SETTING UP OF AN OCCUPATIONAL SAFETY AND HEALTH SYSTEM FOR PUBLIC HOSPITALS IN MALTA

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of

Masters of Health Science in Health Services Management

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August 2003
To my children

Ryan and Nicole

Precious gifts from God
DECLARATION

I, the under signed, declare and certify that this dissertation is entirely my own work submitted in partial fulfilment of the requirements for the Masters of Health Science in Health Services Management, as supervised by Dr. N. Azzopardi Muscat.

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EXECUTIVE SUMMARY

Few workplaces are as complex as the hospital setting whereby employees are exposed to a list of potential hazards. Maintaining the health, safety and wellbeing of such workforce is essential and besides being a statutory requirement it will eventually bring economic benefits to the organisation. Occupational health and safety needs to be managed and within this context an Occupational Safety and Health Management System can be a helpful instrument.

The study aimed to carry out a situation analysis on occupational health and safety practices at Malta’s main general hospital (St. Luke’s Hospital) with a view to making appropriate recommendations for the setting up of an Occupational Safety and Health Management System for public hospitals.

An exploratory design making use of qualitative methods was used. Data was collected through focus group interviews with different categories of employees working at St. Luke’s Hospital, personal interviews with selected personnel and analysis of existing policies at St. Luke’s Hospital related to health and safety.

Findings revealed that several potential physical and psychological hazards in the hospital still need to be addressed. A general agreement that something need be done by the all parties involved (management and employees) was noted giving encouraging signs for possible future collaboration between the management and staff. A lack of health and safety policies and guidelines in the hospital was also revealed and communication of the few existing policies is poor
and requiring further attention. The few training initiatives being tackled concern elements of controlling physical risks (e.g. needlestick injury).

Following such findings some recommendations are made. The setting up of an Occupational Health and Safety Management Team is deemed as being of immediate importance. Other recommendations include formulation of a health and safety policy document and review of existing policies, provision of specialised staff counselling and guidance clinics, further training related to occupational health and safety and the introduction of an employment exit review system.

The main limitations of the study were related to interpretation bias, absence of quantitative data, time constraints and lack of interviewing experience from the researcher.
CHAPTER ONE

1.0 Introduction and background

1.1 Management of health and safety.

Several work related accidents and occupational health disorders could easily be prevented if organisations allocate adequate resources for health and safety (Chissick & Derricott, 1981). Preventing work related accidents, occupational injuries and disease can bring about economic benefits to the company/organisation whilst help in improving the company's performance (European Agency for Safety and Health at Work, 2002a). On the other hand, problems associated with inadequate health and safety management can result in time off work due to injury, stress, temporary or permanent disability to the employees and increased staff turnover (National Audit Office, 2003). Promoting a healthy and safe working environment is essential for any organisation if it wants to achieve the best results from its human resource potential (Cassar, 1998).

Unfortunately, although the above-mentioned statements are widely known, employers sometimes consider occupational health and safety measures as an extra additional expense or burden (Grech, 2002) and fail to understand the benefits that can be derived from such a setup. In organisations where the benefits derived from health and safety practice at work are understood, an
Occupational Safety and Health Management System is often set up as part of the risk management strategy to protect the workforce and meet legislative requirements. The main aim behind an Occupational Safety and Health Management System is to promote a safe and healthy working environment by ensuring that hazards and risks in the workplace are eliminated or controlled in a systematic manner (ILO - OSH, 2001).

1.2 Statement of the problem.

Public hospitals in Malta offer a range of services of a considerably good quality standard. However, issues related to physical working conditions and other occupational health and safety matters are sometimes not given their due importance. Such state is reflected in frequent complaints from the employees, which at times end up into a management-union dispute. Immediate action is necessary in order to reduce possible negative effects on the present workforce that may ultimately result in a decreased quality of care and additional costs to the organisation. The situation need also be addressed in view of current legislative requirements.
1.3 Overview of occupational health and safety in Malta.

1.3.1 National legal framework.

The first law to be enacted in Malta with reference to health and safety was the Factories Regulations Act of 1926. This Act dealt with the employment of woman and children together with the general conditions of employment relating to factories. A second milestone in health and safety legislation was the enactment of the Factories Ordinance in 1940. Under the Factories Ordinance, an important set of regulations entitled Factories (Health, Safety and Welfare) Regulations were issued in 1986. The major problem with the Factories Ordinance and the Factories Regulations was that a number of workers were not covered by the law due to the strict interpretations given to the terms factory and place of work. In 1994 the Act for the Promotion of Occupational Health and Safety (Act VII of 1994) which effectively repealed the Factories Ordinance was adopted. This Act was applicable to all places of work in Malta including businesses of self-employed persons and through this Act, employers were rendered responsible for health and safety of workers. As part of the process to transpose European Union acquis into Maltese legislation, an Act entitled Occupational Health and Safety Authority Act (Act XXVIII of 2000), set up the OHSA. This authority is responsible for ensuring the promotion of physical, psychological and social well being of workers in all work places in Malta (Laws of Malta, 2002).
1.3.2 Statistics on accidents and fatalities at work.

According to statistics published by the National Statistics Office the number of annual accidents that happen at the workplace in Malta is around 5,000 each year (see Figure 1) with the majority of accidents occurring amongst male employees (Appendix 5) within elementary occupations (construction, manufacturing and transport). Females working in elementary occupations also feature at the top of the list for involvement in workplace accidents. However, it is important to point out that associate professionals, particularly nurses, come in the second highest risk category for accidents at work (National Statistics Office-Malta, 2002).

**Figure 1** Accidents at Work in Malta (1999-2001)

As regards fatalities (see Figure 2 or Appendix 6), there has been an average of 8 fatal accidents per year since 1993 (National Statistics Office-Malta, 2002).

**Figure 2** Fatal Accidents at Work in Malta (1993-2001)

![Graph showing fatal accidents from 1993 to 2001](image)


In 2002, the Occupational Health and Safety Authority (Malta) published a market research report forming part of a 'Twinning Project' funded by the European Union with the aid of the Health and Safety Authority (Ireland) and the Health and Safety Executive (UK). This report noted a progressive decline in
reported occupational injuries amongst employed persons in Malta for the period 1991 - 2001. An estimated decline of 3.2% annually had been reported, bringing the figures down from 7,062 in 1991 to 5,103 in 2001 (Occupational Health and Safety Authority, 2002). In a separate survey issued by the National Office of Statistics, a decrease of 15% in the number of occupational accidents in Malta was noted within the first quarter of 2002 as compared with figures for the same quarter in the previous year (Occupational health authority concerned at accidents statistics, 2002). Another report from the National Office of Statistics showed a steady annual decline in occupational accidents between the period 1999 and 2001 (National Statistics Office-Malta, 2002).

