FACTORS INFLUENCING ABSEBTEEISM AMONGST PROFESSIONAL NURSES IN LONDON

by

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DECLARATION

I declare that **FACTORS INFUENCING ABSENTEEISM AMONGST PROFESSIONAL NURSES IN LONDON** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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SUMMARY

This quantitative explorative, descriptive study described factors that influenced absenteeism among nurses in a selected NHS hospital in London. The survey used self-completion questionnaires. Roy's Adaptation Model was used to contextualise the results obtained from fifty completed questionnaires. Four modes used to categorise the data analysis were physiological needs, self-concept, and role function and interdependence relations. Minor ailments, upper respiratory tract infections and exhaustion as a result of working long hours were found to be the most important causes of absenteeism. Parental responsibilities and taking care of sick children/family members, further influenced rates of absenteeism, while a high workload was considered by respondents as a major contributing factor to their absence from work. Nurses who are often absent due to physical, social or psychological problems should receive counselling and be referred to appropriate resource persons such as occupational nurses, social workers or psychologists. Child care facilities should be provided within the workplace. The units should have adequate staff to cover each shift and workloads should be manageable. Units need ongoing monitoring of absenteeism so that factors contributing to absenteeism rates in specific units could be identified and addressed.

KEY TERMS

- factors
- absenteeism
- nurses
- hospital
- London

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LIST OF ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

CIPD - Chartered Institute of Personnel and Development

CAN - Canadian Nurses' Association

CNAC - Canadian Nursing Advisory Committee

CLBC - Canadian Labour and Business Centre

DoH - Department of Health

GNP - Gross National Product

HIV - Human Immunodeficiency Virus

ICN - International Council of Nurses

ILO - **International** Labour Organization

MSEXCEL - Microsoft Office Excel

NHS - National Health System

NMC - Nursing and Midwifery Council (of the UK)

RAM - Roy's Adaptation Model

RCN - Royal College of Nursing

RNs - Registered nurses

TB - Tuberculosis

UK - United Kingdom

UKCC - United Kingdom Central Council for Nursing, Midwifery and Health Visiting

USA - United States of America

UNISA - University of South Africa

VON - Victorian Order of Nurse

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Absenteeism is a major concern. Its economic impact can severely affect any organisation, threatening the sustainability of the organisation. Even when an absent employee receives no pay, overtime may occur or certain jobs may not be performed (Czakan 2005:1). Absenteeism refers to a situation when a person, who usually works 35 hours or more per week, worked less than 35 hours during the week concerned. This could be due to illness, injury or medical problems, civic or military duty and maternity or paternity leave (Harter 2001:53). Excessive absenteeism creates many problems for managers and causes work schedules to be upset and delayed. It affects other employees who are faithfully committed because they have to bear the burden of doing the task of the absent employee in addition to their own jobs. Absenteeism has serious financial implications for companies.

In the United Kingdom (UK) it was found that the rate of absenteeism increased among full-time employees. According to Harter (2001:53) the rate of absenteeism in the UK among full-time employees was 2.5% in 1998 compared to 2.4% in 1996. The number of work days lost due to absenteeism is a cause for alarm. In the UK it was found that 177 million days were lost in 1994 and this cost 11 billion UK pounds. The cost of sickness absence to the British economy has been estimated as similar to the total annual expenditure for the National Health Service (NHS) (Johnson, Croghan & Crawford 2003:338). A new report released on 30th March 2009 indicated that the NHS could save £1 billion a year through reduced rates of absenteeism. The NHS could also save £1 billion from its annual £3 billion cost of sickness absence by following the example of private firms, by helping the nurses to do more exercises and eat healthy food (Civil Service Network 2009:1).

1.2 RESEARCH PROBLEM

Research starts with a problem which is usually multifaceted. Polit and Beck (2004:731) defined a research problem as "a situation involving an enigmatic, perplexing or conflicting condition that can be investigated through disciplined inquiry". A research study begins as a question that a researcher would like to solve (Polit & Hungler 1997:43). The problem statement should identify the key study variables, their possible interrelationships and the nature of the population of interest. The researcher identified increased absenteeism among professional nurses in London hospitals to be a problem. The researcher worked in one of the hospitals where there are high rates of absenteeism among nurses. Absenteeism of professional nurses may pose serious threats to the well-being of patients and to the provision of quality health care to the British population.

1.2.1 Background to the problem

Absenteeism is non-attendance for scheduled work. Employees are absent from work for a number of reasons. A distinction is often made between white, grey and black absenteeism. In the case of white absenteeism, it is quite obvious that the employee is ill. Absenteeism is called grey if the illness is psychological or psychosomatic such as headache and tiredness. Absenteeism is called black if someone who is not ill reports him/herself as being sick. This is also known as illegal absenteeism. This black variant of absenteeism can be seen as anti-cooperative behaviour towards other employees within the team: the same amount of work has to be done by fewer employees (Sanders & Nauta 2004:726).

Factors affecting work absence can be national or regional, organisational or departmental and personal. Precarious employment characterised by instability, exposure to hazards and poor salaries can be other factors. Characteristics of employees like gender, working hours and cohesiveness contribute to absenteeism. Absenteeism may be due to work or non-work factors. Work factors are those that bring job satisfaction, such as good working conditions, non-work factors are those outside the organisation like weather. Other causes of absenteeism are: job dissatisfaction, sickness, parenting responsibilities, scheduling, sick pay benefits, occupational injuries and illness and employees' attitudes towards

absenteeism (Harter 2001:53). Occupational stress is another cause of absenteeism (Paton 2005a:1). According to Payne (1999:14) nurses working in British hospitals are overworked and underpaid. The culture of sickness absenteeism allegedly costs the government billions of pounds.

1.2.2 Problem statement

The research by NHS (National Health System) partners has calculated that stress-related workplace absence costs NHS trusts an average of 450 000 UK pounds a year. The survey of 146 NHS trusts recorded an overall absence rate of 4.9% in 2004 compared to 5.2% the previous year (Paton 2005a:1). This shows that NHS hospitals in London experience high rates of absenteeism. In another study conducted in Sweden, it was found that the mean number of absenteeism days for each registered and assistant nurse in 1975 was 22.4 days and in 1990, 51.9 days. The expected rate of absenteeism by the year 2000 was estimated at 67 to 83 days per person per year (Plati, Lanara, Katostaras & Mantas 1994:143). The health sector loses more days per worker because of illness, disability and personal or family responsibilities than any other industry in Canada. In 2008, the average full-time health-care employee was absent from work 14.9 days, compared with 7.9 days among full-time employees in the general population according to the Canadian Nurses Association (CNA 2009:1). Almost 12% of the United States of America's (USA) Gross National Product (GNP) and 10% of the UK's GNP is lost because of stress-related absenteeism (Siu 2002:18). The problem is: what are the factors that influence absenteeism amongst professional nurses in London NHS hospitals.

1.3 SIGNIFICANCE OF THE STUDY

Absenteeism among professional nurses is a major concern for employers. It is costly and results in decreased standards of care. Despite the international interest in, and research on absenteeism, much remains unknown about its determinants (Zboril-Benson 2002:89). This study will identify factors that influence absenteeism and recommend ways in which nurse managers could address the factors that contribute to absenteeism rates among professional nurses in one NHS hospital in London.

1.4 PURPOSE OF THE STUDY

The statement of the research purpose communicates more than just the nature of the problem. Through the researcher's selection of verbs, a statement of purpose suggests the manner in which he/she seeks to solve the problem, or evaluate the state of knowledge on the topic (Polit & Beck 2004:75). The purpose of the study is to identify factors influencing absenteeism amongst professional nurses in a selected NHS hospital in London and to recommend strategies to address the problem of absenteeism of nurses in that hospital.

1.4.1 Research questions

According to Fain (2004:95), a research question focuses on describing variables, examining relationships among variables and determining differences between two or more groups regarding the selected variables. Research studies do not always contain hypotheses but may instead be organised around research questions. A research question is a concise, interrogative statement written in the present tense and including one or more variables (or concepts). Research questions are used when prior knowledge of a phenomenon is limited and research seeks to identify or describe the phenomenon as in explanatory or descriptive studies or both. Cormack (2003:77) defined a research question as either an interrogative or declarative statement.

The following questions will be answered:

- What physiological factors influence absenteeism rates among professional nurses in a selected NHS hospital in London?
- Which factors related to professional nurses' self concept influence their absenteeism rates in a selected NHS hospital in London?
- How do professional nurses' role function influence their absenteeism rates in a selected NHS hospital in London?
- How do professional nurses' interdependence relations influence their absenteeism rates in a selected NHS hospital in London?

- What can be done to reduce absenteeism rates among professional nurses in a selected NHS hospital in London?

1.4.2 Research objectives

A research objective is a general statement of the purpose of the study. The statement is broken down into specific objectives to be achieved or research questions to be answered by the study (Cormack 2003:18). Some researchers specify questions which the research is designed to answer. The researcher specifies the type of research and purpose of the study by using phrases such as “to describe and to identify”. This study aimed to identify factors influencing absenteeism amongst professional nurses in a selected NHS hospital in London.

The objectives of this study were to:

- Identify and describe the physiological factors that influence nurses’ absenteeism rates in a selected NHS hospital in London.
- Identify and describe the factors related to professional nurses’ self concept which influence their absenteeism rates in a selected NHS hospital in London.
- Identify and describe how nurses’ role function influence their absenteeism rates in a selected NHS hospital in London.
- Identify and describe how professional nurses’ interdependence relations influence their absenteeism rates in a selected NHS hospital in London.
- Recommend strategies to address the problem of nurses’ absenteeism rates in a selected NHS hospital in London.

1.5 DEFINITION OF CONCEPTS

Absenteeism: It is defined as an instance when a person who usually works 35 or more hours per week worked less than 35 hours during the reference week for one of the following reasons: illness, injury, or medical problems, stress personal and social problems such as transport or financial problems (Harter 2001:53).

Adaptation: A positive response to the changing environment (Fraser 1996:44) is known as adaptation.

Adaptive level: The ability of a person to adapt in the face of change (Fraser 1996:44) can be graded into different adaptive levels.

Annexed absenteeism: The number of times of absence attached to weekends and holiday periods for a specific 12-month period (Somers 1995:53) is known as annexed absenteeism.

Environment: All circumstances, conditions or changes which challenge the person as an adaptive system (Pearson, Vaughan & Fitzgerald 1996:111).

Factor: Something that actively contributes to an accomplishment, result or process (http://en.wikipedia.org/wiki/factor).

Influence: A power affecting a person, thing or course of events, especially one that operates without any direct or apparent effort (http://en.wikipedia.org/wiki/influence).

Professional nurse: A person who has undergone training and is registered with the Nursing and Midwifery Council (NMC). In the UK professional nurses are called staff nurses. Senior staff nurses are called junior sisters and senior sisters are the ward managers.

1.6 THEORETICAL FOUNDATION OF THE STUDY

This study is based on Roy's Adaptation Model (RAM). Roy's Model maintains that a person has four subsystems, namely, physiological needs, self-concept, role function and interdependence. The professional nurse is in constant interaction with the environment. The environment has different job organisation factors that influence actions. The reactions of professional nurses will be unique in each situation (Fraser 1996:44).

1.6.1 Assumptions

Assumptions are statements or principles that are taken as truths based on a person's values and beliefs (Fain 2004:192). This study is based on the following assumptions:

- There are factors within the organisation that influence nurses' absenteeism rates.
- There are factors outside the organisation that influence nurses' absenteeism rates.

RAM can be used to contextualise aspects addressed by this study. This model sees a person as adapting in four ways, namely, physiological, self-concept, role function and interdependence. All the modes are interrelated, therefore change will create the need for adaptation in more than one mode. Internal or external environmental changes create needs that require an individual to make an internal and/or external response; seen as behaviour which is activated in order to reduce the need (Fraser 1996:45).

1.6.2 Theoretical framework

Theory is defined as an integrated set of defined concepts and statements that present a view of a phenomenon and can be used to describe, explain, predict, and/or control that phenomenon. Theories are abstract rather than concrete. Abstract ideas focus on more general things while concrete ideas are concerned with realities or actual instances; they are particular rather than general (Burns & Grove 1999:129). A framework is a brief explanation of a theory or those portions of a theory that will be tested in a study. Every study has a framework. Research is almost always concerned with abstract rather than tangible phenomena, for example, good health, pain, emotional disturbance, patient care and grieving (Polit & Hungler 1997:32). An individual constantly interacts with the environment and this determines the adaptive level of the individual (Chin & Kramer 1995:45). The adaptive level is a constantly changing point made up of focal, contextual and residual stimuli which represent the person's own standard of the range within which one can respond to stimuli with ordinary adaptive responses (Marriner-Tomey & Alligood 1998:245). RAM identifies that the person has four subsystems, namely, physiological needs, self-concept, role function and interdependence relations. The professional nurse is in constant interaction with the environment. The environment has different job

organisation factors that influence actions. The reactions of professional nurses will be unique in each situation.

1.6.2.1 The person (physiological needs)

RAM is addressing and incorporating a humanistic and holistic view of a person. The model views an individual as a whole system, responding or adapting to changes or stimuli. These stimuli are within the individual or in the surrounding environment (Pearson et al 1996:110). The nature of the person includes biological (such as physiological), psychological and social components (Sims, Price & Ervin 2000:30). The professional nurse confronts physical, social and psychological changes in the environment and is continually interacting with these. Daily experiences such as weather and traffic conditions support this constant interaction. To cope with the world's changes, the person uses both innate and acquired mechanisms. In order to maintain homeostasis or integrity, people must respond or adapt to any changes that occur, either from internal or external factors which are categorised into three groups, namely, focal, contextual and residual. Focal factors are those things which immediately affect the individual, like bereavement. Contextual factors are all stimuli present at the time, which may influence a negative response to the focal stimuli, such as social isolation. Residual factors are beliefs, attitudes and traits of an individual, developed from the past but affecting the current response (Pearson et al 1996:110). Roy explains physiological factors as exercise and rest, elimination, fluid and electrolytes, oxygen circulation, temperature regulation, the senses and the endocrine system (Fraser 1996:44).

According to a report in 2002 prepared for the Canadian Nursing Advisory Committee (CNAC) by the Canadian Labour and Business Centre (CLBC) an estimated 13 700 (7.4%) of publicly employed nurses were absent each week due to illness or injury CNAC report 2002:3). Lost hours due to illness and injury were estimated to 311 364 hours per week (22.7 hours per absent nurse). Nurses' working conditions are surrounded by physical and chemical risks that contribute to a high incidence of absenteeism (Barboza & Soler 2003:177). An organisation should meet all those needs in the working situation to have satisfied employees. Workloads should be shared equally among nurses to allow them sufficient time to rest. Time for breaks should be allocated to allow rest. Well conditioned

and ventilated ward environments to suit the weather could help to reduce nurses' stress levels. These will make the nurse happy and enable her to look forward to the next day's work. Unfavourable conditions will make nurses respond negatively to the environment and contribute to increased rates of absenteeism.

1.6.2.2 Self-concept

Self-concept consists of feelings and beliefs that permit an individual to know who he/she is and feeling that the self is adequate to meet its needs and desires (Pearson et el 1996:114). The person consists of two aspects, namely the personal self and the physical self. The personal self is the moral-ethical self, self-consistency ideal and self-esteem. Self-concept is determined by interactions with others. The behaviours of others at group level influence the individual to react in a certain way. According to Roy (Aggleton & Chalmers 2000:79) each system strives for stability within itself, in its relationships with other systems and within the broader environment. Nurses have to strive for physiological balance and homeostasis. Health and illness comprise one inevitable dimension of a person's life (Sims et al 2000:305). The professional nurses are in constant interactions with organisational rules and regulations which affect them differently. In order to adapt to the changing environment, a healthy body and mind are necessary. Stress at the workplace should not be unmanageable. The main causes of stress-related absence were workload, management style/relationships at work, organisational changes and pressure to meet targets. Professional nurses might be absent from work due to stress at work (Absence 2004:1).

1.6.2.3 Role function

Roy describes role as the title given to the individual, as well as the behaviour that society expects an individual to perform in order to maintain the title, for example, mother, son, student, carpenter (Pearson et al 1996:114). Role function is the performance of duties based on a given position within the society. Delegation of duties to professional nurses should be done according to their levels of skill, qualifications and experience (Sims et al 2000:31). The steps of the nursing process can be applied to assess needs, set goals, plan, implement and evaluate the skills and capabilities of professional nurses (Chin &

Kramer 1995:83). Assessing the behaviours that manifested from the adaptive mode of an individual, creating a nursing diagnosis of the person's adaptive state, setting goals to improve adaptation of the individual, implementing interventions to achieve the set goals and evaluating if the goals have been met. Using the nursing process to assess their skills, qualifications and experience could enhance the correct placement of nurses. These could boost their self-esteem and encourage them to come to work. If professional nurses feel incompetent in their organisation they might decide to stay away from work more often than professional nurses who feel more competent in coping with their jobs' demands.

1.6.2.4 Interdependence relations

This is the fine balance between dependence on others and independence. Dependence is demonstrated by a need for affiliation with others for their support and approval. Independence is demonstrated by the ability to achieve, to make decisions and to initiate actions by oneself. This involves ways of seeking help, attention and affection. In relationships with others, the person adapts (Sims et al 2000:31). The behaviour of an individual is related to the behaviour of others at group level. Professional nurses work together as a team. Teams have different characteristics and relationships. According to Sanders and Nauta (2004:726), studies were conducted on the relationships between characteristics of teams and rates of absenteeism. The results of this research showed that members of strong cohesive working groups experienced leaving their colleagues alone as being highly undesirable and they avoided being absent from work. Absenteeism is regarded as being anti-co-operative behaviour towards one's colleagues. Cohesiveness comes from interpersonal attraction indicating how far employees are committed to the goal of the group, to what extent the group is able to influence its members, and to what degree individuals identify themselves with the team (Sanders & Nauta 2004:726).

Nurses working within teams depend on each other for getting their jobs done within specific periods of time. Work ethics of nurses in a group constitute an important social stimulus for creating and maintaining any in-group. If one professional nurse is not satisfied with the organisational practices, rules, regulations, policies and/or conditions of service these dissatisfactions might eventually affect other professional nurses.

Organisational commitment can be defined in terms of a behavioural or attitudinal framework. A behavioural commitment is characterised by a willingness to remain part of the organisation and to comply with organisational rules. An attitudinal framework defines commitment as a state in which an individual identifies with an organisation and its goals and wishes to incorporate these values and goals into his or her personal identity (Gayle & Dahlke 1996:30). A lack of job satisfaction might influence professional nurses' rates of absenteeism.

