53	238 / 44.88	154 / 54.38	23 / 62.45
NO. MALES / AVERAGE AGE	7 / 19.09	52/ 24.63	70 / 35.19	59 / 43.75	32 / 54.72	4 / 63.73
NO. EMPLOYEES / AVERAGE AGE	22 /19.01	52 / 24.63	70 / 35.19	297 / 44.66	186 / 54.44	27 / 62.64

SUMMARY

HIGHEST FEMALE AGE RANGE	30 - 39
HIGHEST MALE AGE RANGE	30 - 39
HIGHEST EMPLOYEE AGE RANGE	40 - 49

Selection Criteria: Department(s) ALL; Cost Centre(s) ALL; Work Group(s) ALL

Order By Department
Report Type SUMMARY

Department 01 DIAGNOSTIC IMAGING

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	6 24.30	1 38.84	2 46.23	0 .00	0 .00	9 30.79
No.Employees/Average Age	0 .00	6 24.30	1 38.84	2 46.23	0 .00	0 .00	9 30.79

Department 01 DIAGNOSTIC IMAGING

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	1 17.94	19 26.76	29 33.93	8 44.54	9 55.68	1 64.38	67 36.30
No.Employees/Average Age	1 17.94	19 26.76	29 33.93	8 44.54	9 55.68	1 64.38	67 36.30

Department 02 PATHOLOGY

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	4 27.20	3 34.85	0 .00	3 56.69	0 .00	10 38.34
No.Employees/Average Age	0 .00	4 27.20	3 34.85	0 .00	3 56.69	0 .00	10 38.34

Department 02 PATHOLOGY

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	8 26.17	16 33.60	9 44.92	7 54.90	0 .00	40 38.39
No.Employees/Average Age	0 .00	8 26.17	16 33.60	9 44.92	7 54.90	0 .00	40 38.39

Department 03 OPERATING THEATRE

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	0 .00	0 .00	1 46.30	0 .00	0 .00	1 46.30
No.Males/Average Age	0 .00	1 24.92	0 .00	0 .00	0 .00	0 .00	1 24.92
No.Employees/Average Age	0 .00	1 24.92	0 .00	1 46.30	0 .00	0 .00	2 35.61

Department 04 CARDIOLOGY

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	2 24.72	2 35.19	2 41.98	0 .00	0 .00	6 33.96
No.Employees/Average Age	0 .00	2 24.72	2 35.19	2 41.98	0 .00	0 .00	6 33.96

PERSONNEL ANALYSIS BY AGE

Department 04 CARDIOLOGY Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	5	25.89	12	35.13	6	44.88	4	51.43	1	63.73	28	38.92
No.Employees/Average Age	0	.00	5	25.89	12	35.13	6	44.88	4	51.43	1	63.73	28	38.92

Department 05 PULMONARY Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	3	25.85	0	.00	0	.00	0	.00	1	60.12	4	34.42
No.Employees/Average Age	0	.00	3	25.85	0	.00	0	.00	0	.00	1	60.12	4	34.42

Department 08 PHARMACY Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	0	.00	1	35.19	0	.00	0	.00	0	.00	1	35.19
No.Employees/Average Age	0	.00	0	.00	1	35.19	0	.00	0	.00	0	.00	1	35.19

Department 08 PHARMACY Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	6	25.96	10	34.73	2	45.45	0	.00	1	61.11	19	34.48
No.Employees/Average Age	0	.00	6	25.96	10	34.73	2	45.45	0	.00	1	61.11	19	34.48

Department 09 NURSING SERVICES Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	4	18.64	10	23.29	8	32.99	1	40.46	0	.00	0	.00	23	26.60
No.Employees/Average Age	4	18.64	10	23.29	8	32.99	1	40.46	0	.00	0	.00	23	26.60

Department 09 NURSING SERVICES Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	9	19.11	44	24.52	19	34.29	13	43.78	7	54.84	0	.00	92	31.04
No.Employees/Average Age	9	19.11	44	24.52	19	34.29	13	43.78	7	54.84	0	.00	92	31.04

Department 11 PHYSIOTHERAPY Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	2	24.71	0	.00	0	.00	1	53.35	0	.00	3	34.26
No.Employees/Average Age	0	.00	2	24.71	0	.00	0	.00	1	53.35	0	.00	3	34.26

PERSONNEL ANALYSIS BY AGE

Department 11 PHYSIOTHERAPY Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	3 27.56	4 32.57	2 47.27	1 52.59	1 60.95	11 38.27
No.Employees/Average Age	0 .00	3 27.56	4 32.57	2 47.27	1 52.59	1 60.95	11 38.27