Such statistical results look positive and encouraging, however it is important that they are interpreted with caution. It should be noted that in the above-mentioned reports, the figures only represent claims made to the Department of Social Security for subsequent sickness benefits, thus leaving out unreported cases or possibly counting more than one claim for the same accident. Under the Factories Regulations of 1986, all employers in Malta have the legal obligation to inform the Occupational Health and Safety Authority about any accident at their place of work that results in either injury or death. As this obligatory practice is not regularly undertaken (Occupational health authority concerned at accidents statistics, 2002) there is a difficulty in correlating the appropriate data and statistics on occupational injuries or ill health to provide an accurate picture regarding the current situation on the Maltese Islands.
### 1.3.3 Costs of work related accidents in Malta.

A study commissioned by Malta's Ministry of Social Policy in 1997 estimated that approximately 280,598 working days were lost as a result of occupational injuries with a resultant direct and indirect cost of around LM 8,048,413. The same report concluded that the estimated cost required for providing the necessary medical treatment and rehabilitation to the sick and injured persons is somewhere around LM24 million annually (Construction work injuries double, 2000). More recent figures pertaining to the costs of occupational accidents in Malta for the year 2002 are estimated to be within the region of LM 14 million (Vella, 2003).

### 1.4 Occupational health and safety in the hospital sector.

The health care sector is a labour intensive industry and workers within this sector represent highly diverse educational and social levels. This workforce comprises a wide range of professional, technical and support personnel working in a large variety of settings including hospitals, health centres and home care facilities (Yassi & Warshaw, 1998). In a pilot study carried out within all member states of the European Union (European Agency for Safety and Health at Work, 2000), healthcare workers emerged amongst the top categories of workers most frequently exposed to a set of selected hazard exposure indicators.
Few workplaces are as complex as the hospital setting, which not only provides the basic health care needs for a large number of people, but is often a teaching and research centre. As a result, the list of potential hazards encountered in hospitals is vast and includes elements of exposure to radiation, toxic chemicals, biological hazards, heat, noise, dusts and stress amongst others (National Institute for Occupational Safety and Health, 1998). Certain potential hazards vary in presence and intensity according to the different service areas or departments within the hospital such as administration offices, surgical suites, laboratories, wards, pharmacy, housekeeping, laundry and dietary facilities. All these areas and other service delivery points have their own specific potential occupational hazards which need to be considered in addition to other healthcare wide hazards such as stress (Occupational Safety and Health Authority, 2002). There is also the tendency amongst health care workers, that when dealing with special emergency situations they often tend to put the safety and comfort of the client above their own. Such practices often pose serious health problems to the workers themselves (Yassi & Warshaw, 1998), which could also be transmitted to their relatives and friends.

In hospitals, like in any other organisation, health and safety risks need to be controlled in order to try and minimise injuries and work-related ill health. The basis of effective risk control is founded on the roots of an effective health and safety management system. This can be described as the process through which
a workplace turns uncontrolled hazards into controlled risks (Health and Safety Executive, 2001).

Under current legislation, all employers are required as far as possible to ensure the health and safety of their staff. Poor attention to health and safety issues within the hospital can affect staff recruitment and retention accompanied by wider detrimental effects on the quality of service, staff morale and general public opinion (National Audit Office, 2003). As preparations are on their way for the transferring of services and personnel from St. Luke's Hospital to the new Mater Dei Hospital, it is important to seize the opportunity and start preparing for the setting up of a Safety and Health Management System. Efforts should not only be concentrated on the physical aspects of the project but also on the wider vision based on modern principles of management incorporated in the philosophy and operational procedures of the new hospital (Deguara, 2002). A systematic approach whereby health and safety objectives are managed in the same way as financial, service or quality objectives will eventually help to achieving a high standard of health and safety performance within the hospital.

The implementation of such a system is usually accompanied by a considerable amount of expenditure (especially in the beginning) for the organisation but also provides several benefits (European Agency for Safety and Health at Work, 2002b) including:

- Increasing awareness of hazards and risk factors.
• Providing a means for a systemic analysis of risks, hazards and incidents.

• Better measures of occupational safety and health performance within the organisation.

• Enhanced communication amongst employees.

• Achieving stronger motivation and identification of employees with the organisation.

1.5 Aim of the study project.

The study aimed to carry out a situation analysis on occupational health and safety practices at Malta’s main general hospital (St. Luke’s Hospital) with a view to making appropriate recommendations for the setting up of an Occupational Safety and Health Management System for public hospitals.

1.6 Objectives of the study.

In order to achieve the above aim the following study objectives were set:

1. To assess the knowledge, practices and attitudes of different categories of workers employed within the hospital vis-à-vis safe working practices.
2. To analyse and evaluate the effect of any existing policies, protocols or documents regarding health and safety within the hospital.

3. To outline those aspects to be tackled in preparation for the setting up of an Occupational Safety and Health Management System for local public hospitals.

4. To identify the resources required for setting up an OSHMS.

1.7 Justification for the study.

Revolutionary changes in work processes, coupled with subsequent changes in responsibilities of employees have created a need to strengthen and adapt methods used to ensure that health and safety is protected and promoted at the enterprise level. Solutions are required to allow employers to take account of health and safety principles at all operational levels and convert them into appropriate measures on a routine basis. Occupational health and safety has to be managed and within this context an Occupational Safety and Health Management System can be a helpful instrument. Whilst there is a general agreement about the main requirements for an effective system, particularly the need for active management and employee involvement there are specific organisational issues that need be explored. Imposition of a system may not work. Further knowledge on issues like culture and perceptions on health and safety can
help to ensure successful implementation of an Occupational Safety and Health Management System leading to this first study to be carried out on this topic in Maltese hospitals.

1.8 Service/management implications.

Particular findings from this study could prove useful to assist management by:

1. Understanding the issue of health and safety within the hospital setting, pointing particular areas that require attention and/or action to be taken.