1.6.2.5 Application of Roy's Adaptation Model to factors influencing professional nurses' rates of absenteeism

RAM emphasises one process of adaptation of the individual to the environment. The model enhances a client-centred nursing approach supporting the idea of professional accountability for nursing as a scientific, service-oriented discipline. It also points out that the beliefs on which this model is based may not be scientifically proven but are generally accepted as being true (Pearson et al 1996:110). The researcher will base the research project on the perception that a professional nurse is a unique bio psychosocial being. The literature review will focus on the four sub-systems, namely, physiological needs, self-concept, role function and interdependence relations.

1.6.2.6 Interpretation of Roy's Adaptation Model

The central idea within RAM is that people strive for equilibrium, or stability, within and between three systems (biological, psychological and social) and within the broader environment. Experienced nurses are likely to be attracted to this idea because people in the health care situations frequently demonstrate the human capacity to adapt to significant physical and personal change (Aggleton & Chalmers 2000:86). Roy sees a human being's adaptive system as receiving stimuli from the environment inside and outside the zone of adaptation. Roy's Adaptation Model provides mechanisms for coping with environmental stimuli and changes (Polit & Hungler 1999:114). Professional nurses need to adapt to the organisation's conditions of service as well as to the environment outside the organisation (Sims et al 2000:32). The inside environment comprises the rules, regulations, policies, practices and the structure of the organisation. The outside

environment includes aspects such as weather, infrastructure, social conditions such as child care and physical well-being.

1.7 RESEARCH METHODOLOGY

A quantitative research approach will be used to conduct this study. Quantitative research uses a controlled design to obtain quantified data (Polit & Hungler 1999:712). This study attempts to quantify factors influencing nurses' rates of absenteeism in a selected NHS hospital in London.

1.7.1 Research design

A research design is an overall plan for conducting the study in order to answer the research questions. The research design spells out the basic strategies that the researcher adopts to develop information that is accurate and interpretable (Polit & Hungler 1999:155). The research design is described as a blueprint for conducting a study; maximising control over factors that could interfere with the validity of the findings; guiding the planning and implementation of a study in a way that is most likely to achieve the intended goal (Burns & Grove 1999:477). This study will use a quantitative descriptive design to identify and describe factors that influence nursing absenteeism in selected hospitals in London. This design supports the collection of numerical data by using a structured self-report instrument, and statistical data analyses (Polit & Hungler 1999:466).

1.7.2 Research method

Descriptive research can be used to determine the frequency with which a particular variable occurs (Cormack 2003:168). A quantitative design is structured so that measurement and testing are prominent characteristics (Fain 2004:193). This study will use self administered questionnaires as a data collection instrument (Cormack 2003:165). From a quantitative point of view, the world is seen as stable and predictable and the researcher believes that the "truth" is absolute and there is one single reality that can be defined by one careful measurement. To discover reality, quantitative research systematically reduces or breaks down complex information or situations into the simpler

component parts in order to gain a better understanding of the whole (Cormack 2003:166). The quantitative researcher objectively distinguishes himself/herself from the subjects of investigation, believing that boundaries must exist between them in order to ensure objectivity. The researchers achieve this by remaining detached from the study and endeavouring to avoid influencing the study with their own perceptions and/or values (Cormack 2003:167). This is to avoid being biased. The researcher wished to study the factors influencing absenteeism among professional nurses at one NHS hospital in London.

1.7.3 Population

Cormack (2003:23) refers to the population as the class of cases to which the researcher wishes to generalise the research. All nurses employed by one selected NHS hospital in London during the time of data collection comprised the population for this study. The participants had to be professional nurses willing to participate in the research.

1.7.4 Sampling

A sample is a proportion of the defined population selected to participate in the study and intended to reflect all the characteristics of that population. The researcher will utilise purposive or judgemental sampling as a design for the study. This is non-probability sampling in which the researcher selects certain cases in the study. In this study professional nurses in a selected hospital were requested to participate in the study. A convenient sample of nurses who were at work on the days that the questionnaires were distributed was chosen. The Trust consists of four hospitals. One hospital within the Trust was selected. Professional nurses who worked in the selected hospital comprised the accessible population.

1.7.5 Data collection approach

Quantitative research uses a systematic process of gathering information and using numerical data to obtain information about the focus of interest. Quantitative data collection methods include the use of instruments. An instrument may be a piece of

equipment, structured interview or paper and pencil test. The data gathering instrument used in this study was a questionnaire designed to elicit information through the nurses' written responses. Although structured to the extent that each respondent faced exactly the same questions in the same order, the degree of structure of individual items within the questionnaire ranged from open-ended questions to closed-ended (fixed alternative) questions (Fain 2004:144). Questionnaires in this study contained both closed and open ended items. Questionnaires were delivered by the researcher to all professional nurses working in one participating NHS hospital in London. Stamped addressed envelopes to return the completed questionnaires were included.

1.7.6 Data analysis

The amount of data collected might be large or small depending on the purpose of the study. Numerical information on a number of variables was collected. This numerical information formed the data set for analysis. One main purpose of descriptive analysis is to summarise the data, extracting the salient points from the results, rather than presenting every reference to every item (Cormack 2003:367).

1.8 RELIABILITY AND VALIDITY

Fain (2004:128) explains reliability as indicating the consistency with which an instrument or test measures whatever it is supposed to measure. The more reliable a test or instrument the more a researcher can rely on those scores that would be obtained if the test had been re-administered. A number of reliability tests have been devised to determine consistency with which questionnaires collect data. The best-known reliability tests include test-retest, alternate-form and split-half (Parahoo 1997:273). Careful design of the questionnaire is essential for the collection of good quality data. Crookes and Davies (2004:98) emphasise that constructing a reliable and valid questionnaire to collect high-quality data is a subtle and sophisticated art. Validity is the accuracy with which an instrument or test measures what it is supposed to measure. Content validity is the extent to which an instrument or test measures an intended content area. It is used in the development of a questionnaire, interview schedule, interview guide or instrument. The researcher and the nursing colleagues as well as the supervisors of this study validated

whether the content of each question was appropriate to its intended purpose before distributing questionnaires (Cormack 2003:31). Both the validity and reliability of the questionnaire will be further discussed in Chapter 3.

1.9 ETHICAL CONSIDERATIONS

Researchers are bound by the professional codes provided for conducting of research in general. Intellectual honesty and integrity are required at each level of enquiry (Cormack 2003:53). The study should contribute to further knowledge of the researcher. The researcher should recognise the personal limitations at every level. Honesty is part of the requirements for personal integrity and accuracy. The researcher should be trustworthy. Honesty in reporting findings which do not support the researcher's research questions is important. Researchers are scientifically accountable to their peers for the advancement of theory and methods (Cormack 2003:53).

1.9.1 Responsibility to participants

Informed consent should be obtained from respondents. Each respondent had the right to decline to participate or to withdraw at any time and to refuse to respond to specific items. The researcher should maintain the respondent's anonymity. A prepaid envelope accompanied each questionnaire. The respondents were not expected to write their names on completed questionnaires. The research data collected would not be shared with anyone unless the researcher has been given explicit permission to share the information.

1.9.2 Permission to conduct the study

Permission to conduct the study was sought from the local Research Ethics Committee within the Trust (see Annexure B). This committee exists for the scrutiny of proposed research projects and for protection of participants' rights and interests. The head nurse (UK matron) of the hospital chosen for the study and training facilitator were informed about the study and nurses were requested to complete the questionnaires for the study. No disruption of hospital services was caused by the researcher during the data collection

phase. Permission was obtained from the Research and Ethics Committee, Department of Health Studies, University of South Africa (UNISA) (see Annexure C).

1.9.3 Responsibility to the institution

No harm was done to respondents or non-respondents as the survey only required nurses to complete questionnaires. The participating institution would receive a copy of the completed research report (Cormack 2003:59).

1.10 LIMITATIONS OF THE STUDY

The study's limitations include that results might not be generalisable beyond the participating hospital because of sample deficiency and design problems. A quantitative study approach yields useful but limited data and provides only a partial view of the phenomenon it investigates (Parahoo 1997:58). Limitations encountered during this study will be specified in more detail in Chapter 5.

1.11 OUTLINE OF THE STUDY

Chapter 1 introduced the study and discussed the research problem, significance of the study, purpose and objectives, defined key concepts, addressed the theoretical foundation, research design and method, reliability and validity, ethical considerations and limitations of the study.

Chapter 2 reviews literature relevant to the research topic, namely factors influencing absenteeism among professional nurses.

Chapter 3 presents the research methodology adopted to study absenteeism among professional nurses in a selected hospital in London.

Chapter 4 presents the analysis and discussion of the data collected.

Chapter 5 presents the conclusions of the study, identifies limitations which could influence the generalisability of the research results and provides recommendations to address the problem of absenteeism among professional nurses in London.

1.12 Summary

This chapter presented an orientation to the study. The purpose of the study, research questions and objectives were explained. Relevant concepts were defined and the structure of the dissertation was outlined. Chapter 2 presents the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the literature reviewed about factors influencing nurses' absenteeism rates. According to Fain (2004:50), a literature review involves identification and analysis of relevant publications that contain information pertaining to the research problem. The literature review serves several important functions that make it worth the time and effort. Cormack (2003:22) describes the literature search as a critical review of previous literature relating to a research topic, the aim of which is to prepare the ground for new research. It provides the researcher and the reader with knowledge of the field being researched and contextualises the research problem being considered. The literature review may identify gaps in the previous literature that the new research can address, or may suggest research to be replicated.

Several sources of literature are available to help the researcher conduct a literature review. These sources are divided into two categories: primary and secondary sources. A primary source is written by the person(s) who developed the theory or conducted the research. A secondary source is a brief description of a study, written by the person(s) other than the original researcher. A literature review occurs in three stages, namely, searching, reading and writing the literature review. The literature search was conducted by an electronic literature search, that is, accessing huge bibliographic files on computer-electronic data bases. The following keywords were provided: nurses' absenteeism rates, job satisfaction, shortage of nurses, nurses' conditions of service, burnout among and turnover of nurses. Books and articles were scanned electronically using online catalogue systems. Several libraries were visited in search of literature on nurses' absenteeism rates.

Libraries visited were:

- Charing Cross Hospital library (Imperial College of Nursing).

- Royal College of Nursing (RCN) library in Central London.
- University of South Africa (UNISA) library in Pretoria.
- University of South Africa (UNISA) library in Polokwane.

The following search engines were utilised:
- Athens – Charing Cross Hospital login.
- www.askjeeves.com
- www.google.com
- www.rcn.org.uk
- www.unisa.ac.za

2.2 PURPOSE OF THE LITERATURE REVIEW

Literature reviews can serve a number of important functions in the research process. It can serve as an important function for nurses seeking to develop evidence-based practice (Polit & Beck 2004:89). A literature review provides an orientation as to what is known and not known about an area of inquiry, to ascertain what type of research can best make a further contribution to the existing base of evidence about the topic being investigated. Fain (2004:51) states that the literature review determines what is known and what is not known about a subject, concept, or problem.

The purpose of the literature review in this study was to obtain information on factors influencing nurses' absenteeism rates. This would assist the researcher to better understand the topic, ascertain pre-knowledge in relation to the research problem and identify some potential solutions. The researcher should discover what remains to be done in the field of study and what could be replicated (Polit & Hungler 1999:79-80). The literature review in this study revealed that considerable research had been done on nursing absenteeism but a limited number focussed on London NHS hospitals. Factors influencing nurses' absenteeism rates will be discussed in connection with the person (physiological needs), self-concept, role function and interdependence relations. Finally, steps will be suggested to reduce rates of absenteeism among professional nurses, based on the retrieved literature.

2.3 ROY'S ADAPTATION MODEL (RAM)

The literature review will be discussed according to the research questions that guided this study, namely:

What physiological factors influence absenteeism rates among professional nurses in a selected NHS hospital in London?

Which factors related to professional nurses' self concept influence absenteeism among professional nurses in a selected NHS hospital in London?

How do professional nurses' role function influence their absenteeism rates in a selected NHS hospital in London?

How do professional nurses' interdependence relations influence their absenteeism rates in a selected NHS hospital in London?

What can be done to reduce absenteeism rates among professional nurses in a selected NHS hospital in London?

RAM is addressing and incorporating a humanistic and holistic view of a person. This model views an individual as a whole system, responding to or adapting to changes or stimuli. These stimuli are within the individual or in the surrounding environment (Pearson et al 1996:110). The nature of the person includes biological, psychological and social components (Sims et al 2000:30).

2.3.1 Physiological factors that influence nurses' absenteeism rates

RAM views an individual as a whole system, responding or adapting to changes in the environment. These changes are within the individual or in the surrounding environment (Pearson et al 1996:110). Roy explains physiological factors that influence individual well-being such as exercise and rest, nutrition, elimination, fluid and electrolytes, oxygen,

circulation, temperature regulation, the senses and the endocrine system (Pearson et al 1996:114).

2.3.1.1 Work-related illnesses

Johnson et al (2003:337) state that the NHS is the largest employer in Europe and nurses, midwives and health visitors are the largest professional group within the NHS. The average days lost because of work-related illness in the nursing profession is one of the highest for any occupational group. Absence attributed to sickness cannot be wholly eradicated because of the inevitability of disease and ill-health.

In a report prepared for the Canadian Nursing Advisory Committee (CNAC) by the Canadian Labour and Business Centre (CLBC) in 2002, it was estimated that 13 700 (7.4%) of all publicly employed nurses were absent each week due to illness or injury. The rate of absence due to illness and injury is the highest among registered nurses (RNs) age 55 and over. RNs working full-time have a rate of absence due to illness and injury, that is, 80% higher than the rate found among the overall labour force in Canada (CNAC report 2002:3). Some nurses are nearing retirement which could cause greater shortages leading to the remaining staff being overworked. The ongoing shortage of nurses and the lack of auxiliary staff, like porters and housekeepers, necessitate nurses to undertake these non-nursing tasks which might lead to increased injuries. It was also observed that many nurses did not report for work on the day succeeding the completion of night duty due to exhaustion (Gupta 2000:2).

According to Zboril-Benson (2002:33) the major causes of absenteeism that were identified included minor ailments and fatigue related to work overload. Higher rates of absenteeism were associated with longer shifts, working in acute care situations and working full-time.

According to Dale (2006:1), Judith Shamian, the chief executive officer of the Victorian Order of Nurses (VON) in Canada, maintained that nurses had the highest absenteeism rates of all health care professionals. The pressure, stress and demands of their jobs contribute to missing working days due to illness and injury. Absenteeism costs extra money to cover these shifts by paying nurses to work overtime. However nurses pick up

this burden and become overworked and fatigued leading to increased incidents of sickness or accidents. Registered nurses are more likely to work paid than unpaid overtime. In Canada the number of nurses working overtime increased by 58.0% between 1997 and 2005 (Canadian Nurses Association 2006:1).

In the recent study conducted by the Canadian Nurses association it was found that the aggregate annual hours lost to illness- and injury-related absenteeism appear to have increased steadily over the period 1987 to 2002. The rate of absenteeism among full-time nurses was approximately 50.0% higher than the absenteeism rates among part-time nurses (Canadian Nurses Association 2006:1).

According to Belem and Gaidzinski (1998:697), the absence of nurses jeopardises the work organisation causing overload on the remaining nurses and reducing the quality of care rendered to patients. Absence could be categorised as being unforeseen or foreseen. Unforeseen absence like illness and injury were causing the nurses at work to be overloaded as they were performing their jobs and those of their absent colleagues. On the contrary, foreseen absences such as absence due to planned operations, days of study leave or months of maternity leave enable the employers to make timely alternative arrangements.

Northern Ireland experiences the longest waiting lists for planned surgery in Western Europe due to the shortage of nurses. An average of 1 933 health service staff were absent on sick leave each day in 2003 in Northern Ireland. The increasing stresses on nurses working day after day, night after night may be leading to greater levels of sick leave. Almost 40% of operating theatres in Northern Ireland's hospitals are not utilised, indicating that the UK's health service is under stress due to shortages of nurses (RCN 2003d:1).

In the United Kingdom (UK), 177 million days were lost in 1994 due to sickness absence, and this has been calculated to be £11 billion in that year. The cost of sickness absence to the British economy has been estimated as similar to the total annual expenditure for the NHS. It is estimated that sickness among nurses in England cost £90.9 million per year and £714 million per year when all NHS costs are considered. Nurses' withdrawal

behaviour (absenteeism and turnover) are costly and destabilising in terms of patient care and undermine nurses' morale (Johnson et al 2003:338). Between 2004 and 2008 sickness rates among NHS staff have stabilised at 5.3% - 5.4% saving £6 million per year (BBC news:2009).

2.3.1.2 International recruitment of nurses

The Royal College of Nursing (RCN) points out that 70% of NHS nurses in the UK said their Trust is struggling with deficits. Patient services are poor because of vacant nursing posts and job losses. Some of the nursing posts are frozen and wards are closed in some hospitals. Patients' treatments are delayed, and waiting lists are long in order to save money. The government tries to recruit more nurses from all over the world to double the number of nurses coming into the profession, but nurse shortages in the UK remain high. Due to ongoing shortages, UK nurses are overworked and stressed (RCN 2003e, 2004, 2005a & 2006b).

Northern Ireland has many internationally recruited nurses. Overseas nurses make great contributions to the delivery of the health care. Without them Northern Ireland's health services would be severely under-staffed. Nurses and doctors sell their expertise internationally to those countries that can afford to pay them the best salaries. The UK and Ireland need to increase their efforts to recruit and retain both their own nurses and those who had been recruited from overseas countries. There are many vacant posts which need to be filled, failing which would aggravate severe shortages (RCN 2003a & 2006c).

Wales and Scotland are also experiencing shortages of nurses. Between 2000 and 2001 the number of nursing vacancies in Wales increased by 2%. Wales recruited nurses from overseas countries. One third of the nurses in Wales considered leaving the profession and did not anticipate staying in the profession until their retirement ages due to inadequate support and resources for carrying out their duties. Forty percent of nurses had repeatedly suffered violence and assaults on duty. Scotland had a shortfall of 3 000 nurses in 2005. Urgent actions are needed to recruit more nurses from all over the world to work in the UK. Nurses who are overworked and demoralised, stay away from work

(RCN 2002b, 2005b, 2006a). The recruitment of foreign nurses to work in the UK might not solve the shortage of nurses. Factors influencing nurses' absenteeism rates in the UK must also be addressed to enhance the quality of nursing care rendered to UK patients.

2.3.1.3 Gender

Gupta (2000:1) pointed out that female workers have higher absenteeism rates than males. However, research appears to be inconclusive regarding the effect of gender on absenteeism. Absenteeism was reported to be high among males aged 18-25 years but was lower in the age group 40-65. Unmarried females and males had lower rates of absenteeism than married employees.