Department 12 MATERIALS Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	5 34.94	1 45.02	1 55.26	0 .00	7 39.28
No.Employees/Average Age	0 .00	0 .00	5 34.94	1 45.02	1 55.26	0 .00	7 39.28

Department 13 H&S AND PROJECTS Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	0 .00	1 38.98	0 .00	0 .00	0 .00	1 38.98
No.Employees/Average Age	0 .00	0 .00	1 38.98	0 .00	0 .00	0 .00	1 38.98

Department 13 H&S AND PROJECTS Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	0 .00	1 49.03	1 54.80	0 .00	2 51.92
No.Employees/Average Age	0 .00	0 .00	0 .00	1 49.03	1 54.80	0 .00	2 51.92

Department 14 CATERING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	1 19.97	9 25.80	5 34.55	6 41.60	1 54.25	1 64.39	23 34.49
No.Employees/Average Age	1 19.97	9 25.80	5 34.55	6 41.60	1 54.25	1 64.39	23 34.49

Department 14 CATERING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	21 25.31	17 36.37	26 45.19	15 54.25	5 62.72	84 41.10
No.Employees/Average Age	0 .00	21 25.31	17 36.37	26 45.19	15 54.25	5 62.72	84 41.10

Department 15 ADMINISTRATION Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	2 19.64	0 .00	0 .00	2 44.16	1 52.96	0 .00	5 36.11
No.Employees/Average Age	2 19.64	0 .00	0 .00	2 44.16	1 52.96	0 .00	5 36.11

PERSONNEL ANALYSIS BY AGE

Department 15 ADMINISTRATION Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	1 19.79	1 27.67	5 34.34	5 47.59	8 54.09	1 63.71	21 45.41
No.Employees/Average Age	1 19.79	1 27.67	5 34.34	5 47.59	8 54.09	1 63.71	21 45.41

Department 17 CONSULTANTS STAFF/INCOME CONTINUAN Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	2 33.81	1 43.51	0 .00	0 .00	3 37.04
No.Employees/Average Age	0 .00	0 .00	2 33.81	1 43.51	0 .00	0 .00	3 37.04

Department 17 CONSULTANTS STAFF/INCOME CONTINUAN Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	7 25.72	24 34.91	25 45.62	13 54.00	5 63.93	74 42.97
No.Employees/Average Age	0 .00	7 25.72	24 34.91	25 45.62	13 54.00	5 63.93	74 42.97

Department 18 DIETETICS Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	1 23.28	2 37.44	0 .00	2 52.18	0 .00	5 40.50
No.Employees/Average Age	0 .00	1 23.28	2 37.44	0 .00	2 52.18	0 .00	5 40.50

Department 22 RADIOTHERAPY Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	3 24.32	2 35.54	0 .00	0 .00	0 .00	5 28.81
No.Employees/Average Age	0 .00	3 24.32	2 35.54	0 .00	0 .00	0 .00	5 28.81

Department 22 RADIOTHERAPY Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	8 26.49	7 35.99	4 44.69	3 54.35	0 .00	22 36.62
No.Employees/Average Age	0 .00	8 26.49	7 35.99	4 44.69	3 54.35	0 .00	22 36.62

Department 25 MEDICAL Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	2 28.45	6 32.38	1 43.55	0 .00	0 .00	9 32.75
No.Employees/Average Age	0 .00	2 28.45	6 32.38	1 43.55	0 .00	0 .00	9 32.75

PERSONNEL ANALYSIS BY AGE

Department 25 MEDICAL Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	1 29.18	8 36.99	3 45.28	1 59.02	0 .00	13 40.00
No.Employees/Average Age	0 .00	1 29.18	8 36.99	3 45.28	1 59.02	0 .00	13 40.00

Department 26 PERFUSION Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	1 21.28	3 35.35	1 45.61	0 .00	0 .00	5 34.59
No.Employees/Average Age	0 .00	1 21.28	3 35.35	1 45.61	0 .00	0 .00	5 34.59

Department 27 RT PHYSICS Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	1 24.07	3 34.23	1 44.29	0 .00	0 .00	5 34.21
No.Employees/Average Age	0 .00	1 24.07	3 34.23	1 44.29	0 .00	0 .00	5 34.21

Department 31 RT LIMERICK Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	2 26.40	1 35.76	0 .00	0 .00	0 .00	3 29.52
No.Employees/Average Age	0 .00	2 26.40	1 35.76	0 .00	0 .00	0 .00	3 29.52

Department 31 RT LIMERICK Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	11 26.70	8 32.62	1 45.82	0 .00	0 .00	20 30.02
No.Employees/Average Age	0 .00	11 26.70	8 32.62	1 45.82	0 .00	0 .00	20 30.02