2. Identify resources that are required to set up an occupational health and safety system within the hospital.

3. Giving an idea of management and operational facilities and structures that need to be modified and geared towards achieving a desired level of health and safety performance.
CHAPTER TWO

2.0 Literature Review

2.1 Introduction.

This chapter discusses literature on Health and Safety Management Systems. The main elements that make up an Occupational Safety and Health Management System are reviewed and account of some particular models in use followed by selected experiences of health and safety management in Malta and abroad is presented. Issues to consider in the management of health and safety like safety culture, risk management and economic factors are also dealt with. This chapter closes by focusing on some hazards typical to the hospital sector.

Information on the subject was gathered through books and journal articles dealing with topics related to health and safety. Websites of international official bodies provided detailed material and online publications have been downloaded and used. Some difficulty to find published literature on experiences with the implementation of health and safety management systems was encountered so a number of reports on the subject had to be used instead.
2.2 Background to safety and health management systems.

An occupational safety and health management system has been defined as a documented and verifiable set of plans, actions and procedures to systematically manage health and safety at the place of work (National Occupational Health and Safety Commission, 2002). The system may be simple or complex and it can be developed in-house or bought “off the shelf” from any the various health and safety management consultancy services available on the local or international market. An effective health and safety management system should help to achieve the following objectives:

- "A safe and healthy workplace;
- prevention/ reduction of illness and injury equally for employees and contractors;
- identification of workplace hazards, assessment and control of risks;
- active involvement in health and safety matters by managers, supervisors and employees and their representatives; and
- provision of OHS information and training for employees at all levels." (National Occupational Health and Safety Commission, 2002).
Various types of safety and health management systems are available, however, all should contain the main elements of policy, organising, planning and implementation, evaluation and action for improvement (Clarke, 1999; ILO- OSH, 2001; National Institute for Occupational Safety and Health, 2002). These main elements are described in detail below.

2.2.1 The health and safety policy.

An integral part of any safety and health management system regards the establishing of clear policies on defined health and safety issues. The employer or management representatives should set out in writing the organisation's safety and health policy in consultation and with the participation of the employees and their respective representatives (union representatives) adopting a tripartite approach. Such an approach is highly recommended when dealing with the organisation's safety policy (ILO–OSH, 2001). As a minimum, the policy should include hazard recognition and prevention, compliance with relevant national laws and regulations and worker participation through an efficiently functioning safety and health committee (ILO-OSH, 2001). Worker participation could also be improved by ensuring that workers and their representatives are regularly informed and trained on all aspects of occupational health and safety associated with their place and nature of work.
Besides the organisation's general health and safety policy, individual departments may have their own policies and/or procedures addressing specific health and safety concerns (Health and Safety Executive, 1997). Both the organisation wide policies and the individual departmental policies have to be available and accessible to the respective employees through appropriate means of communication. A good system to ensure dissemination of the health and safety policies has been adopted by the University Hospital of Wales Healthcare NHS Trust. The hospital's general health and safety policy is given to each employee at the trust and within the sections of the general policy a list of specific policies and guidance documents is published. A copy of the Hospital Safety Manual is kept by all department, unit and ward managers for common access and also available in the hospital library. A note to all employees makes it clear that they should assume responsibility to read and understand the relevant sections of such policy (University Hospital of Wales Healthcare NHS Trust, 1998).

Policy-making as a topic has been highly discussed by various authors and often described as being a rather complex process (Walt, 1994). Walt (1994) suggests that the most common policy making framework in use describes the process by stages or phases:

1. Problem identification and issue recognition.

2. Policy formulation.
3. Policy implementation.

4. Policy evaluation.

The framework suggested by Walt seems rather simple to follow however as suggested by the author himself, policy making does not usually follow such a logical process, thus the framework should just serve as a basic guideline.

Although as already discussed the safety policy is an integral part of the management system as a whole, the policy on its own seldom achieves anything unless it is followed up and supported by systems that make the policy alive (Peterson, 1998). Peterson further suggests that the safety policy alone does not drive performance of safety within the organisation but accountability from all persons involved does. Therefore although substantial effort is necessary to establish and set up the appropriate policies it is relevant to keep focused at all times on the organisational context.

2.2.2 Leading and organising health and safety initiatives.

Ensuring responsibility, accountability, authority, setting up employee training and having established and maintained system documentation are key issues in the organisation of a safety and health management system (ILO-OSH, 2001). The issues of responsibility, accountability and authority could be achieved by establishing structures and processes that:
• Ensure health and safety is a line management responsibility that is accepted and known at all levels in the organisation.

• Identify and try to control work related hazards and risks, promote health at work and carry out accident prevention programmes.

• Communicate and define the responsibility, accountability and authority of persons who evaluate and control hazards and risks at the workplace.

• Ensure that persons responsible for health and safety are given adequate and sufficient resources to fulfil their duties and functions.

• Provide supervision to ensure protection of workers' safety and health.

2.2.3 Planning and implementation.

An initial review of the existing health and safety arrangements within the organisation is recommended to serve as a basis for future establishment of an occupational safety and health management system (ILO-OSH, 2001). The results of the review will serve and support planning, development and implementation of the system. Occupational safety and health management systems planning can be modelled on the four step approach essential for strategic planning at all levels of the organisation (Mondy and Premaux, 1995). The main steps outlined in such a planning process are:
1) Mission determination.

2) Organisational environment assessment.

3) Objective setting.

4) Strategy setting.

If applied to health and safety management systems, these four steps could help to outline existing strengths and weaknesses within the organisation that need be exploited or tackled and pave the way for the implementation process (see Table 1). Generally, issues are more likely to be defined as threats than as opportunities by managers (Duncan, Ginter & Capper, 1993), however managers must pay special attention to the opportunities and exploit them strategically (Rosen & Jansson, 2000).

Table 1 OHS planning and management system implication

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<th>Planning step</th>
<th>OHS Management system implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission determination.</td>
<td>Determine purpose of the system.</td>
</tr>
<tr>
<td>Organisational environment</td>
<td>Plan arrangements based on initial review.</td>
</tr>
<tr>
<td>assessment.</td>
<td></td>
</tr>
<tr>
<td>Objective setting.</td>
<td>Safety and health objectives.</td>
</tr>
<tr>
<td>Strategy setting.</td>
<td>Hazard prevention, change management and procurement of resources.</td>
</tr>
</tbody>
</table>

19
2.2.4 Evaluation of the effectiveness of health and safety measures.

Measuring effectiveness or outcomes helps to determine whether the management system is reaching the intended effects on the employees and the organisation (National Institute for Occupational Safety and Health, 2002). Various methods can be employed for evaluating the effectiveness of health and safety strategies depending on the desired outcome of measurement and evaluation purpose (see Table 2).