Some research reports show that men have higher absenteeism rates than women, whereas others indicate that women have higher absenteeism rates than men (Sanders & Nauta 2004:725).

A survey on sick leave in NHS hospitals in Britain revealed that nurses who had worked for a long time for the NHS were more likely to report sick, and women had higher sickness absenteeism than men (Guardian 2009:2).

2.3.1.4 Exhaustion

Various studies (Zboril-Benson 2002:33, Trinkoff, Storr & Lipscomb 2001:355; Barboza & Soler 2003:177) found that biological factors influenced absenteeism rates amongst nurses. It was also observed that many nurses did not report for work on the day succeeding the completion of night duty due to exhaustion (Gupta 2000:2).

Trinkoff et al (2001:355) conducted a study to determine the influence of physically demanding work and inadequate sleep and the use of pain medication on absenteeism amongst registered nurses. They found a relationship between inadequate sleep, using pain medication and absenteeism rates. Interventions to promote nurses' health should limit the physical demands of their work.

In their study on the effect of job strain, hospital organisational factors and individual characteristics on work-related disabilities among nurses in the Mount Sinai hospital in the USA Bruce, Sale, Shamain, O'Brien-Pallas and Thompson (2002:12), found that almost half of the nurses were absent from work due to illness at least once during the preceding three months. High levels of emotional exhaustion were experienced by more than a third of nurses surveyed. A substantial number of nurses reported experiencing musculoskeletal pain such as back pain and neck pain.

The International Labour Organisation (ILO) (2000:1) associates the nursing role with multiple and conflicting demands imposed by nurse supervisors and managers, goal-oriented demands of 'getting the patient better', providing emotional support and relieving patient stress and medical and administrative staff putting pressure on nurses demanding information regarding patients. These demands lead to work overload and possible role conflict.

Physiological problems related to acute sicknesses such as common colds and fever and chronic illnesses like cancer and TB were some of the factors that prevented employees from reporting for duty (Gupta 2000:2). In the Altnagelvin Area Hospital in Northern Ireland, approximately 1 400 patients were diagnosed with tuberculosis (TB) contracted from nurses that had TB. Nurses who contracted communicable diseases such as TB should not come to work for fear of spreading the disease to both patients and colleagues (RCN 2003c).

According to Barboza and Soler (2003:177) nurses' working conditions are surrounded by physical and chemical risks that contribute to absenteeism as well as to sick leave days. Better work environments, as well as the improvement of professionals' work conditions, should be provided to nurses.

Nurses are exposed to factors such as illnesses, infectious diseases, injuries at work, lack of rest and inadequate sleep due to long shifts that contribute to their absenteeism rates at work. Most hospitals in the UK face shortages of nurses which result in nurses working overtime. These long shifts bring about exhaustion, fatigue and nurses being overworked. Inadequate support and lack of resources to carry out duties are other factors. Some

research reports show that gender and marital status contribute to absenteeism rates. Females are more likely to be absent from work for reasons other than illness or injuries in order to fulfil family responsibilities such as caring for sick family members. The higher rates of absenteeism for married nurses could also be due to greater family responsibilities and household chores (Isah, Omorogbe, Orji and Oyovwe 2008:12).

2.3.2 Professional nurses' self concept influencing absenteeism

Self-concept consists of feelings and beliefs that permit an individual to know who he/she is and feeling that the self is adequate in meeting needs and desires (Pearson et el 1996:114). The person consists of two aspects, namely the personal self and the physical self. The personal self is the moral-ethical self, self-consistency ideal and self-esteem. Self-concept is determined by interactions with others. The behaviours of others at group level influence the individual to react in a certain way. Nurses have to strive for physiological balance and homeostasis (Aggleton & Chalmers 2000:79).

2.3.2.1 Alcohol and drug abuse

Narcotic use and diversion among nurses is a growing problem. Diversion is used as a coping mechanism. Engaging in enjoyable activities can temporarily distract attention from problems, provide pleasure, and restore energy for more creative problem solving ventures. In 1984 the American Nurses Association (ANA) publicly recognised the problem of narcotic use among nurses. Substance abuse among nurses reportedly ranged from 2.0% to 18.0% in the USA. Narcotics bring about chemical impairment in the area of job performance and increased rates of absenteeism due to tardiness and there is use of sick time with vague excuses (Hrobak 2006:1-2).

According to Werch (2002:1), alcohol interacts with the biological, psychological, and environmental well-being of an individual. Alcohol use has health and social consequences for those who drink, for those around them, and for the nation as a whole. Nurses who abuse alcohol are a danger to both patients and other nurses. They tend to be violent to patients and other nurses, productivity is low, and absenteeism rates are high.

Eckersley and Williams (1999:2) pointed out that nurses who abuse alcohol and drugs are more likely to be involved in workplace accidents, causing injuries to themselves or to patients. A significant relationship between day-to-day alcohol use and absenteeism was found. This particular problem of absenteeism usually occurs the day after a nurse has been involved in drinking alcohol, but there are no specific days in a week.

2.3.2.2 Age

Siu (2002:1) conducted a study on predictors of absenteeism and the result was found to be age, involvement (the degree of commitment displayed towards employees by the organisation), psychological stress and job satisfaction. Absenteeism may be influenced by gender, work-team spirit and organisational climate. Across the European Union there is a trend of increasing absenteeism and early retirement due to mental health problems, particularly stress and depression (McDaid, Curran & Knapp 2005:365).

2.3.2.3 Management

According to Redundancy (2003:4), the biggest single influence on absence levels is management action. However, where nurses feel more insecure, this can also have an effect. Job insecurity can undermine morale and commitment and so push up rates of absenteeism (Redundancy 2003:4).

The main causes of stress-related absence in the UK were workload, management style or relationships at work, organisational changes, and pressure to meet targets (Absence 2004:1).

According to Siu (2002:3) support from supervisors and colleagues at work reduces absenteeism. Changing the psychosocial environment at work could be a way of reducing sick leave. As far as nurses are concerned, it is reported that poor morale was one of the main stressors leading to greater self-reported sickness-absence. Nurse managers could alter the psychosocial environment at work and cultivate an organisational climate supporting nurses and facilitating effective communication. Such positive climates could help to reduce nurses' absent days. The other factor, namely, the organisational trait is

seen as shaping the interaction between the worker and the organisation. The degree of commitment displayed towards employees by the organisation and the degree of flexibility which is frequently used in an organisation or shown by the co-workers and supervisors, both relate to issues of care and support previously been shown to be important in relation to nurses' stress levels.

Supervisory styles, and even slight deviations from set standards could lead to frustration of nurses and they might refrain from work during the duty hours of such a specific supervisor, increasing absenteeism rates (Gupta 2000:2).

Nurses are under a lot of psychological stress at work and job insecurity adds to the level of stress experienced. Management style which does not create a positive work climate causes nurses' morale to be low. Some nurses use narcotics, alcohol and drugs as diversion mechanisms to cope with the stressful situations faced.

The Chartered Institute of Personnel and Development (CIPD) in the UK conducted a survey in December 2002 which showed that public sector employees (NHS and local government employees) were more stressed than their private sector counterparts. Reportedly NHS employees and local government employees found their work either stressful or very stressful, compared with all other employees (Redundancy 2003:1).

2.3.2.4 Shift patterns

The International Council of Nurses (ICN) in their Position Statement (ICN 2000:1), maintains that nurses as shift workers require to adapt physically, emotionally and socially to these employment patterns. The stress of shift work is known to increase levels of absenteeism. Rotating shifts have been associated with more sleep disturbances, digestive problems, fatigue and alcohol intake, along with psychological problems and decreased work performance. Nurses on rotating shifts were found to take more sick leave and give more serious reasons for these sick days relative to fixed shift workers.

2.3.3 Role function influencing nurses' absenteeism rates

Role function is the performance of duties based on given positions within society (the way one performs these duties is constantly responsive to outside stimulation). Roy emphasises that all nursing activities will be aimed at promoting the person's adaptation including physiological needs, self-concept, role function and relations to interdependence during health and illness (Simms et al 2000:30). Nurses are influenced by organisational and social factors in order to adapt to their daily work demands.

2.3.3.1 Qualifications

Parker and Kulik (1995:595) stated that nurses who are in possession of bachelor's degrees have lower rates of absenteeism than nurses without these academic qualifications. On the other hand Al-Ma'aitah, Cameron, Horsburg and Armstrong-Stassen (1999:27) stated that nurses with bachelor's degrees share equal status with nurses who hold diplomas. Nurses with degrees could therefore lose interest in their work and resort to higher rates of absenteeism than nurses with diplomas. If the job description does not match the employee's skill level, either he/she is over skilled or under skilled, this leads to dissatisfaction and frustration of the employee leading to withdrawal behaviours and increased absenteeism rates (Gupta 2000:2).

2.3.3.2 Family responsibilities

Borda and Norman (1997:391) pointed out that family responsibility is the most important variable influencing absence, and sick children are major contributors to absence amongst women. Higher absence rates amongst women are also due to their traditional responsibilities to care for their families. Absence decreases with career progression due to decreased kinship responsibilities as children grow older, and increase with increasing family size. Kinship responsibilities also influence men's absence behaviour. Single men are absent more frequently than married men, probably because the latter must support their families financially.

Gupta (2000:2) pointed out that every individual comes across one or the other psychological problem ranging from personal problems including ego, complex and family problems, marriage problems and/or being overburdened with family responsibilities. This might contribute to nurses being absent from work leading to increased absenteeism rates.

Absenteeism can increase in summer for many reasons when respiratory infections such as asthma may force employees to stay at home because they might be affected or are taking care of a family member who is ill. Absenteeism might be influenced by seasonal changes. Some may have parental responsibilities that become even more obvious when children are off from school for summer breaks while others may just find the lure of the warmer weather and brighter days enough of an excuse to use sick leave (Softworks Computing Limited:2005).

2.3.3.3 Challenges faced by foreign nurses in the UK

In the UK nurses recruited from overseas countries, might face racism, discrimination and exploitation. They might be charged exorbitant and illegal fees to come to the UK. Some nurses describe employment as “slavery”. They might be excluded by their UK colleagues and singled out for negative attention. Although most nurses were fully qualified in their own countries with an average of 14 years’ nursing experience, many were required to undergo adaptation programmes before they were allowed to work as professional nurses in the UK. Many believed that they were used as cheap labour, with employers delaying the registration process so that they could keep them on a lower pay. In some cases nurses’ passports were taken away and they were threatened with deportation if they complained or tried to leave specific employers. Nurses experiencing these challenges are working under severe stress, feel isolated as they are not accepted as part of the team and end up absenting themselves from work (RCN 2003b).

2.3.3.4 Financial factors

Bhengu (2001:49&52) found that low salaries which prevent nurses from keeping up with the inflation rate, contribute to absenteeism by compelling these nurses to take a second job, known as “moonlighting”. The primary employer needs the nurse to provide patient

care services for limited pay, while on the other hand the secondary employer may make promises to pay nurses adequately for the services rendered. These lead to situations where nurses undertake jobs outside their workplaces, resulting in physical and mental strain, and higher rates of absenteeism. Furthermore, nurses who are unable to balance their financial responsibilities might be absent from work because of a lack of the financial means to pay for transport to work.

Flannery and Grace (1999:42) stated that money is typically a primary motivating factor only when people are financially desperate. Bozell (2001:2) supports the opinion that money is not a motivating factor, and points out that when nurses are asked to prioritise their reasons for absence from work, money is mentioned almost as the last reason.

2.3.3.5 Transport problems

Research done by Van der Walt (1999:50) concluded that a nurse using unreliable transport often arrives at work by chance, and usually does not know whether transport will be available the next day. Arendse (1996:14) as well as Baguma (2001:188) state that limited financial resources impede nurses' access to public transport. This means that some of the nurses might also have financial problems in paying their transport fares. Therefore financial constrains might necessitate some absences from work.

2.3.4 Professional nurses' interdependence relations as factors that could influence absenteeism rates

This is the fine balance between dependence on others and independence. Dependence is demonstrated by a need for affiliation with others for their support and approval. Independence is demonstrated by the ability to achieve, to make decisions and to initiate actions by oneself. These involve ways of seeking help, attention and affection. In relationships with others, the person adapts (Sims et al 2000:31). The behaviour of an individual is related to the behaviour of others at group level. Professional nurses work together as a team. Teams have different characteristics and relations.

2.3.4.1 Teamwork

Interdependence is the fine balance between dependence on others and independence. Dependence is demonstrated by a need for affiliation with others for their support and approval. Independence is demonstrated by the ability to achieve, to make decisions and to initiate actions by oneself. This involves ways of seeking help, attention and affection. In a relationship with another, the person adapts (Sims et al 2000:31). Nurses work in teams and depend on each other. If one member of the team is absent from work there is no balancing of work among the team as they have to perform the job of the absent member in addition to their own work.

Haccoun and Jeanrie (1995:167) stated that the individual's perception of the norm of absence from the work group plays a role in absenteeism. The nurse's understanding of what is normal and acceptable in the workplace depends on the individual's personality, but not on the work group. The nurse who perceives the absence norm of his or her group as normal will automatically be influenced to adopt such behaviour. The individual's absence patterns depend on the personal attitude of the nurse towards his or her work. Nurses with negative work attitudes are more absent than those with positive attitudes in the workplace.

Sanders and Nauta (2004:726), report that there are some studies (Geurts, Buunk, & Shaufeli, 1991; Martocchio, 1994; Van Yperen, 1998; Van Yperen, Hagedoorn & Geurts, 1994) on relationships between characteristics of teams and absenteeism. These studies indicate that members of strong cohesive working groups see deserting their colleagues as being highly undesirable and will avoid absenteeism. Employees within a team are more or less dependent on each other for getting the work done.

According to Sanders and Nauta (2004:725) their research on intra-group relationships has shown that differences in characteristics within a group are major sources of intra-group problems and conflicts, which can be related to absenteeism. Individuals have tight relationships if they share important characteristics with each other. This also increases the level of communication within their own group and decreases interaction with other subgroups. This will in turn increase the cohesiveness within the group. Cohesiveness

comes from interpersonal attractions and also indicates how far employees are committed to the goal of the group, and to what extent the group is able to influence its members, and to what degree individuals identify themselves with the team. A cohesive group will have a strong impact on its members, who will strive to keep the group intact and remain a member of the group, conform to the group norms, and regard the group's interest above their own. Cohesiveness is an important characteristic of teams because team members are more willing to show cooperative behaviour if the informal relationships are stronger, and they tend to be more sensitive to others and more willing to aid and assist them. Absenteeism can be seen as anti-co-operative behaviour within the group.

According to Taunton, Perkins, Oetker-Black and Heaton (1995:82), relationships are less supportive in urban areas than in smaller facilities, where replacement resources such as pools of nurses and temporary help agencies are less accessible than in larger organisations. According to Harter (2001:54) the human resource framework emphasises that individuals have needs, feelings, and prejudices. The key to effectiveness is to tailor organisations to people. Nurses need to be socialised to the rules and regulations of the organisation in order to take some decisions without waiting for some senior opinion. Nurses are more satisfied with their work when shared governance and case management practice models are used. Shared governance or participative management is when employees are involved in task forces and committees. This involvement gives employees the chance to make decisions about certain policies, protocols, or programmes within the organisation. Shared governance or participative management styles are effective mechanisms to encourage clinical decision-making, autonomy, control, confidence, and trust in nurses. The case management model is considered to be the most reflective way to empower nurses through roles, which increase their control, authority, enthusiasm, and confidence. When making policy strategies to decrease absenteeism in the workplace, including cultivating a culture which does not tolerate excessive absence, adhering to policies and procedures pertaining to absenteeism, supporting shared governance, effective communication with nurses to examine the causes of absenteeism, using absentee-control programmes, and bargaining should be included. Nurses will be more likely to adhere to those policies and procedures if they participated in developing them.

2.3.4.2 Organisational policies

Professional nurses are in constant interaction with organisational rules and regulations which affect them in different ways. In order to adapt to the changing environment it is necessary to have a healthy body and mind. Somers (1995:49) indicates that organisational commitment has three facets: affective, continuance, and normative. Affective commitment is defined as an emotional attachment to an organisation characterised by the acceptance of organisational values and by the willingness to remain with the organisation. Continuance commitment interact with affective commitment in predicting job withdrawal intentions and absenteeism while normative commitment is defined as a perceived duty to support the organisation and its activities. Affective commitment emerged as the most consistent predictor of these outcome variables and was the only view of commitment related to absenteeism. In contrast, normative commitment was related to withdrawal intentions while no direct effect for continuance commitments were observed.

In the interdependence mode the person adapts according to a system of interdependence, which involves ways of seeking help, attention and affection (Sims et al 2000:31). The more the individual identifies with the group, the more the person's behaviour conforms to the group's norms and values. Rules of the organisation should be communicated to the employees. Values of the organisation include respect for fellow employees and loyalty to the organisation.

Promoting a sense of membership includes socialisation of new members. The socialisation of new staff members include transmitting the values, assumptions, and attitudes of older employees to newer employees. The values, assumptions, and attitudes of older employees should include employees' respect, organisational loyalty, and the questioning of absenteeism according to the absenteeism policy of the organisation. Organisational commitment can be defined in terms of behavioural or attitudinal frameworks. A behavioural commitment is characterised by the willingness to remain a part of the organisation. The attitudinal framework defines the commitment as a state in which an individual identifies with an organisation and its goals and wishes to incorporate these values and goals into his identity (Dale 1996:30).

Nurses need to have good interpersonal relationships at work and work as a team. The team has to conform to the rules and regulations of the organisation. Cooperation is enhanced when nurses experience feelings of belonging and strong cohesiveness within the team.

2.3.5 Steps reported in the literature that could address absenteeism rates

Many health care institutions do not have suitable methods to measure and monitor absenteeism. Nurse managers have to acquire knowledge and skills in order to manage the high absenteeism rates in workplaces. Reasons for absenteeism should be measured in order to manage it (Bydawell 2000:18).

2.3.5.1 Absenteeism-control programmes

Absentee-control programmes can have the greatest impact on reducing absenteeism. Nurse leaders can use reward and coercive power to decrease absenteeism. Reward power is defined as a person's ability to reward the behaviour of others. Coercive power is defined as the capability to punish non-compliance of followers. Positive absentee-control programmes are interventions that offer rewards or positive motivation for good attendance. These include: personal recognition, buying back of unused sick leave, and bonus payments for exemplary attendance. Another programme is the disciplinary-control program which include interventions that provide an aversive consequence to poor attendance. These include: disciplinary action, fault free performance, and year-end reviews. The combination of rewards and discipline programmes can potentially have the greatest impact on reducing absenteeism. Involving employees in establishing and monitoring these programmes will help the employees to conform to these policies and assume personal responsibilities (Harter 2001:55).