Department AERO AEROMEDICAL CENTRE Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	0 .00	0 .00	1 42.23	1 51.26	0 .00	2 46.75
No.Employees/Average Age	0 .00	0 .00	0 .00	1 42.23	1 51.26	0 .00	2 46.75

Department CCAR CRITICAL CARE Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	1 28.26	5 36.24	1 41.20	0 .00	0 .00	7 35.81
No.Employees/Average Age	0 .00	1 28.26	5 36.24	1 41.20	0 .00	0 .00	7 35.81

Department CCAR CRITICAL CARE

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	18	27.64	33	34.75	29	44.28	21	53.75	1	60.48	102	40.37
No.Employees/Average Age	0	.00	18	27.64	33	34.75	29	44.28	21	53.75	1	60.48	102	40.37

Department CNCR CANCER CENTRE

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	0	.00	0	.00	1	42.33	0	.00	0	.00	1	42.33
No.Employees/Average Age	0	.00	0	.00	0	.00	1	42.33	0	.00	0	.00	1	42.33

Department CONS CONSULTANTS (SECURITY)

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	0	.00	0	.00	5	44.52	3	53.74	0	.00	8	47.98
No.Employees/Average Age	0	.00	0	.00	0	.00	5	44.52	3	53.74	0	.00	8	47.98

Department CS CLINICAL SERVICES

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	0	.00	1	30.49	2	46.84	0	.00	0	.00	3	41.39
No.Employees/Average Age	0	.00	0	.00	1	30.49	2	46.84	0	.00	0	.00	3	41.39

Department FIN FINANCE

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	2	26.59	3	34.86	3	44.34	2	55.36	0	.00	10	40.15
No.Employees/Average Age	0	.00	2	26.59	3	34.86	3	44.34	2	55.36	0	.00	10	40.15

Department FIN FINANCE

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	1	19.74	6	26.94	13	33.73	3	44.07	4	55.81	0	.00	27	36.12
No.Employees/Average Age	1	19.74	6	26.94	13	33.73	3	44.07	4	55.81	0	.00	27	36.12

Department HC HEALTHCHECK

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	2	23.52	4	33.08	5	43.86	4	52.50	1	60.22	16	41.80
No.Employees/Average Age	0	.00	2	23.52	4	33.08	5	43.86	4	52.50	1	60.22	16	41.80

Department HR HUMAN RESOURCES Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	1	21.89	0	.00	1	44.42	0	.00	0	.00	2	33.16
No.Employees/Average Age	0	.00	1	21.89	0	.00	1	44.42	0	.00	0	.00	2	33.16

Department HR HUMAN RESOURCES Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	1	18.79	0	.00	4	36.03	0	.00	2	53.92	0	.00	7	38.67
No.Employees/Average Age	1	18.79	0	.00	4	36.03	0	.00	2	53.92	0	.00	7	38.67

Department HRT HEART CENTRE Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	2	21.85	0	.00	0	.00	0	.00	0	.00	2	21.85
No.Employees/Average Age	0	.00	2	21.85	0	.00	0	.00	0	.00	0	.00	2	21.85

Department IT INFORMATION TECH Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	0	.00	2	34.56	1	44.49	0	.00	0	.00	3	37.87
No.Employees/Average Age	0	.00	0	.00	2	34.56	1	44.49	0	.00	0	.00	3	37.87

Department IT INFORMATION TECH Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	0	.00	3	36.56	2	45.54	1	54.25	0	.00	6	42.50
No.Employees/Average Age	0	.00	0	.00	3	36.56	2	45.54	1	54.25	0	.00	6	42.50

Department MCG MATER CARDIOLOGY GROUP Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	1	22.68	0	.00	0	.00	0	.00	0	.00	1	22.68
No.Employees/Average Age	0	.00	1	22.68	0	.00	0	.00	0	.00	0	.00	1	22.68

Department MCG MATER CARDIOLOGY GROUP Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	1	19.21	3	26.01	9	33.64	7	45.35	1	54.06	1	64.07	22	37.98
No.Employees/Average Age	1	19.21	3	26.01	9	33.64	7	45.35	1	54.06	1	64.07	22	37.98

PERSONNEL ANALYSIS BY AGE

Department MEDS MEDICAL/SURGICAL Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	1 21.53	2 34.56	1 41.25	0 .00	0 .00	4 32.97
No.Employees/Average Age	0 .00	1 21.53	2 34.56	1 41.25	0 .00	0 .00	4 32.97