Table 2 Types of health and safety intervention evaluations

<table>
<thead>
<tr>
<th>Type of evaluation</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs assessment</td>
<td>Determines what type of intervention is needed.</td>
</tr>
<tr>
<td>Process evaluation</td>
<td>Assesses the quality of the intervention delivery and identifies areas for improvement.</td>
</tr>
<tr>
<td>Effectiveness evaluation</td>
<td>Determines whether an intervention has had the effect intended on outcomes and estimates the size of the effect.</td>
</tr>
<tr>
<td>Cost – outcome analysis</td>
<td>Determines the net cost of an intervention relative to its effect.</td>
</tr>
<tr>
<td>Cost- effectiveness analysis</td>
<td>Compares different intervention alternatives using cost – effect ratios.</td>
</tr>
<tr>
<td>Cost - benefit analysis</td>
<td>Compares different intervention alternatives using net benefits.</td>
</tr>
</tbody>
</table>

2.3 Models of occupational health and safety management systems.

The current debate on health and safety management systems is focused on the fact that there is no common understanding of the health and safety management systems concept (European Agency for Safety and Health at Work, 2002b). It appears that different approaches and models exist that are frequently merely partial elements regarded as complete systems.

A literature search for health and safety management system models revealed that there seem to be various models available in use. A great deal of research on such models has been performed on the Australian continent where one finds the SABS Standards Model (WorkCover Corporation, 1999) and the WorkSafe Plan (WorkSafe, 1999) in common use. Substantial similarities exist between these two models with the main difference being in the way they name their five major elements (see Table 3).

Table 3 Major elements of SABS Standards Model vs WorkSafe Plan

<table>
<thead>
<tr>
<th>SABS</th>
<th>WorkSafe Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment and policy</td>
<td>Management commitment</td>
</tr>
<tr>
<td>Planning</td>
<td>Planning</td>
</tr>
<tr>
<td>Implementation</td>
<td>Consultation</td>
</tr>
<tr>
<td>Measurement and evaluation</td>
<td>Hazard management</td>
</tr>
<tr>
<td>Management system review and improvement</td>
<td>Training</td>
</tr>
</tbody>
</table>

21
In Europe, the European Agency for Safety and Health at Work suggests the use of the Reference Model formulated by the International Occupational Hygiene Association (IOHA, 1998). This model is divided into five major elements with their respective content variables (see Table 4). The Reference Model is build upon the idea of continuous improvement (plan, do, check, act).

As argued by Bottomley (1999) there is a high level of agreement on the essential elements making part of such system models. The same author also highlights the fact that very few models actually define a system by what it is, but rather by what it is made up of (essential key elements) or what it is intended to achieve (objective). Whilst the elements considered as essential for an effective system are important, the defining characteristic of such models should be the linking of separate elements to form an integrated approach.
<table>
<thead>
<tr>
<th>Elements</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSH Input (Initiation)</td>
<td>- Management commitment and resources.</td>
</tr>
<tr>
<td></td>
<td>- Regulatory compliance and system conformance.</td>
</tr>
<tr>
<td></td>
<td>- Accountability, responsibility and authority.</td>
</tr>
<tr>
<td></td>
<td>- Employee participation.</td>
</tr>
<tr>
<td>OSH Process (Formulation and Implementation)</td>
<td>- Health and safety policy/goals and objectives.</td>
</tr>
<tr>
<td></td>
<td>- Performance measures.</td>
</tr>
<tr>
<td></td>
<td>- System planning and development.</td>
</tr>
<tr>
<td></td>
<td>- Baseline evaluation and hazard assessment.</td>
</tr>
<tr>
<td></td>
<td>- OSHMS manual and procedures.</td>
</tr>
<tr>
<td></td>
<td>- Training system.</td>
</tr>
<tr>
<td></td>
<td>- Hazard control system.</td>
</tr>
<tr>
<td></td>
<td>- Preventive and corrective action system.</td>
</tr>
<tr>
<td></td>
<td>- Procurement and contracting.</td>
</tr>
<tr>
<td>OSH Output and Feedback</td>
<td>- OSH goals and objectives.</td>
</tr>
<tr>
<td></td>
<td>- Illness and injury rates.</td>
</tr>
<tr>
<td></td>
<td>- Workforce health.</td>
</tr>
<tr>
<td></td>
<td>- Changes in efficiency.</td>
</tr>
<tr>
<td></td>
<td>- Overall performance of the organisation.</td>
</tr>
<tr>
<td>OSH Feedback</td>
<td>- Communication system (document and record management system).</td>
</tr>
<tr>
<td></td>
<td>- Evaluation system (auditing, self inspection, incident investigation, health/ medical surveillance programme).</td>
</tr>
<tr>
<td>OSH System elements</td>
<td>- Continuous improvement.</td>
</tr>
<tr>
<td></td>
<td>- Management review.</td>
</tr>
<tr>
<td></td>
<td>- Integration.</td>
</tr>
</tbody>
</table>

2.4 Health and safety management in relation to management approach and system strategy.

Occupational health and safety management systems can be categorised according to dimensions taking into account the type of management approach adopted or system strategy orientation. The two main dimensions as devised by Gallagher (1997) are:

*Dimension 1: Traditional management vs innovative management.*

*Dimension 2: Safe workplace oriented strategy vs safe person control strategy.*

2.4.1 Traditional management.

In this type of management, health and safety is integrated into the supervisor's role with the supervisors themselves and/or specialists in the field acting as key persons. Employees might be involved but their involvement is not particularly viewed as critical for the overall system.

2.4.2 Innovative management.

Management has a key role in health and safety efforts within the organisation and a high level of integration into broader management systems is emphasised
e.g. quality assurance. In contrast to traditional management, employee involvement is critical and mechanisms are in place to ensure a high level of participation.

2.4.3 **Safe workplace oriented strategy.**

Adopting a prevention strategy focusing on hazard control paying particular attention at the design stage with the application of hazard identification, hazard assessment and hazard control principles.

2.4.4 **Safe person control strategy.**

A prevention strategy focused on controlling employee's behaviours towards health and safety issues.