According to Bamford, Klein and Engelbrecht (2000:2) the absenteeism rate can be addressed by using the following steps: Employers should establish the magnitude and patterns of the absenteeism. They should make sure that everyone is aware of their rights and responsibilities regarding leave and the consequences of breaking these rules.

Employer should address the problem as a whole and deal with the individual in each case where one individual is repeatedly absent from work. Ongoing monthly monitoring will assist managers to know if the absenteeism rate is being adequately addressed.

The RCN believes that there should be a clear action to prevent exploitation of registered nurses, including extending the Department of Health's Code of Practice to cover independent sector employees. A comprehensive strategy to address racism in the NHS and care homes and at institutional level within the health services. Improved induction and adaptation courses for both registered nurses and UK staff who are working with them. Appropriate remuneration and grading for internationally recruited nurses should be offered. The RCN suggests a minimum of Grade D from the commencement of the employment include the period of adaptation. In this way, a clear demonstration is given to internationally recruited nurses that their skills and experience are valued (RCN 2003b:2).

2.3.5.2 Active health partners

Some hospitals in the UK use active health partners. Employees report sick by calling nurses from so-called active health partners. Nurses in this firm screen the calls from employees. The idea is to ask callers in detail about their ailments in order to advise them what steps they should take such as staying in bed or going to the doctor. This helps to weed out the not so genuine callers who may feel under pressure due to the variety of questions asked by the nurses (Softworks Computing Limited 2005:1).

Sickness absence management within the NHS is challenging but provides opportunities to improve the working lives of NHS nurses. Management should not only look at its financial costs and its impact on services but also to the health and well-being of NHS nurses. Nurses need to be away from work when ill to protect their patients and colleagues from infections such as the influenza virus and TB (Johnson et al 2003:337).

Gupta (2000:2), sees a solution to absenteeism as offering continuous counselling of employees at work. That could provide a different social working environment helping nurses to reduce tension diverting their attention from problems at home.

2.3.5.3 Organisational policies and practices

Taunton et al (1995:80) examined hospital policies and practices related to absenteeism rates in the USA. They found that unit level governance structures, patient acuity levels and staffing ratios, unpopular schedule changes and reassignment, compounded staffing problems associated with vacant positions, contributing to absenteeism rates among professional nurses.

Employee-friendly practices can strongly influence nurses' well-being. Employee friendly working arrangements including childcare and flexible working hours create a balance between work and home. Nurses sometimes displayed significant signs of poor psychological health, symptoms of depression and anxiety leading to increased absenteeism rates. Bullying and harassment have the greatest effects on nurses' psychological well-being and are closely related to high sickness absence rates. As many as 30.0% of nurses on long-term sick leave experienced bullying and harassment by either patients or their relatives. Reportedly 43.0% of nurses in the NHS hospitals had been harassed or assaulted by patients or relatives. Nurses need to feel protected, supported and valued by their employees. Safe working environments should be provided. In that case nurses show greater psychological well-being and job satisfaction rendering quality patient care (RCN 2002a:1). Bruce et al (2002:13) pointed out that to reduce absenteeism, nurses often suggested improving benefits, while stakeholders regarded improved benefits, changes in policy and reduced workload as potential solutions.

2.3.5.4 Organisational commitment

Gayle and Dahlke (1996:30) conducted a one year study at the Minnesota Hospital in the USA on absenteeism and organisational commitment. These findings support a statistically significant relationship between position held and absenteeism rates among nurses. This research viewed absenteeism as an indicator of organisational commitment. Those who invested more time in an organisation could make a greater behavioural commitment to the organisation. Less absenteeism was seen among full-time nurses than among part-time nurses. However, according to Sanders and Nauta (2004:725) there are differences in individual performance within the organisation between part-time and full-

time nurses. This was examined and some results showed that full-time nurses have higher absentee rates. Other results, however, show that part-time nurses have higher rates of absenteeism. Another factor that influences employees' performance is work ethics. Work ethics is defined as a collection of values and behaviours related to the work place that people feel are moral. Work ethics are strong if workers feel that they have to fulfil all the formal responsibilities that come with a job and weak or low if people are more tolerant to the fulfilment of formal responsibilities (Sanders & Nauta 2004:736).

In a survey conducted by the RCN on the well-being and working lives of nurses, it was found that nurses need to feel protected, supported and valued by employers. Where they do, they show greater psychological well-being and satisfaction with their job, and are also more satisfied with the quality of care delivered where they work (RCN 2002c:5).

The organisation needs to show commitment to employees so that employees can accept the organisational values and show commitment (Somers 1995:49). Good employment practices make a difference to nurses and patients. The RCN identified employment practices which could lead to improvements in nurses' well-being at work and job satisfaction. These include that a good employer provides well-designed employee-friendly services, values and consults staff, provides a safe environment and protects and supports staff (RCN 2002c:6). Implementing these practices may result in enhanced productivity and quality care, reductions in absenteeism rates and reliance on bank staff and agency staff, reduced nurse turnover rates, improved morale and reduced stress as well as improved staff safety.

2.3.5.5 Flexible working hours

The introduction of flexible working practices such as flexitime allowing nurses to do part-time work if they want to do so and job sharing to balance the workload will reduce absenteeism rates. The manager should ensure that the employees take their allocated annual leave. This will help nurses to rest and come back refreshed and with reduced stress levels (Softworks Computing Limited 2005:1). The ICN (2000:1) recommends that employers introduce shift plans that consider rest periods to reduce absenteeism.

A survey by an organisation (Employees Advisory Resource) in the UK has found that flexible working hours and being generous when it comes to compassionate leave, helped cut down absenteeism rates. Employers who treat their nurses with respect and offer help, such as flexible hours, will get the most from their workforce (Paton 2005b:1).

2.4 Summary

This chapter presented the literature review on factors influencing absenteeism with reference to RAM. The literature review covered the four modes of the model influencing absenteeism, namely physiological needs, self-concept, role function and interdependence.

Chapter 3 describes the research methodology adopted to gather data about factors influencing absenteeism amongst professional nurses in a selected London hospital.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the methods and procedures that were adopted to obtain the data required for the study. It describes the research design, the population, the sampling technique, data collection instrument, pre-testing of the instrument, data analysis and ethical aspects of the research.

3.2 RESEARCH DESIGN

According to Fain (2004:194), a research design is a flexible set of guidelines by which a researcher obtains answers to enquiries. Research designs may be defined from a broad or narrow perspective. From a broad perspective, the design suggests approaches for observation and analysis but does not specifically tell the researcher what to do. Researchers regard a research design as the total strategy for the investigation, connecting the theoretical perspective and the problem identification with data collection and analysis. From a limited perspective, researchers consider the design as a precisely conceived blueprint that brings empirical evidence to bear on the research problem. It provides the methodological direction, such as sampling and random assignment. Polit and Hungler (1999:155) describe a research design as a researcher's overall plan for obtaining answers to the research questions. The research design incorporates some of the most important methodological decisions that the researcher makes in conducting a study. Some of these important decisions are the data collection plan, sampling plan and the data analysis plan. Parahoo (1997:142) describes the research design as a plan that describes how, when and where data are to be collected and analysed. It is sometimes interchangeable with the term 'methodology'. The design methodology of the study comprises the following aspects: the approach; the time, place and source of the data; and the method of data collection.

This study used a quantitative exploratory descriptive design to identify and describe factors that influence absenteeism rates of professional nurses in a selected NHS hospital in London. Roy's Adaptation Model was used as a conceptual framework for contextualising the study. This study identified which of the physiological, self concept, role function and interdependence factors contributed to nurses' absenteeism rates. Recommendations to reduce absenteeism rates among nurses will be formulated.

3.2.1 Quantitative research

According to Polit and Beck (2004:729), quantitative research is the investigation of a phenomenon that lends itself to precise measurement and quantification, often involving a rigorous and controlled design. The researcher in this study attempted to quantify factors affecting nurses absenteeism rates in a selected NHS London hospital.

3.2.1.1 Characteristics of quantitative research

Quantitative research has the following characteristics:
It is a set of orderly, disciplined procedures used to acquire information. It moves in an orderly and systematic fashion from the definition of a problem and the selection of concepts on which to focus, through the design of the study and collection of information, to the solution of the problem using a deductive form of reasoning. It is narrow in scope (De Vos 2003:104, Parahoo 1997:54, Polit & Beck 2004:15). The following specific characteristics are applicable:

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- The phenomenon under study is controlled in order for the research findings to provide an accurate reflection of reality and thus errors will be reduced.
- Researchers gather evidence that is rooted in objective reality and gathered directly or indirectly through the senses.
- It test the hypothesis and/or answers the research questions that are stated at the beginning of the research process.
- The sample is usually representative of the population.
- The design determines the researcher's choices and actions.

- Data are presented in figures and graphs which are understandable in quantitative terms.
- Data collectors are to avoid adding their own impressions or interpretations.
- Data analysis follows a standardised procedure.

3.2.1.2 Exploratory descriptive design

This study was exploratory as it explored the factors influencing absenteeism rates amongst professional nurses in a London hospital. Exploratory research is conducted to gain insight into a situation, phenomenon, community or individual. It is also undertaken when the phenomenon under study has not been investigated or when little is known about it. In this study the phenomenon is nurses who are absent from work and the factors that influence nurses not to go to work. The answer to a 'what' question would constitute an exploratory study (De Vos 2003:109).

Descriptive research presents a picture of the specific details of a situation, social setting or relationship, and focuses on 'how' and 'why' questions (De Vos 2003:109). The aim of descriptive research is to discover new facts about a situation, people, activities or events, or the frequency with which certain events occur. It focuses on conditions that exist, practices that prevail, beliefs that are held, ongoing processes, and developing trends (Cormack 2003:213). The other purpose of descriptive research is to observe, describe, and document aspects of a situation (Polit & Beck 2004:192).

3.2.1.3 Characteristics of an exploratory descriptive research design

According to Cormack (2003:271), an exploratory descriptive research design has the following characteristics:

- It explores a particular area to discover what is there, the meaning attached to the discoveries, and how these can be organised.
- It usually occurs in a natural setting.
- It is to uncover new knowledge and insight of the researcher.

- It calls for a degree of flexibility so that any new leads can be followed up, moving the study into new areas as the researcher proceeds and as his/her knowledge of the studied phenomenon increases.
- The researcher should possess the ability to analyse the data collected and derive new meanings.

3.3 RESEARCH SETTING

According to Polit and Beck (2004:28), research settings are specific places where data collection occurs. Settings for nursing research can range from totally naturalistic environments to formal laboratories. The researcher makes decisions about where to conduct a study based on the nature of the research questions and type of information needed to address it. Burns and Grove (1999:25) indicate that the setting is the location where a study is conducted. There are three common settings for conducting research: natural, partially controlled, and highly controlled. A natural setting, or field setting, is an uncontrolled, real-life situation. Conducting the study in a natural setting means that the researcher does not manipulate or change the environment for the study. The nature of the setting can influence the data collected and it is therefore important for the researcher to carefully select the research setting. In this study the natural setting is chosen where data were collected from the nurses in the selected London hospital and nurses were free to choose where to complete the questionnaires. One hospital in the Trust was chosen where the researcher was working, as it is in this hospital that the problem of absenteeism amongst nurses was identified and was higher than in the other three hospitals. The hospital had three hundred and sixty professional nurses. The Trust consists of four hospitals. The researcher regarded this setting as appropriate because she experienced high absenteeism rates within the hospital.

3.4 RESEARCH POPULATION AND SAMPLE

Parahoo (1997:218) defines the population as the total number of units from which data can potentially be collected. These units may be individuals, organisations, events or artefacts. According to Fain (2004:104) the population is an entire set of subjects, objects, events or elements being studied. It is a well-defined group whose members possess

specific attributes. A sample is a proportion or subset of the population. A carefully selected sample can provide data representative of the population from which the sample is drawn (Parahoo 1997:218).

3.4.1 Population

Professional nurses employed in one selected London NHS hospital comprised the population for this study. Polit and Beck (2004:289) indicate that a population is the entire aggregation of cases in which a researcher is interested. To be part of the study the population should possess the eligibility criteria. The population for this study comprised professional nurses employed in the selected London NHS hospital in November 2008 – April 2009.

3.4.2 Sampling

Convenience sampling was used in this study, which is non-probability sampling. Questionnaires were given to the head nurse of a selected hospital to distribute to professional nurses accessible at the time of distribution. Professional nurses working in the selected hospital were to participate in the study, not necessarily those who were often absent from work.

3.4.3 Characteristics of non-probability sampling

Fain (2004:116), Gerrish and Lacey (2006:177), as well as Polit and Hungler (1999:284) explain the characteristics of non-probability sampling as follows:

- it allows the researcher to handpick the sample based on his/her knowledge of the phenomenon under study.
- it is convenient and economic.
- it is considered to be less rigorous because bias may be introduced, making the sample not representative of the total population.

- It is used in exploratory studies where random sampling is too costly and where an appropriate sampling frame is not available, or when it is the only way to study the population of interest.

3.5 DATA COLLECTION

Polit and Beck (2004:716) define data collection as the gathering of information to address a research problem. A structured approach, using a questionnaire was used to obtain data relevant to the study in order to answer the research questions. The purpose of the study was to identify the factors that influenced nurses' absenteeism rates. Every professional nurse who was employed at the selected hospital in London in November 2008 - April 2009, at the time of data collection, received the information about the study and a questionnaire. A stamped self addressed envelope was included to encourage the return of completed questionnaires. Anonymity was ensured because each respondent was given his/her own questionnaire and the responses could not be linked to any particular person. Participants gave consent by participating in the study. Data analysis commenced when the data collection was completed. A total of 150 questionnaires were distributed and out of these 52 were returned to the researcher of which two had not been completed. Out of 150 questionnaires 50 (33.3%) completed questionnaires were received.

3.5.1 Data collection instrument

According to De Vos (2003:165), quantitative research data collection instruments often employ measuring instruments. The specific measuring instruments are questionnaires, checklists, indices and scales. In this study a questionnaire was used. Questionnaires can include a fixed set of questions to be answered in a specific sequence and with pre-designated response options – known as closed-ended questions. Structured methods give participants limited opportunities to qualify their answers or to explain the underlying meaning of their responses (Polit & Beck 2004:318). The questionnaire was designed to collect data about factors influencing nurses' absenteeism rates.

3.5.1.1 Characteristics of questionnaires

According to Cormack (2003:302) and Parahoo (1997:249), questionnaires:

- are economical and reach a large population within a relatively brief time compared to gathering data through interviews.
- provide a quick confidential and anonymous method of collecting a large amount of information from a large number of people. Anonymity is very important in this study as it makes the respondents feel free to state their opinions about factors that influence them to stay away from work without fear of their employer knowing about any specific individual's reasons for being absent.
- are predetermined (constructed in advance), standardised (the same questions in the same order are asked of all respondents) and structured (respondents are mainly required to choose from the list of responses offered by the researcher).
- enable the planning in advance of analysis.
- eliminate interviewer bias because the respondents complete the questionnaires without any inputs from the researcher.
- do not require training of research assistants/interviewers.

3.5.1.2 The development of the questionnaire

The questionnaire was based on the literature review (chapter 2) and other instruments used in similar studies. This study attempted to identify factors influencing nurses' rates of absenteeism in one NHS hospital in London. The literature review indicated physiological needs, self-concepts, role function, interdependence relations and steps reported in literature that could address absenteeism rates. In chapter 4 data will be analysed according to the relevant sections of the questionnaire and thereafter summarised in terms of RAM.

The questionnaire was compiled and discussed with the researcher's two supervisors and a statistician. Changes suggested by these persons were implemented. The suggestion was that questionnaires should be grouped according to the four sub-systems of RAM to

make data analysis simple. The subsystems were physiological needs, self-concept, role function and interdependence relations.

3.5.1.3 Structure of the questionnaire

The questionnaire consisted of 84 items divided into the following sections:
Section A: Personal data consisted of 19 items.
Section B: Data related to physiological needs, self concept, role function and interdependence comprised 47 items.
Section C: Steps that could be taken to address absenteeism consisted of 18 items.

The questionnaire comprised open and closed-ended questions, attempting to identify factors influencing nurses' absenteeism rates in a selected NHS hospital in London.

3.5.1.4 Pre-testing the questionnaire

Pre-testing of a questionnaire is performed to determine the feasibility of using a particular instrument in a study. It provides an opportunity to try out the instructions for completion of the instrument, especially if it is used for the first time. This entails a trial administration of a newly developed instrument in order to identify flaws and time requirements (Brink & Wood 1998:373). A researcher gains some experience in interacting with the respondents and also learns what could be expected in the major study. Questionnaires are usually pre-tested on a small number of people with similar characteristics to those in the research study, to identify questions that are misinterpreted, or items that are frequently missed. Modifications can then be made to the questionnaire before large numbers are printed for distribution to the entire selected sample of respondents. The participants who took part in the pre-testing of the questionnaire were not included in the major study. In this pre-test, the researcher distributed the questionnaires to eight professional nurses in a hospital which did not participate in the actual study. These nurses were requested to complete the questionnaires and to post them to the researcher. Stamped addressed envelopes were provided for this purpose.

The purpose of this pre-test was to determine the clarity, validity and time required to complete it. The principles of anonymity, confidentiality and privacy were clarified. All eight questionnaires were completed and returned. No problem was encountered during the completion of questionnaires. No recommendations to change any questions were made and therefore the questionnaires were kept unchanged.

3.5.2 Reliability of the research instrument

Fain (2004:128) explains reliability as indicating the consistency with which a test or instrument measures whatever it is supposed to measure. The more reliable a test or instrument, the more a researcher can rely on those scores that would be obtained if the test was re-administered. A number of reliability tests have been devised to determine the consistency with which questionnaires collect data. If a study's results are reliable, the same results would be obtained if the study were to be replicated using the same method of data collection and the same questionnaire. Careful design of the questionnaire is essential for the collection of good quality data. Crookes and Davies (2004:98) emphasise that constructing a reliable and valid questionnaire to collect high-quality data is a subtle and sophisticated art. The supervisors for the study assessed the questionnaire before it was used. Reliability was further enhanced through conducting a pre-test.

3.5.3 Validity of the research instrument

It is the accuracy with which an instrument measures what it is supposed to measure. The researcher should ask "is it valid for what and for whom" (Fain 2004:131). Validity is divided into two categories, namely, internal and external validity.

3.5.3.1 Internal validity

Internal validity is referred to as the extent to which the effects detected in the study are a true reflection of reality rather than the result of extraneous variables (Cormack 2003:30).