Department MEDS MEDICAL/SURGICAL Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	26 27.19	36 33.80	17 44.56	14 54.66	3 61.05	96 37.81
No.Employees/Average Age	0 .00	26 27.19	36 33.80	17 44.56	14 54.66	3 61.05	96 37.81

Department MKTG MARKETING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	0 .00	2 37.78	0 .00	0 .00	0 .00	2 37.78
No.Employees/Average Age	0 .00	0 .00	2 37.78	0 .00	0 .00	0 .00	2 37.78

Department MKTG MARKETING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	1 30.29	1 43.15	1 54.08	0 .00	3 42.51
No.Employees/Average Age	0 .00	0 .00	1 30.29	1 43.15	1 54.08	0 .00	3 42.51

Department NURG GENERAL NURSING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	0 .00	0 .00	1 50.36	0 .00	1 50.36
No.Employees/Average Age	0 .00	0 .00	0 .00	0 .00	1 50.36	0 .00	1 50.36

Department NURG GENERAL NURSING Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	2 24.30	8 34.57	18 44.78	11 56.02	0 .00	39 44.80
No.Employees/Average Age	0 .00	2 24.30	8 34.57	18 44.78	11 56.02	0 .00	39 44.80

Department ONC ONCOLOGY SERVICES Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	2 35.30	0 .00	0 .00	0 .00	2 35.30
No.Employees/Average Age	0 .00	0 .00	2 35.30	0 .00	0 .00	0 .00	2 35.30

Department ONC ONCOLOGY SERVICES

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	12 26.38	31 33.88	8 44.80	9 54.93	1 61.64	61 37.40
No.Employees/Average Age	0 .00	12 26.38	31 33.88	8 44.80	9 54.93	1 61.64	61 37.40

Department OR O.R. SERVICES

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	2 23.53	8 36.74	10 43.24	2 52.58	0 .00	22 39.93
No.Employees/Average Age	0 .00	2 23.53	8 36.74	10 43.24	2 52.58	0 .00	22 39.93

Department OR O.R. SERVICES

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	9 28.94	40 35.80	37 44.78	16 54.13	0 .00	102 41.33
No.Employees/Average Age	0 .00	9 28.94	40 35.80	37 44.78	16 54.13	0 .00	102 41.33

Department POR PORTERING

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	0 .00	0 .00	0 .00	2 57.10	0 .00	2 57.10
No.Employees/Average Age	0 .00	0 .00	0 .00	0 .00	2 57.10	0 .00	2 57.10

Department POR PORTERING

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	5 33.92	8 43.22	13 54.39	2 62.92	28 48.15
No.Employees/Average Age	0 .00	0 .00	5 33.92	8 43.22	13 54.39	2 62.92	28 48.15

Department QA QUALITY

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Males/Average Age	0 .00	0 .00	0 .00	2 40.69	0 .00	0 .00	2 40.69
No.Employees/Average Age	0 .00	0 .00	0 .00	2 40.69	0 .00	0 .00	2 40.69

Department QA QUALITY

Age Group	<20	20 - 29	30 - 39	40 - 49	50 - 59	> 60	Total
No.Females/Average Age	0 .00	1 28.61	4 34.90	4 43.91	0 .00	0 .00	9 38.21
No.Employees/Average Age	0 .00	1 28.61	4 34.90	4 43.91	0 .00	0 .00	9 38.21

Department SS SUPPORT SERVICES

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	0	.00	0	.00	0	.00	1	53.34	0	.00	1	53.34
No.Employees/Average Age	0	.00	0	.00	0	.00	0	.00	1	53.34	0	.00	1	53.34

Department SW SOCIAL WORKERS

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	0	.00	0	.00	0	.00	2	44.92	0	.00	0	.00	2	44.92
No.Employees/Average Age	0	.00	0	.00	0	.00	2	44.92	0	.00	0	.00	2	44.92

Department TS TECHNICAL SERVICES

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Males/Average Age	0	.00	2	23.36	0	.00	3	46.64	1	59.22	1	64.77	7	44.38
No.Employees/Average Age	0	.00	2	23.36	0	.00	3	46.64	1	59.22	1	64.77	7	44.38

Overall Totals

Age Group	<20		20 - 29		30 - 39		40 - 49		50 - 59		> 60		Total	
No.Females/Average Age	14	19.11	221	26.15	350	34.51	238	44.85	155	54.37	23	62.47	1001	38.63
No.Males/Average Age	7	19.11	51	24.73	70	35.22	58	43.66	33	54.60	4	63.75	223	37.89
No.Employees/Average Age	21	19.11	272	25.89	420	34.63	296	44.62	188	54.41	27	62.66	1224	38.49

*** END OF REPORT ***