In an examination of 20 case studies (Gallagher, 1997), Gallagher formulated a cross-typology of these two dimensions resulting in four categories of occupational safety and health management systems (Table 5).
### Table 5  Types of occupational safety and health management systems

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Innovative/ Safe person</strong></td>
<td><strong>Innovative/ Safe place</strong></td>
</tr>
<tr>
<td>'Sophisticated behavioural'</td>
<td>'Adaptive hazard managers'</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional/ Safe person</strong></td>
<td><strong>Traditional/ Safe place</strong></td>
</tr>
<tr>
<td>'Unsafe act minimisers'</td>
<td>'Traditional engineering and design'</td>
</tr>
</tbody>
</table>


2.4.5 Sophisticated behavioural (category 1).

This category represents a high level of employee involvement with an upstream prevention activity approach. A high level of integration or alignment concerning health and safety management with other broader organisational management systems exists.

2.4.6 Adaptive hazard managers (category 2).

A system whereby prevention activity is centred on controlling hazard at source in accordance with an identification, assessment and control framework. A
higher level of integration or alignment to other management system in the organisation is essential.

2.4.7 Unsafe act minimisers (category 3).

The emphasis for such a health and safety management system is on high supervision of employee behaviour and strict rules to prevent employee risk taking.

2.4.8 Traditional design and engineering (category 4).

The prevention activity is centred on the controlling of any particular hazard at source. In such a framework employees might be involved but are not considered as a central element in the management of health and safety. This is a system whereby a traditional health and safety committee exists with managers and supervisors playing an active key role on the issue.

According to Bottomley (1999), Gallagher's study shows that although there are various ways to manage health and safety issues, on balance it seems that the adaptive hazard managers type of system presents the most interesting approach to adopt. "The focussed hazard orientation of the adaptive hazard managers combined with employee participation highlights that OHS management
is built on OHS knowledge, resources and the ability to integrate these into mainstream business activities" (Bottomley, 1999).

2.5 OHSMS experiences at organisational level in Malta.

Published literature regarding specific organisational experiences in implementing health and safety management systems is rather scarce and there seems to be a vacuum on the subject with regards to local organisations in Malta. Although efforts were made by personally contacting eight organisations on the Island, only one organisation responded positively. The only organisation that provided some feedback was ST Thompson Microelectronics (Malta), which seems to have a well-developed system in place. All employees at ST Microelectronics are provided with the company’s Occupational Health and Safety Manual giving particular details on responsibilities, precautions, policies and general health related issues (SGS Thompson Microelectronics Malta, 1996). The manual suggests that a high level of employee involvement is encouraged with a high level of integration between health and safety management and other key organisational management systems.

2.6 International experiences with OHSMS.

On the international sphere there are a few pieces of published literature on the subject. Most of the experiences published are derived from the construction
and manufacturing industry whilst examples dealing with healthcare organisations are still rather scarce.

An interesting report on health and safety management in the hospital setting comes from the UK. In 1996, the UK Department of Heath agreed that health and safety management within NHS trusts should be integrated into the trust's risk management framework and a risk management tool was developed (National Audit Office, 2003).

Hospital Trusts in the UK are encouraged to develop an integrated risk management framework covering both clinical and non-clinical risks; comprising detailed risk management, organisational control standards and assessment criteria (National Audit Office, 2003). Referring back to the categorisation of health and safety management systems, this type of system is highly similar to category 2 (innovative /safe place; adaptive hazard managers). The majority of trusts have adopted such initiatives and improved their overall approach to health and safety, however there are still a few trusts that have room for further improvement (National Audit Office, 2003). Areas requiring further attention as outlined in the report 'A safer place to work' have to do with staff training, incident reporting and documentation systems and procedures for assessing the costs of accidents (National Audit Office, 2003).
2.7 Workplace safety culture.

The term safety culture is rather difficult to define and even more difficult to measure. Peterson (1998) puts it as "the way it is around here". In a definition by Spears and Johnson (2002), safety culture is "expected to be a common shared emphasis on safety and a common valuation of safe working" within an organisation. Reason (1997) fragments safety culture into a number of different sub-cultures: a just culture, a flexible culture and a learning culture. Despite such various uses and definitions, it is clear that without the support of the employees, the organisation cannot reach and execute its activities safely (Spears and Johnson, 2002). As quoted by Hopkins (2002), Hudson suggests that only after passing a certain stage of development in its focus on safety can an organisation be said to have a positive safety culture. However most organisations do have a safety culture with the difference being on the varying degrees of focus and commitment involved making them positive, full or strong safety cultures (Hopkins, 2002).

Organisational culture plays an essential part in active safety management and a homogenous perception of safety amongst all employees involved is essential for the achievement of a strong safety culture. Achieving a homogenous perception at all levels within an organisation is not easy as employees may differ in their safety perceptions depending on the position and/or hierarchical level held. Research within this field suggests that management leadership and
commitment towards a positive safety culture highly influences the employees' perceptions of safety (Arboleda, Morrow, Crum & Shelley, 2003; O'Toole, 2002). Employees will raise their respective perception towards safety when they start to see management as credible and that the words of safety policy are lived on a daily basis with sufficient resources being channelled for such efforts (Peterson, 1998).

In his work, Bottomley (1999) suggests that a positive link exists between the approach an organisation takes to health and safety and the respective organisational safety culture. A systematic approach to health and safety management issues is usually adopted in the presence of a strong safety culture in contrast to a reactive approach often found in organisations with a weak safety culture (Table 6).

Table 6  Safety culture and approach to health and safety

<table>
<thead>
<tr>
<th>Reactive approach</th>
<th>Systematic approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hazards are dealt with reactively</td>
<td>• Hazards are identified</td>
</tr>
<tr>
<td>• Risk controls are dependent on individuals</td>
<td>• Risk controls are described in procedures</td>
</tr>
<tr>
<td>• Risk controls are not linked</td>
<td>• Risk controls are linked by a common method</td>
</tr>
<tr>
<td>• OHS activity happens but is not planned</td>
<td>• OHS activity is planned</td>
</tr>
<tr>
<td>• Controls are reviewed after an incident</td>
<td>• Controls are monitored and reviewed regularly</td>
</tr>
<tr>
<td>• Responsibilities not defined</td>
<td>• Responsibilities are defined for everyone</td>
</tr>
</tbody>
</table>

2.7.1 Culture and perceptions of safety in Malta.

As suggested by Zammit (2002), overall awareness on the subject has increased in Malta within the recent years. Amongst the main attributes to the increased awareness could be the initiatives taken at a national level by the setting up of the Commission for the Promotion of Occupational Health and Safety under ACT VII of 1994 (Department of Information, 1994) and the Occupational Health and Safety Authority in 2002.