3.5.3.2 External validity

Face validity refers to whether the instrument looks as though it is measuring the appropriate construct. Although face validity should not be considered as primary evidence for the quality of the instrument, it may be helpful for a measure to have face validity if other types of validity have also been demonstrated (Polit & Hungler 1999:418). Questionnaires were checked and approved by supervisors and a statistician before being send to respondents.

Construct validity is concerned with the questions: What is this measuring device really measuring? Is the abstract concept under investigation being adequately measured with this instrument. Construct validity is more concerned with the underlying attribute than with the scores that the instrument produces (Polit & Hungler 1999:420). In this study questionnaires were used to measure many factors influencing absenteeism rates. Respondents gave their various reasons for absenteeism according to the questions asked.

Polit and Beck (2004:217) describe external validity as a way to generalise the research findings to the other settings or samples. Population validity relates to whether the results of a particular study can be applied (generalised) to different groups of people. According to Polit and Hungler (1999:231), if the characteristics of the sample are representative of those of the population, then generalisation is straightforward. The findings of the study can only be generalised from the sample chosen. As the sample of registered nurses who participated in this study were all from one NHS hospital in London, external validity might have been compromised in this study.

3.6 DATA ANALYSIS

The amount of data collected may be large or small depending on the purpose the of study. Numerical information on a number of variables were collected. These form the data set for analysis. One main purpose of descriptive analysis is to summarise the data, extracting the salient points from the results, rather than presenting every item on every subject (Cormack 2003:367). Questionnaires were coded for easy entry into the computer.

The statistician performed quantitative data analyses. The statistical tests performed included the frequencies of responses. The Microsoft Office Excel computer program (MSEXCEL) was used to analyse data and to generate figures portraying the results. Comments made by respondents on open ended questions were included in the report.

3.7 ETHICAL CONSIDERATIONS

Ethical concerns permeate every aspect of the study's design and the execution of the design. The use of humans in research studies raises ethical concerns. The proliferation of research has led to growing concerns about the protection of the rights of study participants. Rights of participants refer to the right to freedom, the right to privacy and right to anonymity and confidentiality. Participation in the study was voluntary and respondents were free to withdraw from the study at any stage even if they had consented to participate in the study. No name appeared on any questionnaire. Information given by the respondents was managed with strict confidentiality. Nobody, except the researcher and statistician saw the completed questionnaires. Ethical research involves explaining the study to participants and giving information about voluntary participation and consent (Polit & Beck 2004:141). Subsequent to the acceptance of the research report, the completed questionnaires would be destroyed by the researcher.

3.7.1 Permission to conduct the study

Permission to conduct the study was sought and obtained in writing from the Research Ethics Committee in the UK (see Annexure B). Permission was also obtained from the Trust where the study was conducted (see Annexure C). The head nurse (UK matron) of the hospital chosen for the study and training facilitator were informed about the study and nurses were requested to complete the questionnaires for the study. There was no disruption of hospital services caused by the researcher during the collection of data.

3.7.2 Principles of research ethics

The principles of beneficence, respect for human dignity, justice and informed consent were observed during data collection.

3.7.2.1 Principle of beneficence

This principle contains multiple dimensions, namely: freedom from harm, freedom from exploitation, benefits from research and the risk/benefit ratio (Polit & Beck 2004:143). Study participants may be harmed in a variety of ways, including harm that is physical, injury and fatigue, psychological, stress and fear, social loss of friends, and economic loss of wages. In this study there were no physical dangers, or situations that exposed respondents to harm resulting from completing the questionnaires, but some psychological discomfort might have resulted from the nature of some questions. No direct personal benefit was offered. However, any benefits from the research results could benefit the nurses and hospital by helping to reduce nurses' absenteeism rates. The researcher's telephone numbers were provided should any respondent have wished to discuss any aspect.

3.7.2.2 Principles of respect for human dignity

The principle of respect for human dignity includes the right to self-determination and to full disclosure. Participants should be capable of controlling their own activities. They have the right to decide voluntarily whether to participate in a study, without risking any penalty or prejudicial treatment. Participants have the right to ask questions, to refuse to give information, to ask clarification or to terminate their participation. In full disclosure the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities, and likely risks and benefits (Polit & Beck 2004:147). Participants were informed about the nature of the study, participative benefits such as helping to explore factors influencing absenteeism rates and voluntary participation in this study. This was attached to the questionnaire in the form of a covering letter and a list of instructions (see Annexure D).

3.7.2.3 Principle of justice.

This principle includes participants' right to fair treatment and their right to privacy. Participants completed the questionnaires wherever they were comfortable doing so. Anonymity was ensured as each participant had to complete the questionnaire and send it

back to the researcher without disclosing his/her name. Confidentiality was maintained by not reporting any information provided by the participants publicly in a manner that could identify them and data could not be accessed by others (Polit & Beck 2004:150). There were no names required on the questionnaires that could identify the participants.

3.7.2.4 Informed consent

There was no consent form to be signed but the purpose of the study was explained and information was given about voluntary participation and consent in the covering letter and in the list of instructions. Voluntary completion of questionnaires in the participant's own time and return of completed questionnaires could be implied as consent. Signed consent forms would have destroyed the anonymity of the questionnaire.

3.8 Summary

This chapter discussed the research methodology of the study and described the research design, population, sample, data collection, data-collection instrument and the ethical considerations. Chapter 4 presents the data analysis and discussions.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

4.1 INTRODUCTION

This chapter discusses the data analysis and findings from questionnaires completed by registered nurses employed by one NHS hospital in London at the time of the study between November 2008 and April 2009. A total of 150 questionnaires were sent out and 52 were retuned of which two had not been filled in. The total number of questionnaires were analysed but the number of respondents (n) will differ in the discussion of each question as some respondents did not answer all the questions. The purpose of this study was to identify factors influencing absenteeism amongst professional nurses in a selected NHS hospital in London.

The objectives of this study were to:

- Identify and describe the physiological factors that influence nurses' absenteeism rates in a selected NHS hospital in London.
- Identify and describe the physiological factors related to professional nurses' self concept which influence their absenteeism rates in a selected NHS hospital in London.
- Identify and describe how nurses' role function influence their absenteeism rates in a selected NHS hospital in London.
- Identify and describe professional nurses' interdependence relations that influence their absenteeism rates in a selected NHS hospital in London.
- Recommend strategies to address the problem of nurses' absenteeism in a selected hospital in London.

Questionnaires were sent to one selected NHS Trust hospital and RNs were requested to complete them. Data from the questionnaires were statistically analysed using the

computer program MSEXCEL. The findings are discussed according to the sections of the questionnaires using Roy's Adaptation Model.
The sections of the questionnaire were:

- Section A: Biographical (personal) data
- Section B: Physiological needs
    - Self concept
    - Role function
    - Interdependence relations
- Section C: Steps that could be taken to address absenteeism

It should be noted that for the purpose of data analysis and graphic presentation Section B's responses were grouped according to RAM's needs. Questions in this section related to the physiological needs, self concept, role function, and interdependence relations.

4.2 BIOGRAPHICAL DATA

Section A dealt with the respondents' biographic information. Respondents were registered nurses representative of different professional ranks at the selected hospital. The section contained both open and closed ended questions.

4.2.1 Age of respondents

The ages of the respondents (n=50) ranged from 24 to 56 years. Of the respondents, 12.0% (n=6) were between the age of 20 and 29 years and 44.0% (n=22) between 30 and 39 years old. Twenty percent (n=10) of the respondents were aged between 40 and 49 years while 24.0% (n=12) fell within the age of 50 and 59 years. Sixty four percent (n=32) of respondents were between the ages of 30 and 49.

Table 4.1 Age distribution of respondents (n=50)

Age	Frequency	Percentage(%)
20-29	6	12.0%
30-39	22	44.0%
40-49	10	20.0%
50-59	12	24.0%
Total	**50**	**100.0%**

4.2.2 Gender distribution

Respondents comprised 82.0% (n=41) females and 18.0% (n=9) males. This was expected because the nursing profession in the UK is a female dominated workforce as indicated in the NMC register. In 2008, 89.3% of nurses on the NMC register were females and 10.7% were males (NMC 2008:5). The data are presented in figure 4.1.

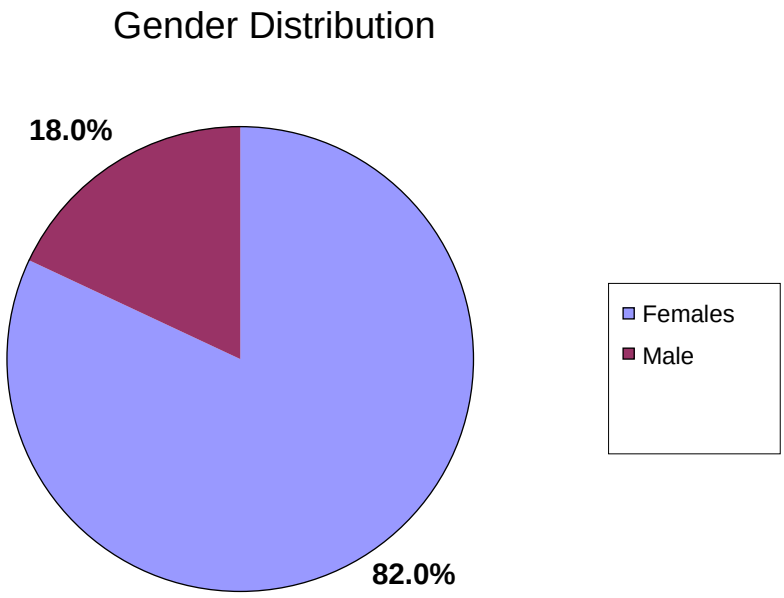

Figure 4.1 Gender distribution of respondents

4.2.3 Marital status and number of dependents

The marital status and number of dependents of respondents might play a role in the incidence of absenteeism. Of the 48 respondents to this question, 60.4% (n=29) were married, 8.3% (n=4) were divorced, while 4.2% (n=2) were widowed. Those respondents who had been separated from their husbands comprised 2.1% (n=1). There were 22.9% (n=11) who had never been married and 2.1% (n=1) who lived with partners (indicated as others in figure 4.2).

Table 4.2 Number of dependants of respondents (n=35)

Dependants	Frequency	Percentage %
1	7	20.0%
2	12	34.3%
3	9	25.7%
4	7	20.0%
TOTAL	**35**	**100.0%**

Out of 35 respondents, 20.0% (n=7) had one dependant, 34.3% (n=12) had two, 25.7% (n=9) had three and 20.0% (n=7) had four. Five respondents had no dependant while ten did not answer this question. This study indicated that the majority of respondents were married 60.4% (n=29) and females 82% (n=41). This study again indicated that 26.0% (n=13) respondents (4.2.18) were absent from work due to caring for family members and 50.0% (n=22) of respondents in (item 13) were absent from work due to family responsibilities. According to Erickson, Nichols and Ritter (2000:268) married nurses with younger children could be absent from work more often due to family responsibilities than single nurses without children. The marital status of the respondents is shown in Figure 4.2.

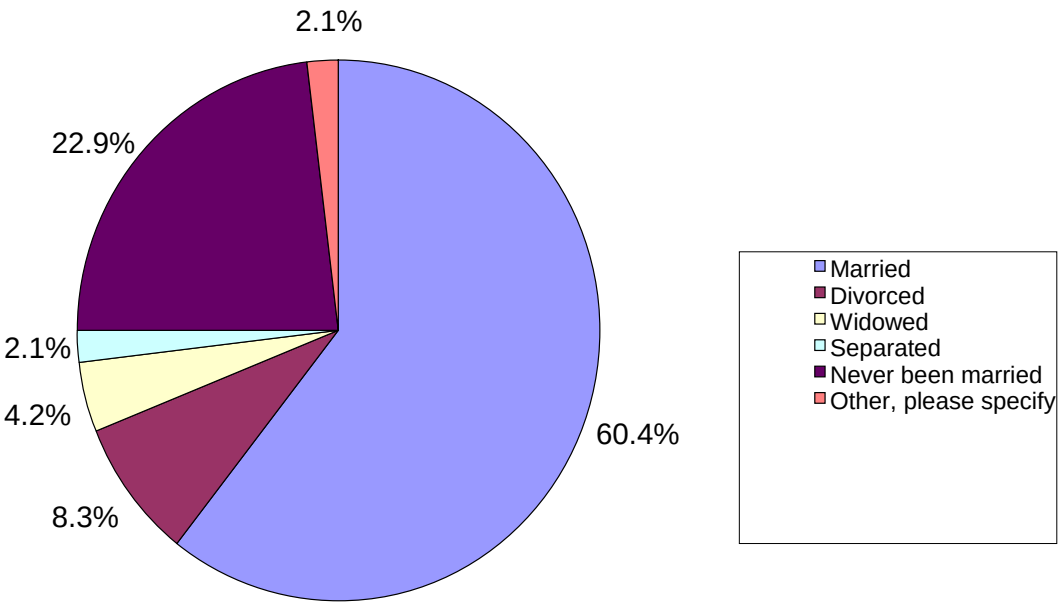

Figure 4.2 Marital status of respondents

4.2.4 Respondents' highest nursing qualifications

Table 4.3 presents the highest nursing qualifications that respondents had obtained. Of the 49 RNs who responded to this question, 46.9% (n=23) had obtained diplomas while 51.0% (n=25) had bachelor's degrees. Two percent (n=1) had the State Registered Nursing Qualification, which is an old classification of qualification for nurses who had undergone three years of training to be registered as a nurse in the UK. According to the NMC's basic demographic information one-third of nurses and midwives on their register at 31 March 2008 held one registerable or recordable qualification and it was impossible to identify with any degree of certainty which one a nurse was using in his/her current practice (NMC 2008:4).

Table 4.3 Highest academic qualifications held by respondents (n=49)

Qualification	Frequency	Percentage(%)
Diploma	23	46.9%
Bachelor's degree	25	51.0%
Other	1	2.0%
Total	49	**100.0%**

4.2.5 Respondents' monthly income

The salaries of nurses in the UK are differentiated according to categories. Individuals' monthly incomes depend on the number of hours worked per month. Out of 48 RNs who responded (table 4.4), 16.7% (n=8) received between£1000 - £1 499, those who received £1 500 to £1 999 were 43.8% (n=21), whereas 39.6% (n=19) received a salary of £2 000 and more per month. Two respondents did not respond to this question. A large number of respondents (61.4%) in this study did not indicate any dissatisfaction with their salaries (item 10).

Table 4.4 Monthly (30 days) income of respondents (n=48) in Pound Sterling (£)

Income	Frequency	Percentage(%)
£1 000 - £1 499	8	16.7%
£1 500 - £1 999	21	43.8%
£2 000 and more	19	39.6%
Total	**48**	**100.0%**

4.2.6 Respondents' nursing categories

Table 4.5 presents the respondents' nursing categories. Two respondents did not answer the question. Of the 48 registered nurses who responded, 29.2% (n=14) were staff nurses, 33.3% (n=16) were senior staff nurses, 25.0% (n=12) were junior sisters, 10.4% (n=5) were senior sisters and 2.1% (n=1) was a head nurse.

Table 4.5 Respondents' nursing categories (n=48)

Categories	Frequency	Percentage (%)
Staff Nurses	14	29.2%
Senior Staff Nurses	16	33.3%
Junior Sister	12	25.0%
Senior Sister	5	10.4%
Other, please specify	1	2.1%
Total	**48**	**100.0%**

4.2.7 Years of experience since obtaining a basic nursing qualification

Of the 50 respondents, 24% (n=12) had 0 to 5 years of experience since they qualified as registered nurses, 22% (n=11) had 6 to 10 years of experience, 22% (n=11) had 11 to 15 years of experience, 12% (n=6) had 16 to 20 years of experience, 6% (n=3) had 21 to 25 years of experience whereas 14% (n=7) had 25 years or more of experience after completion of their basic training.

Table 4.6 Years of experience since obtaining basic nursing qualifications (n=50)

Years of experience	Frequency	Percentage (%)
0 – 5	12	24.0%
6 – 10	11	22.0%
11 – 15	11	22.0%
16 – 20	6	12.0%
21 – 25	3	6.0%
25 and more	7	14.0%
Total	**50**	**100.0%**

4.2.8 Number of years worked for the present employer

Of the respondents, 54% (n=27) were working for the present employer for 0 to 5 years while 28% (n=14) had been employed in the institution between 6 to 10 years. Only 4% (n=2) had been employed in the institution between 11 to 15 years, 6% (n=3) 16 to 20 years, 4% (n=2) between 21 to 25 years whereas 4% (n=2) had been employed by the institution for longer than 25 years.

Table 4.7 Years working for present employer (n=50)

Years worked	Frequency	Percentage (%)
0 – 5	27	54.0%
6 – 10	14	28.0%
11 – 15	2	4.0%
16 – 20	3	6.0%
21 – 25	2	4.0%
25 up	2	4.0%
Total	**50**	**100.0%**

4.2.9 Number of days worked per week

Table 4.8 reveals that 36.0% (n=18) worked two days per week, 42.0% (n=21) worked three days per week and 22.0% (n=11) worked four days per week.

Table 4.8 Days worked per week (n=50)

Days worked	Frequency	Percentage(%)
One	0	0
Two	18	36.0%
Three	21	42.0%
Four	11	22.0%
Total	**50**	**100.0%**

4.2.10 Number of hours worked per day

The results in table 4.9 show that out of 50 respondents, 8.0% (n=4) worked six hours per day, 36.0% (n=18) worked seven and half a hours per day whereas 56.0% (n=28) worked twelve and a half hours per day. In this study 56.0% of respondents indicated that they worked twelve and half hours which could lead to exhaustion. According to Cartledge (2001:353) flexible work schedules give nurses a sense of autonomy and ability to fulfil family responsibilities. On the other hand long working hours contribute to exhaustion.

Table 4.9 Hours worked per day (n=50)

Hours worked	Frequency	Percentage(%)
Six hours	4	8.0%
Seven and half hours	18	36.0%
Twelve and half hours	28	56.0%
Total	**50**	**100.0%**

4.2.11 Respondents' perceptions regarding the staff allocation in their units

Almost half of the respondents, 44.0% (n=22) stated that their units were well staffed whereas 56.0% (n=28) indicated that their units were not well staffed Nurses' absenteeism contribute to understaffed units, staffing instability and other factors that could negatively impact on patient care (Unruh, Joseph & Strickland 2007:673). The hospital policy regarding the ratio of nurses to patients depended on the dependence acuity scale. According to Hurst (2005:75) patient dependency may form an important part of nursing staff and workload of an individual.