In contrast, the report entitled 'Perceptions of Health and Safety in Malta' (Occupational Health and Safety Authority, 2002) concluded that Maltese employers and employees are not taking health and safety issues seriously. With reference to the employers, the report confirms that in general:

- Health and safety measures are still viewed as an extra expense.
- Employers are not sufficiently aware of all their legal obligations.
- Employers fail to inform and consult with their respective employees regarding certain risks related to the nature and place of work.

Interesting aspects relating to the perceptions of the employees themselves have also been outlined, such as:

- The workers themselves quite often lack a general awareness about safety precautions at their respective workplace.
In cases where information was available, workers still acted negatively and resisted the introduction of safe working practices (with particular emphasis to personal protective equipment).

Such findings clearly show that there is still a great deal of work to be undertaken on this particular subject amongst the local Maltese workforce and employers. A national strategy based on the principles of education, communication and enforcement is recommended (Grech, 2002), whilst local organisations and employers need to understand the link between appropriate health and safety management in relation to organisational effectiveness (Cassar, 1998).

2.8 Risk management.

An integral part of health and safety management involves the process of making choices and setting priorities following a planned risk assessment that can produce a number of situations where corrective or preventive measures are technically feasible (Health and Safety Executive, 1998). The subsequent adoption of the action/ activity as a result of the risk assessment can then be valued and analysed through the process of a cost benefit analysis of the measure proposed (Beatson, 1998). In our lives, risk assessments are carried out unconsciously everyday (Champion, 2000). An everyday example is the risk assessment process
associated with the decision of crossing out a busy road. In such a situation, estimating the speed of traffic, our visibility and physical condition are factors taken into account to calculate the risk associated with crossing the road.

The aim of a risk assessment exercise is to make sure that no one gets hurt or becomes ill as a result of a process or hazard at the place of work through a systematic approach (Morris & Willcocks, 1996). The Health and Safety Executive, UK suggests a five-step process for risk evaluation and assessment (Health and Safety Executive, 1998) involving:

2. Deciding who might be harmed and how.
3. Risk evaluation and deciding if existing precautions are adequate or more should be done.
4. Recording of findings.
5. Assessment review and revision.

2.8.1 Hazard identification.

A hazard could be defined as something that has the potential for causing harm (Champion, 2000). An easy initial approach to identify workplace hazards is
by walking around, visually spotting and listing the hazards (Morris & Willcocks, 1996). This approach can be done individually or through a team by involving more people and possibly picking up more information. Categorising the main groups under which the assessment will be carried out (e.g. manual handling, chemicals, electrical safety, machinery etc.) will ensure that the assessment is carried out systematically and facilitates recording of results (Brimson, 1995). A further approach to hazard identification can be done by analysing sickness, absenteeism, accidents and incident records or reports in order to identify any patterns that might get missed (Morris & Willcocks, 1996).

2.8.2 Deciding who might be harmed and how.

Deciding on who are the workers that could be harmed and how can be done by listing all the people who could conceivably be harmed by each identified hazard (Morris & Willcocks, 1996). At this point it is quite relevant to involve the workers themselves as they might be in a better position to point out who is most likely to be at risk. The adoption of a consultative team approach to risk assessments can be highly effective and beneficial (Carrivick, Lee & Yau, 2002).
2.8.3 Risk evaluation.

Risk evaluation can mainly be performed by establishing whether each hazard is likely to be of a low, medium or high level of risk (Brimson, 1995; Health and Safety Executive, 1998). Hazards that are unlikely to cause any injury can be classified in the low risk category. In cases where minor injuries could result from the hazard a medium risk category should be applied and a high-risk label is to be given to all hazards that could possibly lead to serious/ major injury or death (Brimson, 1995). Risk evaluation is a subjective exercise and the issue of judgment depends highly on the evaluators' perception and knowledge (Whelan, 2002; Morris & Willcocks, 1996). There is no mathematical formula that is to be applied for categorising the resultant level of risk. Weighing up between how serious an injury is likely to be and how much is the probability of such an accident likely to occur may help to draw up the risk level (Champion, 2000; Whelan, 2002; Morris & Willcocks, 1996).

In cases where a particular risk could be eliminated the causative hazard should be removed altogether whilst when dealing with hazards that cannot be eliminated, ways to control the potential risk should be sought aiming at making the risk as small as possible (Health and Safety Executive, 1998).
2.8.4 Recording of findings.

The Health and Safety Executive suggests that in places where more than five persons are employed; the findings of the assessment should be recorded reflecting the high, medium or low level of assessment (Health and Safety Executive, 1998). A detailed record of all hazards, risks, persons likely to be effected, existing control measures and any action measures required will help to make a detailed risk assessment that is suitable and capable of review (Brimson, 1995).

2.8.5 Assessment review and revision.

The introduction of new machinery, new staff, different work procedures/systems and new regulations are elements that bring about change in the environment of the organisation (Health and Safety Executive, 1998). Such significant changes require a review of the risk assessment in order to make sure whether the precautions taken are still working effectively or if there is room for further improvement (Champion, 2000; Health and Safety Executive, 1998; Morris & Willcocks, 1996).

Whilst carrying out a risk assessment it is important to note both physical hazards (e.g. machinery) as well as process hazards (e.g. carrying or handling of materials) that involve ergonomic considerations. A study on health and safety
programmes than just those stated for the employer or the organisation. Other benefits that need to be accounted for include benefits to the individual worker in terms of a reduction in loss of income and costs associated with treatment or rehabilitation. Society in general benefits as well in the form of reduction in public health service, administration and investigation costs (Walls, 2002).

A great deal of research has been carried out in the UK on the human and financial costs of work related accidents. In an attempt to assess the broad direct costs to the NHS due to accidents involving staff members it has been calculated that the annual direct cost of health and safety accidents in 2001-2002 would be around £172.8million. If staff work related sickness absence were to be calculated, the figure was estimated to go up to around £265 million (National Audit Office, 2003).

A study carried out in 1996 by the UK National Audit Office entitled “Health and Safety in NHS Acute Hospital Trusts in England” gives a view of the costs and benefits involved when undertaking health and safety initiatives. Within the study it was estimated that a particular district health authority would be required to pay compensation costs of £700,000 in 1991-92, with a further £1.5 million in future years. The investigations followed showed that the largest cause of such costs was attributed to back injuries and thus the health authority embarked on a training programme in manual handling for staff. The cost of the training programme was about £30,000 per year and began in 1991. Following an effectiveness analysis
after three years it resulted that staff were twice as likely to be absent sick with back ailment problems before the training than afterwards. The analysis concluded that in this particular case the total number of days lost due to back injuries was reduced by 20% or six days per staff member per year and it also reduced the level of compensation which they had to pay to injured parties (National Audit Office, 2003). In this case a cost benefit analysis has been carried out justifying the introduction and implementation of the health and safety program.

2.9.2 Cost-benefit analysis of health and safety measures.

A cost benefit analysis exercise values both costs and benefits in monetary terms and by comparing them together [cost benefit ratio], assesses whether the proposed project/programme is desirable through the use of established decision criteria (Mills & Gilson, 1992). Such an exercise is always a forward-looking exercise and an end period for the year-to-year analysis needs to be selected. All the costs and benefits are quantified in terms of a yearly profile and sometimes this might lead to difficulties when less easily identifiable costs (such as the management time involved) are tackled (Beatson, 1998). Sufficiently available and reliable data relating to workplace accidents is required for producing an accurate benefits profile and where such data is lacking it is difficult to carry out a detailed cost benefit analysis (Beatson, 1998).
In the United Kingdom, the Health and Safety Executive has developed a framework for the management and control of risk known as the tolerability of risk (Health and Safety Executive, 1992). This tolerability of risk framework has an upper limit beyond which risks are judged intolerable and if a risk to an individual at work is above this limit, then that risk must be reduced to the just tolerable level at whatever cost involved. Similarly there is a broadly acceptable risk level below which no further action need be taken at all. Between these two levels, risks should be reduced as low as reasonably practicable and this implies some form of trade off between costs and benefits (Health and Safety Executive, 1992). Using this framework helps organisations to decide which health and safety measures could be reasonably practicable following a cost benefit analysis to determine the practicability of various measures.

2.10 Health and safety issues in hospitals.

Hospitals and other health care service facilities present the workers with a vast range of potential health and safety hazards (National Institute for Occupational Safety and Health, 1988). The Occupational Safety and Health Administration of United States classifies the different hazards found in hospitals into five major categories labeled as biological, chemical, psychological, physical and environmental hazards (OSHA, 2001). All these different type of hazards need be taken care of through a planned, systematic approach.
2.10.1 Biological hazards.

Hospital employees are at an elevated risk of occupational exposure to a number of airborne and bloodborne infectious diseases when compared to other occupational categories or the general population (Lipscomb & Rosenstock, 1997). Amongst the biological agents commonly found in hospitals there are:

- Human Immunodeficiency Virus (HIV).
- Methicillin Resistant Staphylococcus Aureus (MRSA).
- Hepatitis B and Hepatitis C virus.
- Tuberculosis.

Needlestick injuries account for the majority of accidents involving biological hazards within hospitals (Rosenstock & Jackson Lee, 2003; Yassi & Warshaw, 1998). The infection control team within the hospital usually tackles such issues. The application of universal precautions by all members of the multidisciplinary team and other workers who could come in contact with biological agents is a strategy that safeguards both employees and patients in the hospital (Fay, 1996; Taylor, 1993; Wicker, 1991). Adopting universal precautions takes into assumption that all blood-containing fluids are potentially infectious; therefore appropriate safeguards should be invoked at all times (Taylor, 1993; Yassi & Warshaw, 1998).
Sharp and needlestick injuries are most frequent amongst nurses, midwives and doctors with the majority of cases occurring when proper safety precautions are not used (Denis, Ecochard, Bernadet, Forissier, Porst, Robert, Volckmann & Bergeret, 2003; Evans, Duggan, Baker, Rumsay & Dominique, 2001). Although studies try to quantify the incidence of needlesticks suffered by healthcare workers it is believed that such data usually represents a partial picture of the real scenario due to the fact that a number of incidents are not reported (Nash, 2001).

At Malta’s main general public hospital (St. Luke’s Hospital) all needlestick injuries are dealt with by the Infection Control Unit that gives a good service to all hospital employees on a 24 hour basis. Data is collected by the same unit and is available for analysis and reference on request. Between the period of January 1999 and December 2002 a total of 481 needlestick injuries have been reported to the unit. Congruent with the studies conducted by Denis et al (2003) and Evans et al. (2001), the employee category with the highest number of reported needlestick injuries at St. Luke’s Hospital was nurses followed by the doctors (see Figure 4).
Figure 3  Needlestick injuries reported to SLH Infection Control Unit by employee category (1999-2002)

Data source: Infection Control Unit, St. Luke's Hospital (Malta).

2.10.2 Chemical Hazards.

Workers in hospital settings are exposed to a variety of chemical agents that are potentially toxic and irritating to the body (OSHA, 2001). Sterilants, anesthetic gases, disinfectants, laboratory reagents and latex products are a few examples of such hazardous chemicals (Yassi & Warshaw, 1998). The control of exposure to chemical hazards is an issue that is specifically regulated by legislation in various countries and in Malta it is regulated under the Occupational Health and Safety Authority Act. Controlling exposure to hazardous
chemicals involves elements of risk assessment, adoption of preventive measures, staff training, surveillance or monitoring of the substance and the availability of proper protective equipment (Hutt, 1994; Menzies, 1995; Yassi & Warshaw, 1998).

2.10.3 Psychological hazards.

Stress, workplace violence, inadequate staffing and shiftwork are factors or situations that could pose psychological problems amongst hospital workers (OSHA, 2001). A considerable body of evidence exists showing that health care professionals are considered as being at a risk of developing stress-related problems because they face some particular stressors which are not part of most other occupations (Payne & Firth-Cozens, 1987). It is also widely recognised that hospitals themselves are anxiety producing, stressful organisations (Menzies, 1970; Revans, 1976) and unfortunately, the stress levels of clinical staff can be severely reflected on the quality of patient care (Firth-Cozens & Moss, 1998).

Besides the stress factor, hospital workers are considered to be at a high risk in experiencing violence at the place of work (Lipscomb & Rosenstock, 1997; National Institute for Occupational Safety and Health, 2002).
2.11 Conclusion.

Following the literature reviewed, some conclusions can be drawn highlighting the importance of a systematic approach to occupational health and safety management.

1. If management agrees to the idea that human resources are so essential to the organisation, then management should also agree to the idea that if employees are to be productive their working environment should be free from physical and/or psychological risks that may impede efficiency.

2. It is argued that a poor working environment is related to factors effecting negative work outcomes like absenteeism, sickness, injury and increased employee turnover. All such factors have a cost attached to them and the organisation should seek to maintain such costs to their minimum as possible. This can be done by setting up systems, practices and policies that safeguard the working environment at all levels.