4.2.12 Annual leave

Out of 45 respondents who answered this question, 2.2% (n=1) had 0 to 9 days, 2.2% (n=1) had 10 to 19 days, 51.1% (n=23) had 20 to 29 days, 24.4% (n=11) had 30 to 39 days and 20.0% (n=9) had 40 days vacation leave allocated to them per year according to the leave policy of the hospital. The leave policy of the Trust reviewed in July 2008 was calculated according to the period of service plus public holidays in that year. From commencement till 5 years' service the employee has 27 days annual leave. After 5 years' service it is increased to 29 days and after 10 years an employee has 33 days vacation leave which exclude public holidays. Those respondents who had 40 days annual leave might have had more than 10 years service with the Trust and included public holidays.

Table 4.10 Number of days leave per annum (n=45)

Number of days leave per annum	Frequency	Percentage(%)
0 – 9	1	2.2%
10 – 19	1	2.2%
20 -29	23	51.1%
30 -39	11	24.4%
40 up	9	20.0%
Total	**45**	**100.0%**

4.2.13 Days sick leave per annum

Out of 43 respondents, 14.0% (n=6) indicated that they had 6 days, 4.7% (n=2) had 7 days, 7.0% (n=3) had 10 days, 46.5% (n=20) had 12 sick days per annum, 2.3% (n=1) had 14 days, 4.7% (n=2) had 15 days, 2.3% (n=1) had 30 days, 2.3% (n=1) had 35 days, 7.0% (n=3) had 3 months, 7.0% (n=3) had 6 months and 2.3% (n=1) was unsure. Respondents with more years working experience have more sick leave days per annum than those with less working experience according to the sick leave policy. The sick leave policy of the NHS hospital reviewed in July 2008 and amended in 2009 was that staff members were given sick leave according to their years of service. An example is that if one had worked for the NHS for a year one would be entitled to one month sick leave per year and two years in the institution one would be entitled to two months sick leave per annum. The sick leave policy was that the nurse manager is the one to assess the nurses and recommend more days according to the condition. The nurse can also be assessed by the family doctor who could recommend more days. For minor ailments which lasted more than 7 days, referral to the occupational nurse is done and a report is written concerning the illness. If the nurse's sick leave is less than seven days a self certificate form is filled in by the nurse when returning to work (Niczyporuk & Stevens 2009:8).

4.2.14 Number of days vacation leave taken

Table 4.11 indicates that 18.6% (n=8) respondents had taken between 0 to 9 days vacation leave during the preceding year, 37.2% (n=16) had taken 10 to 19 days, 32.6% (n=14) had

taken 20 to 29 days and 11.6% (n=5) had taken 30 days and more leave per year. Seven respondents did not answer this question

Table 4.11 Number of days vacation taken (n=43)

Vacation leave taken (Days)	Frequency	Percentage(%)
0 – 9	8	18.6%
10 – 19	16	37.2%
20 -29	14	32.6%
30 Up	5	11.6%

4.2.15 Days of sick leave taken

Out of 38 respondents, 42.1% (n=16) had taken 1-4 days sick leave. 34.2% (n=13) had 5-8, 15.8% (n=6) had 9-12 days, 5.3% (n=2) had fifteen and 2.6% (n=1) had 40 days sick leave. Out of the 38 respondents 71.0% (n=27) had taken 1-7 days' sick leave. These respondents did not submit medical certificates but they filled in forms for self certification according to the NHS policy and procedures (Niczyporuk & Stevens 2009:8). Three respondents did not know how many days sick leave they had during the previous year. Twelve respondents did not answer this question.76% (n=29) of the respondents who took sick leave are those with working experience of 0-10years, while 20%(n=9) are those with more than 20years. This study indicated that the less experienced respondents have a high rate of absenteeism

Table 4.12 Days of sick leave taken (38)

Days of sick leave taken	Frequency	Percentage %
1- 4	16	42.1%
5 – 8	13	34.2%
9 –12	6	15.8%
13 – 15	2	5.3%
More than 15 (40days)	1	2.6%
TOTAL	**38**	**100.0%**

4.2.16 Reasons for sick leave

This question was an open-ended question where each respondent gave an individual answer depending on the type of illnesses from which he/she had suffered. Respondents were absent from work due to different ailments. Table 4.13 presents the data obtained in response to this open-ended question.

Table 4.13 Reasons for sick leave

Reasons for sick leave	Number of respondents
Upper respiratory tract infections	17
Backache	8
Stress	4
Knee problems	2
Migraine	2
Arthritis	1
Injuries (not stated where)	1
Ear infections	1
Shoulder problems	1
Throat infections	1
Depression	1
Hypertension	1
Diarrhoea	1
Gynaecological problems	1
Acute viral infections	1
Headache	1
Fever	1
Toothache	1

Seventeen respondents suffered from upper respiratory tract infections, flu, coughs and colds. Eight suffered from backache, one had arthritis, four respondents had been absent from work due to stress two respondents experienced knee problems. In this study a large number (n=17) of respondents, were absent from work due to upper respiratory tract infections. According to O'Reilly and Stevens 2002:1 influenza has economic consequences, most notably sickness absence and associated work disruption. Two respondents experienced migraine and one was ill with an undisclosed injury while one respondent took leave because of each of the following conditions: coughing, ear infection,

shoulder problem, throat infection, depression, hypertension, diarrhoea, gynaecological problems, acute viral infection, headache, fever and toothache.

4.2.17 Absence from work without leave or sick leave

Only 38.0% (n=9) respondents indicated that they had been absent from work without leave or sick leave ranging from 0 to 5 days while 64.0% (n=31) respondents were reportedly never absent without leave or sick leave.

4.2.18 Reasons for absence without leave/sick leave

Respondents indicated that they faced the following problems that prevented them from going to work: seven had to take care of their children, two had to take care of their sick mothers, four had sick children, three were absent from work because of bad weather and one had a problem with transport. The eleven respondents who were absent because of child caring responsibilities in this study were all females. Each respondent could indicate more than one reason for being absent from work (explaining why these totals exceed 9). According to Isah et al (2008:7) females are more likely to be absent from work for reasons other than illness or injuries in order to fulfil other family responsibilities such as caring for a sick family member.
Each respondent could provide more than one reason.

Table 4.14 Reasons for absence without leave/sick leave

Reasons for absence without leave/sick leave	Number of respondents
Child caring	7
Mother sick	2
Child sick	4
Bad weather	3
Transport problem	1

Each respondent could provide more than one reason.

4.2.19 Summary of personal data

The findings on the study indicate that the majority of the respondents were females (82.0%, n=41) with only 18.0% (n=9) being males. A large number of respondents had from one to four dependants. Their marital status included being married, divorced, single and living with a partner. It was found that eleven respondents who were all females were absent from work because they had to take care of their children. Out of the 41 females in this study, 34 (82.9%) females had been absent from work. According to Isah et al (2008:7) several studies reported absence rates to be higher among females than among males, due to family responsibilities. The higher incidence of absence for married nurses could also be due to greater family responsibilities and household chores.

This study found that 56.0% (n=28) of the respondents stated that their units were not well staffed. Of the RNs, 56.0% (n=28) worked long hours (12½ hours a day), which might imply that the high workload contributed to exhaustion and absence/sick leave of nurses.

4.3 SECTION B: OPINIONS OF RESPONDENTS ON RAM NEEDS

This section consisted of 65 items of which seven addressed the physiological needs, 17 were related to the self concept, 11 related to role function, 12 related to interdependence relations and 18 addressed the possible actions that could be taken to address the absenteeism rate in a selected NHS hospital in London. Respondents were expected to indicate the degree of agreement and disagreement with reasons for absenteeism.

4.3.1 Respondents reasons regarding physiological needs

Table 4.15 presents the respondents' reasons regarding their physiological needs that influence of their absenteeism rates.

Table 4.15 Physiological needs that influenced nurses' absenteeism (n for each row is indicated in the last column)

SA – strongly agree; A - agree; D – disagree; SD – strongly disagree; f – frequency (number)

	I have been absent from work during the preceding 12 months because …	SA f	SA %	A f	A %	D f	D %	SD f	SD %	Total
1	I suffered from minor ailments	16	34.8%	12	26.1%	11	23.9%	7	15.2%	46
2	I suffered from a chronic condition	3	6.5%	12	26.1%	13	28.3%	18	39.1%	46
3	I suffered from work-related injuries	0	0	8	16.3%	22	44.9%	19	38.8%	49
4	I suffered from acute illnesses	12	26.1%	9	19.6%	14	30.4%	11	23.1%	46
5	of inadequate rest due to working long hours	8	17.8%	15	33.3%	12	26.7%	10	22.2%	45
6	I experienced transport problems	4	9.1%	15	34.1%	13	29.6%	12	27.3%	44
7	I could not reach my working place due to bad weather	5	10.9%	14	30.4%	14	30.4%	13	28.3%	46

Table 4.16 Respondents' interpretations regarding self concept issues as reasons for absenteeism reasons for absenteeism

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
1	I suffered from minor ailments	28	60.9%	18	39.1%	46
2	I suffered from a chronic condition	15	32.6%	31	67.4%	46

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
3	I suffered from work-related injuries	8	16.3%	41	83.7%	49
4	I suffered from acute illnesses	21	45.7%	25	54.3%	46
5	of inadequate rest due to working long hours	23	51.1%	22	48.9%	45
6	I experienced transport problems	19	43.2%	25	56.8%	44
7	I could not reach my working place due to bad weather	19	41.3%	27	58.7%	46

In item 1, out of 46 respondents 60.9% (n=28) agreed, while 39.1% (n=18) disagreed that they had suffered from minor ailments. In Item 2, 32.6% (n=15) agreed that they were absent from work due to chronic conditions, whereas 67.4% (n=31) disagreed that their absence from work was due to chronic conditions. In item 4, 45.7% (n=21) respondents agreed and 54.3% (n=25) disagreed that they were absent from work because of acute illnesses. A large number of respondents were absent due to ill health according to the findings in this study. Items 3 and 5 were work-related. In response to item 3, 16.3% (n=8) respondents agreed while 83.7% (n=41) disagreed that their absences from the workplace were due to work-related injuries. This finding is supported by the findings in a survey that was done by the Royal College of Nursing (RCN 2002c:8). This survey on sick leave and work-related illnesses or injuries found that one in four nurses had taken some sick leave in the three months up to the survey. Sixteen percent of nurses' absence in that survey were caused by a work-related illnesses or injuries. The survey shows that those with work-related illnesses or injuries were much less likely to be satisfied with their job (RCN 2002c:8). Out of 45 respondents in item 5, 48.9% (n=22) disagreed, 51.1% (n=23) agreed that they were absent due to exhaustion. Items 6 and 7 indicated that respondents had problems reaching their work place. In response to item 6, 43.2% (n=19) RNs agreed while 56.8% (n=25) disagreed that they encountered problems with transport. In item 7, 19 (43.3%) agreed and 27 (58.7%) disagreed that bad weather was the cause of their absenteeism.

4.3.2 The impact of self-concept issues on nurses' absenteeism rates

Table 4.17 Respondents' reasons regarding self - concept

SA – strongly agree; A - agree; D – disagree; SD – strongly disagree; f – frequency (number)

	I have been absent from work during the preceding 12 months because…	SA f	SA %	A f	A %	D F	D %	SD f	SD %	Total
8	I was using narcotics	1	2.2%	0	0	17	37.8%	27	60.0%	45
9	I was under the influence of alcohol	1	5.9%	0	0	10	58.8%	6	35.3%	17
10	My salary was inadequate	7	15.9%	10	22.7%	13	29.6%	14	31.8%	44
11	I had to do additional jobs for financial gain	4	11.4%	12	34.3%	18	51.4%	1	2.9%	35
12	of parental responsibilities	8	18.2%	10	22.7%	17	38.6%	9	20.5%	44
13	of family responsibility	9	20.5%	13	29.6%	12	27.3%	10	22.7%	44
14	I had to take care of my children during summer school holidays	3	7.1%	5	11.9%	21	50.0%	13	31.0%	42
15	I had to take care of a sick child/family member	7	24.1%	8	27.6%	1	3.5%	13	44.8%	29
16	I was harassed at work	2	4.4%	5	11.1%	20	44.4%	18	40.0%	45
17	I faced racism at work	1	2.2%	3	6.5%	25	54.4%	17	37.0%	46
18	I faced discrimination at work	1	2.3%	3	7.0%	25	58.1%	14	32.6%	43
19	I felt exploited at work	2	4.4%	3	6.5%	25	54.4%	16	34.8%	46
20	I experienced violence in the workplace	0	0	3	7.3%	24	58.5%	14	34.1%	41
21	I experienced criticism from the	2	4.8%	4	9.5%	20	47.6%	16	38.1%	42

	I have been absent from work during the preceding 12 months because…	SA f	SA %	A f	A %	D F	D %	SD f	SD %	Total
	public									
22	I was verbally abused by the patients and/or relatives	4	8.9%	9	20.0%	19	42.2%	13	28.9%	45
23	I was physically abused by the patients and/or relatives	1	2.5%	4	10.0%	19	47.5%	16	40.0%	40
24	I was unfairly disciplined	1	2.3%	0	0	23	53.5%	19	44.2%	43

Table 4.18 Respondents' interpretations regarding self concept issues as a reason for absenteeism

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
8	I was using narcotics	1	2.2%	44	97.8%	45
9	I was under the influence of alcohol	1	5.9%	16	94.1%	17
10	My salary was inadequate	17	38.6%	27	61.4%	44
11	I had to do additional jobs for financial gain	16	45.7%	19	54.3%	35
12	Of parental responsibilities	18	40.9%	26	59.1%	44
13	Of family responsibility	22	50%	22	50%	44
14	I had to take care of my children during summer school holidays	8	19.0%	34	81.0%	42
15	I had to take care of the sick child/family member	15	51.7%	14	48.3%	29
16	I was harassed at work	7	15.6%	38	84.4%	45
17	I faced racism at	4	8.7%	42	91.3%	46

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
	work					
18	I faced discrimination at work	4	9.3%	39	90.7%	43
19	I felt exploited at work	5	10.9%	41	89.1%	46
20	I experienced violence in the workplace	3	7.3%	38	92.7%	41
21	I experienced criticism from the public	6	14.3%	36	85.7%	42
22	I was verbally abused by the patients and/or relatives	13	28.9%	32	71.1%	45
23	I was physically abused by the patients and/or relatives	5	12.5%	35	87.5%	40
24	I was unfairly disciplined	1	2.3%	42	97.7%	43

In response to item 8, only one (2.2%) respondent strongly agreed that his/her absence from work was due to the use of narcotics while 97.8% (n=44) disagreed. In item 9, 5.9% (n=1) agreed that he/she was absent from work because he/she was under the influence of alcohol, while 94.1% (n=16) disagreed. Only 17 nurses respondents, responded to this item. One (2.2%) respondent was reportedly absent from work because of using narcotics. This study found that narcotics and alcohol were reportedly not significant problems causing absence from work. However these were only the nurses' self reports .

In item 10, 38.6% (n=17) of the respondents agreed that their salaries were inadequate while 61.4% (n=27) disagreed. In item 11, 45.7% (n=16) of the respondents agreed that they had to do additional jobs for financial gain, while 54.3% (n=19) disagreed. The living wage of a single person living in the UK is £13 400 a year before tax deductions to afford a basic acceptable standard of living (Allegra Stratton & Agencies 2008). These findings indicated that 45.7% (n=16) of respondents had to do extra jobs to support their incomes

when they were supposed to rest from their scheduled work. Table 4.4 indicates that 60.5% (n=29) were getting salaries of less than £2 000 per month. This salary was sufficient as a living wage in the UK when the data collection took place.

In item 12, 40.9% (n=18) respondents agreed that parental responsibilities caused absences from work while 59.1% (n=26) disagreed with the statement. Out of 44 respondents in item 13, 50.0% (n=22) disagreed that family responsibilities caused their absences whereas 50.0% (n=22) agreed. In item 14, 81.0% (n=34) disagreed and 19.0% (n=8) agreed that they were absent from work because they had to take care of children during summer school holidays. In item 15, 51.7% (n=15) of the respondents agreed that they were absent from work because of their responsibilities to take care of sick children or family members whereas 48.3% (n=14) disagreed.

Harassment, discrimination and racism reportedly did not have a large impact on absenteeism. In item 16, 84.4% (n=38) of the respondents disagreed, that they were absent from work due to harassment, whereas 15.6% (n=7) agreed that they experienced harassment at their workplace to the extent that they did not go to work at a specific time. In Item 17, 8.7% (n=4) agreed and 91.3% (n=42) disagreed that they faced racism at work to an extent that it caused absenteeism. In item 18, 90.7% (n=39) of the respondents disagreed, while 9.3% (n=4) agreed that their absenteeism was due to discrimination at work. In this study only a minority of respondents indicated that their reason for being absent was because of either racism 8.7% (n=4) or discrimination 9.3% (n=4).

Of the respondents (item 19), 89.1% (n=41) disagreed and 10.9% (n=5) agreed that they felt exploited at work. These findings are in contrast with the findings in a survey by the RCN (2003b:1) that found that nurses recruited from overseas were facing racism and exploitation while working in the UK. Some nurses in the RCN survey described their employment as “slavery” (RCN 2003b:1). In Item 20, 92.7% (n=38) respondents disagreed that they were absent from work because they experienced violence in the workplace, whereas only 7.3% (n=3) agreed with the statement. This findings does not indicate that large numbers of nurses were absent from work because they were victims of violence in the workplace.

In item 21, 85.7% (n=36) respondents disagreed, and 14.3% (n=6) agreed that they experienced criticism from the public in the workplace. In response to item 22, 28.9% (n=13) of the respondents agreed while 71.1% (n=32) disagreed that they were absent from work as they were verbally abused by the patients' and/or relatives. Of the respondents to item 23, 87.5% (n=35) disagreed and 12.5% (n=5) agreed that they were physically abused by patients and/or relatives. Although some of the respondents experienced verbal and physical abuse by patients and their relatives the findings indicate that these incidents were experienced by a minority of respondents. This study found that verbal 28.9% (n=13) and physical 12.5% (n=5) abuse were reportedly infrequently experienced by nurses whereas according to the RCN (2006a:1) nurses in Northern Ireland said that they had been physically and verbally abused at work.

In item 24, 97.7% (n=42) respondents disagreed that they had been unfairly disciplined, whereas only 2.3% (n=1) agreed with the statement that he/she was absent from work because he/she had been unfairly disciplined. The majority of respondents disagreed with the statements related to their self concept that influenced their being absent from work. An NHS survey done during 2008 found that internationally recruited nurses reported a higher percentage of bullying and harassment than UK qualified nurses. Most minority ethnic nurses thought that bullying and harassment were racially influenced or connected to their nationality (RCN 2009:3). These findings are in contrast with the findings in this study where only 8.7% (n=4) of the respondents indicated that they were absent from work due to incidents of racism.

4.3.3 Respondents' absence from work due to their role functions

Table 4.19 Respondents' opinions about their role functions (n for each row is indicated in the last column)

SA – strongly agree; A - agree; D – disagree; SD – strongly disagree; f – frequency

	I have been absent from work during the preceding 12 months because …	SA f	SA %	A f	A %	D f	D %	SD f	SD %	Total
25	Of the high workload in the unit	8	17.8%	15	33.3%	12	26.7%	10	22.2%	45
26	I was expected to work overtime in order to complete patient care activities	5	10.9%	14	30.4%	14	30.4%	13	28.3%	46
27	I had to work 12hours shift	7	15.6%	9	20.0%	11	24.4%	18	40.0%	45
28	of inflexible working schedule	3	6.7%	2	4.4%	24	53.3%	16	35.6%	45
29	my qualification were not considered for promotion	3	7.0%	3	7.0%	21	48.8%	16	37.2%	43
30	there was lack of promotion opportunities to the next rank	4	8.7%	6	13.0%	19	41.3%	17	37.0%	46
31	I had to do a job that required more skills than those that I had	0	0	1	2.6%%	23	59.0%	15	38.5%	39
32	I had to perform duties without a job description	0	0	1	2.3%	22	50.0%	21	47.7%	44
33	I was expected to perform duties of other multidisciplinary team members	0	0	1	2.8%	20	55.6%5	15	41.7%	36
34	of insufficient orientation about the job	1	2.2%	1	2.2%	26	57.8%	17	37.8%	45
35	other nurses are often absent from work	17	37.8%	13	28.9%	7	15.6%	8	17.8%	45

Table 4.20 Respondents' interpretations about their absence from work due to their role function

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE f	TOTAL DISAGREE %	Total =n
25	of the high workload in the unit	23	51.1%	22	48.9%	45
26	I was expected to work overtime in order to complete patient care activities	19	41.3%	27	58.7%	46
27	I had to work 12hours shift	16	35.6%	29	64.4%	45
28	of inflexible working schedule	5	11.1%	40	88.9%	45
29	my qualification were not considered for promotion	6	14.0%	37	86.0%	43
30	there was lack of promotion opportunities to the next rank	10	21.7%	36	78.3%	46
31	I had to do the a job that requires more skills than those that I had	1	2.6%	38	97.4%	39
32	I had perform duties without a job description	1	2.3%	43	97.7%	44
33	I was expected to perform duties of other multidisciplinary team members	1	2.8%	35	97.2%	36
34	of insufficient orientation	2	4.4%	43	95.6%	45

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE f	TOTAL DISAGREE %	Total =n
	about the job					
35	other nurses are often absent from work	30	66.7%	15	33.3%	45

Twenty two (48.9%) respondents (item 25) disagreed that they had been absent from work because of the workload in the unit, whereas 51.1% (n=23) agreed with this statement. Of the respondents 56.0% (n=28) indicated that their units were not well staffed. The increasing stresses on health care staff working day after day, night after night, might lead to greater levels of sick leave (RCN 2003d:1). In item 26, 41.3% (n=19) of the respondents agreed that they were expected to work overtime in order to complete patient care activities, while 58.7% (n=27) disagreed. In item 27, 64.4% (n=29) of the respondents disagreed that their absence from work were due to working 12 hour shifts, whereas 35.6% (n=16) agreed.

Of the 45 respondents who responded to item 28, 11.1% (n=5) agreed that they were absent from work due to inflexible working schedules, while 88.9% (n=40) disagreed with the statement. In a survey conducted by the RCN on “working well”, a quarter of the nurses questioned felt that their employers/managers did not do all that they could to help nurses balance home and work commitments, including helping them with flexible working arrangements to suit specific needs (RCN 2002c:7).

In item 29, 14.0% (n=6) of the nurses who responded agreed that they were absent from work because their qualifications were not considered for promotion, while 86.0% (n=37) disagreed with the statement. A large number of respondents to the statement in item 30, 78.3% (n=36) disagreed that their absence from work was due to lack of opportunities for promotion to the next rank, whereas 21.7% (n=10) agreed with the statement.

The majority, (97.4%; n=38) of the respondents to the statement in item 31, disagreed that they were absent from work because they were doing jobs that required more skills than those they had, while only 2.6% (n=1) agreed. One respondent 2.3% (n=1) in item 32 agreed that he/she had been absent from work because he/she was performing duties without a job description, whereas 97.7% (n=43) disagreed with the statement.

In item 33, out of 36 respondents, 97.2% (n=35) disagreed that they were absent from work because they were expected to perform duties of other multidisciplinary team members, while only 2.8% (n=1) agreed. In item 34, 4.4% (n=1) of respondents agreed that they were absent from work due to insufficient orientation to the job, while 95.6% (n=43) disagreed with the statement. It appears as if other nurses' conduct in relation to absence from work influenced respondents' decisions to go to work or not. In item 35, 66.7% (n=30) nurses agreed that they were absent from work because other nurses were often absent from work, while 33.3% (n=15) disagreed with the statement. Role functions need clarity, understanding and commitment for the group to be able to achieve a common goal.

4.3.4 Respondents' absence from work due to their interdependence relations

Table 4.21 Respondents' absence due to their interdependence relations
SA – strongly agree; A - agree; D – disagree; SD – strongly disagree; f – frequency

	I have been absent from work during the preceding 12 months because …	SA f	SA %	A f	A %	D F	D %	SD F	SD %	Total
36	I was treated unfairly by the hospital management	1	2.2%	1	2.2%	22	48.9%	21	46.7%	45
37	I could not get the off-duties requested	4	8.7%	2	4.4%	21	45.7%	19	41.3%	46
38	I experienced lack of communication about changes in the workplace	1	2.2%	5	10.9%	25	54.4%	15	32.6%	46
39	my organisation did not address health and	1	2.2%	1	2.2%	25	55.6%	18	40.0%	45

	I have been absent from work during the preceding 12 months because …	SA f	SA %	A f	A %	D F	D %	SD F	SD %	Total
	safety issues in the workplace									
40	I experienced lack of involvement in decision-making process	2	4.4%	7	15.2%	21	45.7%	16	34.8%	46
41	I experienced conflict with my nurse manager	2	4.4%	3	6.7%	22	48.9%	18	40.0%	45
42	the nurse manager failed to support me when performing patient care activities	1	2.3%	1	2.3%	25	56.8%	17	38.6%	44
43	there was insufficient group cohesion with peers	1	2.1%	5	10.6%	24	51.1%	17	36.2%	47
44	as a nurse trained in a foreign country I felt isolated	1	2.3%	6	13.6%	19	43.2%	18	40.9%	44
45	of inconsistence in handling of absenteeism by management	5	11.1%	10	22.2%	20	44.4%	10	22.2%	45
46	lack of decision-making power by nurses in the units	2	4.4%	8	17.4%	19	41.3%	17	37.0%	46
47	I was not consulted during policy making	2	4.4%	11	23.9%	15	32.6%	18	39.1%	46
48	there is lack of work ethics among nurses in the unit	4	8.9%	5	11.1%	25	55.6%	11	24.4%	45

Table 4.22 Respondents' Interpretation of absence from work due to their interdependence relations

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	Total =n
36	I was treated unfairly by the hospital management	2	4.4%	43	95.6%	45

	I have been absent from work during the preceding 12 months because …	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	Total =n
37	I could not get the off-duties requested	6	13.0%	40	87.0%	46
38	I experienced lack of communication about changes in the workplace	6	13.0%	40	87.0%	46
39	My organisation did not address health and safety issues in the workplace	2	4.4%	43	95.6%	45
40	I experienced lack of involvement in decision-making process	9	19.6%	37	80.4%	46
41	I experienced conflict with my nurse manager	5	11.1%	40	88.9%	45
42	The nurse manager failed to support me when performing patient care activities	2	4.5%	42	95.5%	44
43	There was insufficient group cohesion with peers	6	12.8%	41	93.2%	47
44	As a nurse trained in a foreign country I felt isolated	7	15.9%	37	84.1%	44
45	of inconsistence in handling of absenteeism by management	15	33.3%	30	66.7%	45
46	Lack of decision-making power by nurses in the units	10	21.7%	36	78.3%	46
47	I was not consulted during policy making	13	28.3%	33	71.7%	46
48	there is lack of work ethics among nurses in the unit	9	20.0%	36	80.0%	45

Support from management is important to create a conducive working environment for nurses. In item 36, 95.6% (n=43) of the respondents disagreed that they did not turn up for

duty because they had been treated unfairly by the hospital management, while 4.4% (n=2) agreed with the statement. In response to the statement in item 37, 87.0% (n=40) of the respondents disagreed that they were absent from work because they could not get the off-duties requested, whereas 13.0% (n=6) agreed. This corresponds with the findings in item 28 where a large number of respondents disagreed that an inflexible working schedule caused them to be absent from work.

In item 38, 87.0% (n=40) of the respondents disagreed, while 13.0% (n=6) agreed that they were absent from work because they had experienced a lack of communication about changes in the workplace. According to a survey done by the RCN on "working well" fewer NHS nurses were consulted by their employees about the facilities they wanted or needed (RCN 2002c:7).

Nurses should work in a safe environment, hence health and safety measures should be considered at all times. Out of 45 respondents to item 39, the majority 95.6% (n=43) disagreed that their absence was due to the organisation's failure to address health safety issues in the workplace, while 4.4% (n=2) agreed with the statement. The RCN highlighted two major health and safety workplace issues affecting nurses, namely latex allergy and sharps injuries (RCN 2002c:10) The managers' lack of involving respondents in decision-making and lack of support were addressed in items 40, 41 and 46. In item 40, 80.4% (n=37) of the respondents disagreed that they were absent from work because they experienced a lack of involvement in decision-making processes whereas 19.6% (n=9) agreed that this influenced their absenteeism. A large number of 88.9% (n=40) respondents (item 41) disagreed that their absence was due to conflict with the nurse manager, while 11.1% (n=5) agreed with the statement. Only 4.5% (n=2) respondents agreed that they were absent from work because the manager was unsupportive when they were performing patient care activities, while 95.5% (n=42) disagreed.

Out of 47 respondents to item 43, 12.8% (n=6) agreed that their absence was because of insufficient group cohesion with peers, while 93.2% (n=41) disagreed. Out of 44 respondents in item 44, 15.9% (n=7) agreed that they were absent from work because they felt isolated in the unit as nurses who trained in foreign countries, while 84.1% (n=37) disagreed. In item 45, 33.3% (n=15) agreed that they were absent from work due to inconsistent handling of absenteeism by management, while 30 (66.7%) disagreed.

The manager has to consult with other staff members in the unit during policy-making. This gives the staff a sense of belonging and they become dedicated to their work. Out of the 46 respondents in item 47, 78.3% (n=38) disagreed that their absenteeism was due to a lack of consultation during policy-making, while 21.7% (n=10) agreed with this statement..

Out of 45 respondents in item 48, 20.0% (n=9) agreed they were absent from work because of a lack of work ethics among nurses in the unit, while 80.0% (n=36) disagreed with the statement.

4.3.5 Respondents' opinions regarding the actions to be taken to address absenteeism

Table 4.23 Respondents' opinions regarding actions (n for each row is indicated in the last column) to address absenteeism

	Absenteeism can be addressed by ……	SAF	SA %	Af	A %	DF	D %	SDF	SD %	TOTAL
49	introducing stress-relief programmes	32	68.1%	12	25.5%	2	4.26%	1	2.1%	47
50	rewarding positive behaviour through buying back unused sick leave	30	62.5%	14	29.2%	3	6.3%	1	2.1%	48
51	ongoing monitoring of absenteeism within specific units	32	66.7%	13	27.1%	2	4.2%	1	2.1%	48
52	making nurses aware of their job responsibilities	29	58%	18	36%	3	6%			50
53	introducing a counselling service for nurses	32	68.1%	11	23.4%	3	6.9%	1	2.1%	47
54	correct placement of nurses according to their qualifications	32	65.3%	15	30.6%	1	2.0%	1	2.0%	49
55	recognising specific nurses extraordinary	34	70.8%	13	27.1%	1	2.1%			48

	Absenteeism can be addressed by ……	SAF	SA%	Af	A%	DF	D%	SDF	SD%	TOTAL
	achievements									
56	orientation and induction programmes for all nurses	33	71.7%	11	23.9%	2	4.4%			46
57	formulating a policy to address the maximum number of hours to be worked in a week	25	54.4%	17	37.0%	4	8.7%			46
58	devising a strategy to address racism in the workplace	23	50.0%	16	34.8%	5	10.9%	2	4.4%	46
59	providing a safe working environment for nurses	36	73.5%	10	20.4%	2	4.1%	1	2.0%	49
60	providing flexible working hours	35	72.9%	11	22.9%	2	4.2%			48
61	providing flexible vacation leave	35	72.9%	11	22.9%	2	4.2%			48
62	providing nurses with safe transport	31	66.0%	9	19.2%	4	8.5%	3	6.4%	47
63	introducing programmes on work ethics	22	45.8%	20	41.7%	6	12.5%	0	0	48
64	having adequate staff to cover each shift	32	68.1%	11	23.4%	2	4.3%	2	4.3%	47
65	providing accessible childcare facilities	29	65.9%	11	25.0%	4	9.1%		0	44

4.3.6 Interpretation of data regarding the possible actions to address absenteeism

Table 4.24 Respondents' interpretations actions to be taken (n for each row is indicated in the last column) to address absenteeism

	Absenteeism can be addressed by ……	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
49	introducing stress-relief programmes	44	93.6%	3	6.4%	47
50	rewarding positive behaviour through buying back unused sick leave	44	91.7%	4	8.3%	48
51	Ongoing monitoring of absenteeism within specific units	45	93.8%	3	6.2%	48
52	making nurses aware of their job responsibilities	47	94%	3	6%	50
53	introducing a counselling service for nurses	43	91.5%	4	8.5%	47
54	By correct placement of nurses according to their qualifications	74	96%	2	4%	49
55	By recognising specific nurses extraordinary achievements	47	98%	1	2%	48
56	orientation and induction programmes for all nurses	44	95.7%	2	4.3%	46
57	formulating a policy to address the maximum number of hours to be worked in a week	42	91.3%	4	8.7%	46
58	devising a strategy to address racism in the workplace	39	84.8%	7	15.2%	46
59	providing a safe working environment	46	93.9%	3	6.1%	49

	Absenteeism can be addressed by ……	TOTAL AGREE f	TOTAL AGREE %	TOTAL DISAGREE F	TOTAL DISAGREE %	TOTAL =n
	for nurses					
60	providing flexible working hours	46	95.8%	2	4.2%	48
61	providing flexible vacation leave	46	95.8%	2	4.2%	48
62	providing nurses with safe transport	40	85.1%	7	14.9%	47
63	introducing programmes on work ethics	42	87.5	6	12.5%	48
64	having adequate staff to cover each shift	43	91.5%	4	8.5%	47
65	providing accessible childcare facilities	40	90.9%	4	9.1%	44

This section deals with possible actions and steps that can be implemented to address absenteeism of staff. In response to the statement in item 93.6% (n=44) respondents agreed while 6.4% (n=3) disagreed that introduction of stress-relief programmes could address absenteeism rates. In item 50, 91.7% (n=44) agreed that rewarding positive behaviour through buying back unused sick leave could help to reduce absenteeism rates, while 8.3% (n=4) disagreed with the statement. Out of 48 respondents in item 51 only 6.2% (n=3) disagreed that ongoing monitoring of absenteeism within specific units could address absenteeism rates, whereas 93.8% (n=45) agreed. In response to item 52, out of 50 respondents, 94.0% (n=47) agreed while 6.0% (n=3) disagreed that making nurses aware of their job responsibilities could address absenteeism rates.

In response to the question of introducing a counseling service for nurses to reduce absenteeism (item 53), a large number of respondents 91.5% (n=43) agreed that the introduction of such a service would reduce absenteeism while 3 (6.4%) disagreed and 2.1% (n=1) strongly disagreed. Out of 49 respondents in item 54, 96.0% (n=47) agreed that absenteeism could be addressed by correct placement of nurses according to their qualification, while 4.0% (n=2) disagreed with the statement.

In item 55, 98.0% (n=47) of the respondents agreed whereas only 2.0% (n=1) disagreed that recognising specific nurses' extraordinary achievements might address absenteeism. In item 56, 95.7% (n=44) agreed while only 4.3% (n=2) disagreed that there should be induction and orientation programmes for all nurses. Out of 46 respondents in item 57, 91.3% (n=42) agreed while 8.7% (n=4) disagreed that the formulation of policy to address the maximum number of hours to be worked in a week could reduce absenteeism rates.

In item 58, 84.8% (n=39) of the respondents agreed while 15.2% (n=7) disagreed that absenteeism could be prevented by devising a strategy to address racism in the workplace. In item 59, the majority of respondents, 93.9% (n=46) agreed that the provision of a safe working environment for nurses would help to address absenteeism rates, while only 6.1% (n=3) disagreed with the opinion. In response to the statement in item 60, 95.8% (n=46) nurses agreed while 4.2% (n=2) disagreed that the provision of flexible working hours could address absenteeism rates. In response to item 61, 95.8% (n=46) agreed whereas 4.2% (n=2) disagreed that providing flexible vacation leave could solve the problem of not coming to work. Out of 47 respondents in item 62, 85.1% (n=40) agreed that if nurses were provided with safe transport to work, absenteeism could be reduced while 14.9% (n=7) disagreed. The introduction of programmes on work ethics (item 63) might help to resolve the problem of absenteeism. Only 12.5% (n=6) of the respondents disagreed with this statement, while 87.5% (n=42) agreed. In item 64, 8.5% (n=4) of the respondents disagreed that having adequate staff to cover each shift would reduce absenteeism, whereas 91.5% (n=43) agreed. In item 65, 9.1% (n=4) of the respondents disagreed while 90.9% (n=40) agreed that providing accessible childcare facilities could help nurses to be at work all the time as they would not be experiencing child care problems. A large number of respondents strongly agreed with actions stated in this section that could be implemented to address absenteeism rates as indicated in table 4.24. The RCN in its survey on "working well" recommended that employee-friendly; flexible work practices should be provided to all staff. These would allow nurses to balance their home and work lives. Flexible employers would find that staff are in turn more flexible to managers' needs (RCN 2002c:14).

Question 66 was open ended where respondents could give their opinions regarding any other steps that could be taken to address absenteeism rates in the workplace. Out of the

four respondents who answered this question, one recommended that better Trust policies and procedures should be introduced, while the other mentioned that overtime should be remunerated to inspire nurses to work overtime. The third respondent's opinion was to reward those nurses who do not always go off sick whereas the fourth one pointed out that ward managers had to be role models. This respondent further indicated that there should not be favouritism among the nurses as some ward managers tended to favour some nurses.

4.4 FINDINGS IN TERMS OF ROY'S ADAPTATION MODEL

The researcher used Roy's Adaptation Model to contextualise factors influencing absenteeism. Roy's theory focuses on a human being as an adaptive system, and as such must also adapt to the environment and the forces of nature. It further reveals the continual interaction with the environment. The findings are discussed in terms of physiological needs, self-concept, and role function and interdependence relations.

4.4.1 Physiological needs

The findings of this study indicated that nurses were off sick due to acute and chronic diseases, injuries and backache. Some of the diseases that caused absenteeism were mentioned in section 4.2.18. The most common illnesses that kept nurses away from work were upper respiratory tract infections, stress and backache. Sickness absenteeism among nurses is an important issue in manpower planning. It is one of the major administrative and staffing problems for nurse managers. The other problems that respondents experienced were related to bad weather 58.7% (n=28) and lack of transport 56.8% (n=25) to enable them to get to work. Physiological needs are operating resources, participants, capacities, physical facilities and fiscal resources (Connel School of Nursing 2008:1). If those resources are unavailable one cannot function as expected.

4.4.2 Self-concept

The study found that most females were absent from work due to parental and family responsibilities. In Figure 4.1 it was indicated that most nurses who responded were

females (82.0%). Eleven respondents were absent from work because they had to take care of their children, two were caring for their sick mothers and all these respondents were females. Narcotics and alcohol abuse, were not found to be important factors that influenced absenteeism in this study. Inadequate salaries necessitating respondents doing additional jobs for financial gain, harassment, racism, discrimination exploitation and both verbal and physical abuse by patients and relatives were discussed in relation to table 4.12. Psychological well-being of nurses is greatly affected by workplace practices and conditions. Poor psychological health is directly related to increased sickness absence. Bullying is linked with a high level of sick leave and nurses on long-term sick leave had experienced bullying. In the NHS hospitals there was still a culture where poor inter-staff relations were allowed to perpetuate, and assaults on staff by the public were tolerated (RCN 2002c:5&9). This study indicated that 12.5% (n=5) of respondents agreed that they were absent from work because they experienced physical abuse by patients and/or relatives while at work.

4.4.3 Role function

The findings in this study indicated that the majority of respondents agreed that group cohesion was strong in the units and managers were supporting them. The need to know who one is in relation to others so that one can act and to have role clarity for all participants in a group is important (Current Nursing 2009:7) Nurses' qualifications and skills were considered for promotion to the next rank. Some respondents had problems with off-duties which caused them to stay away from work. Table 4.14 depicts the findings related to role function.

4.4.4 Interdependence relations

This study found that communication and relationships between nurses and managers was not a cause of absenteeism. A majority of respondents (87.0%; n=40) disagreed with the statement that they experienced a lack of communication in the workplace. Most respondents 71.7% (n=33) were consulted during policy formulation within the unit. Concerning interdependence, there should be a need to achieve relational integrity using the process of affectional adequacy, that is, the giving and receiving of love, respect and

value through maintaining effective relations and communication (Connel School of Nursing 2008:2).

4.5 Summary

This chapter discussed the data analysis and interpretation supported by literature. The aim of this study was to identify factors influencing nurses absenteeism rates at one NHS hospital in London. The main findings of the study were summarised in each section.

Chapter 5 concludes the study, discusses its limitations and makes recommendations for practice and further research.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a discussion of the conclusions based on the research findings presented in chapter 4, pertaining to the factors influencing absenteeism among professional nurses in a selected NHS hospital in London. The conclusions will be presented with reference to the objectives. Limitations of the study will be addressed and recommendations for practice and further research will be provided. The purpose of this study was to identify factors contributing towards absenteeism amongst professional nurses in a selected NHS hospital in London and to recommend strategies to address the problem of absenteeism of nurses in that hospital.

5.2 Research design and method

A quantitative exploratory descriptive design was used to identify and describe factors that influence absenteeism rates of professional nurses in a selected NHS hospital in London.

5.3 Summary and interpretation of the research findings

The summary and interpretation of the research findings are based on the analysis of data obtained from 50 questionnaires completed by professional nurses working in a selected NHS hospital in London. The summary will be presented according to the objectives guiding the study and in relation to Roy's Adaptation Model.

The items on which more than half (50.0% and more) of the respondents agreed were regarded, for the purpose of this study, as indicating important reasons that contributed to absenteeism rates.

5.3.1 Profile of respondents

Fifty respondents participated in the survey representing professional nurses in a selected NHS hospital in London, England. Respondents were mainly female (82.0%; n=41) and married (60.4%; n=29). The highest qualifications achieved were Bachelors degrees (51.0%; n=25) while 46.0% (n=23) of the respondents had diplomas. Respondents' categories were 62.5% (n=30) staff nurses and 35.4% (n=17) sisters of whom 24% (n=12) had 0-5 years' experience of working in the same institution and 14% (n=7) had more than 25 years experience.

5.3.2 Physiological needs influencing absenteeism rates

Respondents (60.9%; n=28) indicated that one of the reasons for not going to work was because they suffered from minor ailments. As many as 40.4% (n=17) were absent from work due to upper respiratory tract infections. Fifty one percent (51.1%; n=23) were absent from work due to exhaustion as a result of working long hours. Factors such as lack of transport, bad weather and chronic conditions were not regarded as important causes of absenteeism. The findings in this study indicated that minor ailments and inadequate rest were the most important causes of absenteeism. Absence attributed to sickness cannot be wholly eradicated because of the inevitability of disease and ill health (Johnson et al 2003:336).

5.3.3 Self concept influencing absenteeism rates

Parental responsibilities (40.9%; n=18) and taking care of sick children/family members (51.7%; n=15) were the most important factors that caused respondents' absence from work. This study found that 50.1% (n=22) of the respondents were absent from work due to family responsibilities. As depicted in figure 4.1 most of the respondents (82.0%; n=41) were females with family to take care of. Sixty percent (60.4%;n=29) of respondents were married with dependent children and/or family members.

5.3.4 Role functions' influence on absenteeism rates

Respondents indicated that their reasons for not going to work were because of the high workload in the unit (51.1%; n=23) aggravated by the fact that other nurses were often absent from work. Factors like inflexible working schedules (11.1%; n=5), qualifications not being considered for promotion (14.0%; n=6), lack of skills (2.6%; n=1), performing other multidisciplinary team members' tasks (2.8%; n=1) and insufficient orientation to the job (4.4%; n=2) were not considered by respondents as being major reasons for absenteeism.

5.3.5 Interdependence relations' influence on absenteeism rates

Respondents did not agree that factors falling under the mode of interdependence relations caused absenteeism. They disagreed with all the following statements that the management treated them unfairly (95.6%; n=43), did not get the off-duties requested (87.0%; n=40), there was lack of communication about changes in the workplace (95.6%), lack of involvement in decision-making process (80.4%, n=37) that there was a no support when performing patient care activities (95.5%; n=42), managers did not consult them during policy making (71.7%; n=33),there were inconsistencies in handling absenteeism (66.7%; n=30) and that they experienced conflict with the nurse manager (88.9%; n=40). Respondents further disagreed that health and safety issues in the workplace were not addressed (95.6%), that there was insufficient group cohesion with peers (93.3%, n=41), that there was a lack of work ethics among nurses in the unit (80.0%, n=36) and that nurses trained in foreign countries felt isolated (84.1%; n=37).

5.4 Summary

The main factors influencing absenteeism rates among nurses in one NHS hospital in London, based on the findings of this study were that respondents:

- suffered from minor ailments (60.9%; n=28).
- had inadequate time to rest due to long working hours (51.1%; n=23).
- were responsible for taking care of their sick children or family members (51.7%; n=15).

- were experiencing high workloads in their units (51.1%; n=23).
- indicated that their absences were due to other nurses' frequent absences from work, necessitating them to do their own work and the work of those who were absent (66.7%; n=30).

5.5 RECOMMENDATIONS

Recommendations will be provided for reducing nurses' absenteeism rates and for future research. The recommendations should be implemented and evaluated after a set period of time in order to determine whether absenteeism rates have in fact been reduced. Not all recommendations were made based on the findings (Although an attempt was made to formulate recommendations according to the findings of the study, some of the recommendations are out of the literature and not really related to the findings of the study).

5.5.1 RESEARCH

- It is recommended that similar studies should be conducted in NHS hospitals in the UK to obtain comparative data about factors influencing absenteeism among professional nurses in different hospitals and in different regions of England.
- Further research should be conducted using in-depth interviews to explore factors influencing absenteeism rates.

5.5.2 REDUCING NURSES' ABSENTEEISM RATES

- Employers should reward nurses' positive behaviours through buying back unused sick leave. This would be showing appreciation to those nurses who used fewer days of sick leave.
- The number of days of sick leave acceptable without medical certificate could be reduced to three days.
- Anti-influenza immunisation, proper precautions, supplements and early treatments of symptoms for influenza, colds, coughs and other upper respiratory tract infections

should be encouraged because they could have major impacts on nurses' absence rates and on the duration of such illness-related absences.

- The NHS should do research on the nurses who used the anti-influenza immunisations compared to those who did not get immunised to determine if the vaccinated nurses used fewer days of sick leave.
- Units need an ongoing monitoring of absenteeism so that factors contributing to absenteeism rates in specific units could be identified and addressed.
- Orientation and induction programmes should emphasise the need to address absenteeism among nurses.
- Nurses who are often absent due to physical, social or psychological problems should receive counselling and be referred to appropriate resource persons such as occupational nurses, social workers or psychologists.
- An award scheme for those employees with perfect attendance as an incentive to turn up for work, should be considered. For example, those nurses who never missed a day during summer could be entered into a draw for a weekend away, a trip to beauty spa or a dinner for two (Softworks Computing Limited 2005:1). Such a scheme need not cost the institution much money.
- Policies should address the maximum number of hours worked per week to prevent nurses from becoming exhausted. Working with shortages of staff or working overtime to cover for absent co-workers creates both mental and physical stress (Taunton et al 1995:80).
- The units should have adequate staff to cover each shift and workload to be manageable.
- Child care facilities should be provided within the workplace.
- Nurses should be involved in decision making and policy making of the unit and communication of the multidisciplinary team should be enhanced. Harter (2001:53) stated that less involvement in decision making can result in increased absence due to employees' decreased levels of job satisfaction resulting in excessive rates of absence. Nurses' absenteeism rates could be further reduced by adhering to policies and procedures pertaining to absenteeism, supporting shared governance, maintaining effective communication to address the causes of absenteeism, using absentee control programmes and bargaining.

5.6 LIMITATIONS OF THE STUDY

The interpretation of the research results are subject to the following limitations of the study:

The research was conducted in one selected NHS hospital in London. The findings can therefore not be applied to other hospitals without conducting further studies in randomly selected hospitals in London

Despite efforts to secure a high return rate of completed questionnaires, by sending out three sets of reminders to potential respondents, a low response rate of 33.0% (n=30) was achieved, which could impact negatively on the generalisability of the findings. No guarantees can be provided that those nurses who completed and returned questionnaires had the same experiences as those who failed to do so.

Some respondents might have misinterpreted some items in the questionnaires.

The population included only RNs and consequently, the results might not be generalised to other categories of nurses.

Despite these limitations, this study attempted to identify factors influencing nurses' absenteeism rates and findings and recommendations should be viewed against these limitations.

5.7 CONCLUDING REMARKS

This explorative, descriptive study sought to describe factors that influenced absenteeism among nurses in a selected NHS hospital in London. Fifty registered nurses participated in the study by completing and returning self-administered questionnaires. This study found that the main reasons for nurses' absenteeism were minor ailments, inadequate rest due to long working hours, family responsibilities, caring for sick children or family members, high workload in the units and the frequent absences from work by other nurses.

Recommendations made could contribute to the more effective management and reduction of nurses' absenteeism rates at this hospital in London.

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QUESTIONNAIRE COVERING LETTER (for Staff nurses)

Dear Colleague

I am currently registered with the University of South Africa for the Masters Degree in Health Studies (MA Cur). The title of my dissertation is: Factors influencing absenteeism in London hospitals.

You have been selected to participate in this study. The information obtained may result in a better understanding of the needs of nurses within the Trust. Your kind cooperation will enable me to understand and highlight the factors influencing absenteeism rate in the workplace. Recommendations based on the research findings will be brought to the attention of the relevant authorities. There are no payments for participating in this study. Participation is voluntary.

You are requested to complete the questionnaire by marking the appropriate box with an (X) and by commenting on the open-ended questions in the space provided. Anonymity will be maintained and all collected data will be kept in strict confidentiality. Your name will not be on the questionnaire. Only the researcher and those assisting will have access to the information you provide. If you may need any assistance during the completion of the questionnaire you may contact the researcher at this number 013 8435 2675. Please fold your questionnaire and return to the researcher in the enclosed stamped envelope.

Thank you very much for your cooperation.

Lesetja Madibana

Questionnaire

Instructions for completing the questionnaire:

1. Indicate your response by marking the appropriate box with a cross (x), and provide details where required.

2. Please answer the questions as frankly, honestly and objectively as possible.

3. Please answer questions as they apply to you personally.

SECTION A

1 How old are you? e.g. 39

	Years

2 Indicate your gender?

Male	
Female	

3 What is your marital status?

Married	
Divorced	
Widowed	
Separated	
Never been married	
Other, please specify	

4 What is your highest nursing qualification?

Diploma	
Bachelor's degree	
Master's degree	
Doctorate	
Other, please specify	

5 How many dependants do you have? e.g. 01

6 What is your monthly (30 day) income

Up to £999	
£1 000 - £1 499	
£1 500 - £1 999	
£2 000 and more	

7 What is your current nurse category in the working situation?

Staff nurse	
Senior staff nurse	
Junior sister	
Senior sister	
Other, please specify	

8 How many years of experience do you have after completion of basic nursing training? e.g. 02

9 How many years have you been working for the present employment/organisation?

10 How many days a week do you work?

One	
Two	
Three	
Four	
Five	
More than five	

11 How many hours a day do you usually work?

Four hours or less	
Six hours	
Seven and half hours	
Twelve and half hours	

12 Is your unit well staffed?

Yes	
No	

13 How many days leave do you have per annum?

_____

14 How many days sick leave do you have per annum?

_____

15 How many days vacation leave did you use during the preceding 12 months? _____

16 During the preceding 12 months how many days sick leave did you use? _____

17 What was the most important reason for your sick leave during the preceding 12 months?

_____
_____
_____
_____

18 During the preceding 12 months, how many days were you absent from work without leave or sick leave? _____

19 What was the most important reason for your absence without leave/sick leave during the preceding 12 months?

_____
_____
_____
_____

SECTION B

The following statements address various reasons for absence from work. Please indicate your agreement/disagreement with the statements by marking the appropriate box. (Indicate your answer by marking the appropriate box with a cross (x), according to the scale "strongly agree", "agree", "disagree", "strongly disagree").

	I have been absent from work during the preceding 12 months because …	**1 Strongly agree**	**2 Agree**	**3 Disagree**	**4 Strongly disagree**	**5 Please specify**
1	I suffered from minor ailments					
2	I suffered from chronic condition					
3	I suffered from work-related injuries					
4	I suffered from acute diseases					
5	of the workload in the unit					
6	of inadequate rest due to working long hours					
7	I was expected to work overtime in order to complete patient care activities					
8	I was using narcotics					
9	I was treated unfair by hospital management					
10	of parental responsibilities					

11	of family responsibilities					

12	I was under the influence of alcohol					
13	I had to work 12 hour shift					
14	I could not get the off-duties requested					
15	of inflexible working schedules					
16	I experienced lack of communication about changes in the workplace					
17	my organisation did not address health and safety issues in the workplace					
18	I experienced a lack of involvement in decision-making processes					
19	I experienced conflict with my nurse manager					
20	the nurse manager failed to support me when performing patient care activities					
21	my qualifications were not considered for promotion					
22	There was lack of promotion opportunities to the next rank					
23	I had to do a job that requires more skills than those which I had					

24	I had to perform duties without a job description					
25	I was expected to perform duties of other members of the multidisciplinary team					
26	of insufficient orientation about the job					
27	my salary was inadequate					
28	I had to do additional jobs for financial gain.					
29	I experienced transport problems					
30	I could not reach my working place due to bad weather					
31	I had to take care of my children during summer school breaks					
32	I had to take care of the sick child/family member					
33	I was harassed at work					
34	I faced racism at work					
35	I faced discrimination at work					
36	I felt exploited at work					
37	I experienced violence in the workplace					

38	I experienced criticism from the public					
39	I was verbally abused by patients and/or relatives					
40	I was physically abused by the patients and/or relatives					
41	there was insufficient group cohesion with peers					
42	as a nurse trained in a foreign country I felt isolated					
43	other nurses are often absent from work					
44	there is a lack of work ethics among nurses in the unit					
45	of inconsistent handling of absenteeism by management					
46	I was unfairly disciplined					
47	lack of decision making power by nurses in the units					
48	I was not consulted during policy making.					

SECTION C

To what extent do you agree/disagree with the following actions to address absenteeism among professional nurses in London?

(Indicate your answer by marking the appropriate box with a cross (x), according to the scale "strongly agree", "agree", "disagree", "strongly disagree").

	Absenteeism can be addressed by ……	**1 Strongly agree**	**2 Agree**	**3 Disagree**	**4 Strongly disagree**	**5 Please specify**
49	introducing stress-relief programmes					
50	rewarding positive behaviour through buying back unused sick leave					
51	ongoing monitoring of absenteeism within specific units					
52	making nurses aware of their job responsibilities					
53	Introducing a counselling services for nurses					
54	by correct placement of nurses according to their qualifications					
55	by recognising specific nurses extraordinary achievements					
56	orientation and induction programmes for all nurses					
57	formulating a policy to address the maximum number of hours to be worked in a week					
58	devising a strategy to address racism in the workplace					
59	providing a safe working					

	environment for nurses					
60	providing flexible working hours					
61	providing flexible vacation leave					
62	providing nurses with safe transport					
63	introducing programmes on work ethics					
64	having adequate staff to cover each shift					
65	providing accessible childcare facilities					

66 Please mention any other steps that can be taken to address absenteeism rate in the workplace:

_____

_____

_____

_____

YOUR CO-OPERATION IN THIS STUDY IS HIGHLY APPRECIATED.