3. For an organisation to improve occupational health and safety standards, it must make sure that the implementation of any safety and health management system is in line with the organisational culture whilst having adequate support and management commitment.

4. Occupational health and safety need be tackled in a professional and
systematic manner, thus taking a proactive stance and avoiding situations of management by crisis.

5. Dealing with the various potential risks that are found in hospitals could be an extensive task to accomplish. An integrated approach involving various multidisciplinary workers and professionals in the organisation is essential for the eventual overall success of a health and safety management system.
CHAPTER THREE

3.0 Methods

3.1 Introduction.

An exploratory non-experimental research design was chosen for the study making use of qualitative techniques. The study is divided into two main parts. The first part of the study is made up of focus groups and personal interviews and the second part deals with document analysis. The aim was to elicit information on the occupational health and safety situation at Malta's main general hospital (St. Luke's Hospital). Staff members from various categories working at the hospital are the main protagonists of the project.

3.2 Research design.

"Qualitative research depends upon not numerical but conceptual analysis and presentation" (Fritzpatrick & Boulton, 1994).

Qualitative methods play an important role in health and safety planning and intervention evaluations (National Institute for Occupational Safety and Health, 2002). Employing qualitative methods can yield information with a breath and depth not possible with quantitative methods and participants' stories can provide
rich data that convey deeper meaning to their own experiences (Pollitt, Harrison, Hunter & Marnoch, 1990). Consequently qualitative methods are intended to convey policy makers the experiences of individuals who are themselves going to be affected by such policies (Fritzpatrick & Boulton, 1994).

An exploratory design was henceforth put into practice to reach the objectives of this study. The researcher aimed to use the qualitative data generated to sensitise and provide an understanding into the participants' viewpoint (Knafl & Howard, 1984) and the present situation regarding health and safety within the hospital.

Data collection was divided into two distinct parts each having specified objectives to be reached:

- **Part 1: (Focus group and personal interviews)**

  The objectives of this part are to explore information about perceptions, knowledge and attitudes of employees, managers and other key persons identified as important stakeholders in occupational health and safety management.

- **Part 2: (Document analysis)**

  The objectives of the second part are to analyse and discuss any available written documentation within the hospital that is relevant to occupational health and safety.
The goal behind this qualitative method is the development of concepts which will help to understand social phenomena in a natural setting, giving emphasis to the meanings, experiences and views of all participants (Pope & Mays, 1995). Data generated from the second part of the study was also aimed to help and substantiate data generated from the first part thus adopting a form of triangulation within the framework.

3.3 Setting.

The research took place within St. Luke's Hospital and the choice for such a setting has been set upon the following criteria:

- This hospital is the largest general public hospital on the Maltese Islands.
- A vast selection of different employee categories can be found.

The services being offered at St. Luke's Hospital are similar to services planned for the new Mater Dei Hospital.

3.4 Part 1 (Focus group and personal interviews).

3.4.1 Data collection tools.

The in-depth or personal interview and the focus group interview format are two types of qualitative approach for data gathering. Both approaches have been used in this study. The personal interviews conducted were through a face-to-face situation whereby the researcher asked the selected interviewee specific
questions designed to elicit answers relevant to the area under study. The structure of the interview process was defined through the questions with their respective wording and consequences (Mays & Pope, 1999). This semi-structured approach to interviewing represents a compromise between standardisation and flexibility (National Institute for Occupational Safety and Health, 2002).

Focus groups were conducted in a semi-structured manner consisting of open-ended questions related to the area being explored and from which the interviewer could diverge to pursue an idea or response in more detail (Mays & Pope, 1999). An interview guide (see Appendix 6) was prepared and used in all groups, however questions were altered from one interview to another but still keeping the same topics. All interviews were tape recorded and stored for later data retrieval and analysis.

3.4.2 Study participants.

The population under study for the focus groups was composed of all employees within St. Luke’s Hospital irrespective of profession or grade. The selected study participants were chosen through the use of a purposive or systematic, non-probabilistic sample. According to Mays and Pope (1995) statistical representativeness is not a prime requirement in qualitative research. This approach to sampling gives the researcher the benefit to include a range of selected key informants with access to important sources of knowledge (Mays & Pope, 1995). The use of purposive sampling also gives the researcher a degree
of control rather than being at the mercy of any selection bias inherent in pre-existing groups (Barbour, 2001). As the author worked at St. Luke’s Hospital for a considerable number of years it proved to be an important factor for accessing study participants whereby 75% of those approached agreed to participate immediately whilst being eager to be of help. The fact that health and safety issues personally affect each worker might also be considered as another positive point that increased participation.

In all seven (7) focus group interviews were conducted with different selected categories of employees grouped as:

1. Managers including the category of middle line managers (4 participants).
2. Nurses and midwives from ward/unit settings (2 enrolled nurses, 3 registered nurses and 1 midwife).
3. Nurses from ward/unit settings (4 registered nurses, 2 enrolled nurses).
4. Doctors (2 house officers, 2 senior house officers).
5. Paramedical professionals (1 radiographer, 1 ECG technician, 1 laboratory technician, 1 physiotherapist, 1 pharmacy technician).
6. Care support workers and domiciliary staff (3 health assistants, 2 cleaners).
7. Workers in technical grades (2 HVAC technicians, 1 electrical technician, 2 maintenance technicians).
As suggested by Mays and Pope (1999) the interviewees within each group were selected to be homogenous when possible in order to capitalise on people's shared experiences. All participants selected were contacted personally prior to the research process and given a note with details regarding the planned group session (see Appendix 1).

The participants for the personal interviews were selected due to their respective position held within the hospital. Two personal interviews were conducted with an Infection Control Unit representative and the Human Resources Director of Mater Dei Hospital. The researcher contacted the interviewees personally a few days before the interview and an appointment fixed.

3.4.3 Pilot focus group.

In order to minimise any unforesen problems during the data collection process and to give the researcher an initial feel of group interviewing, a pilot focus group was carried out (Polit & Hungler, 1995). Group members consisted of close friends categorised as 1 union representative, 2 nurse managers and 1 registered nurse. By choosing close friends, the researcher attempted to secure individuals who would be reliable and honest in their criticism. All participants within the pilot group were given the opportunity to comment on the way the interview was conducted and their constructive criticism was highly beneficial.
3.4.4 Ethical considerations.

Before the start of the data collection process permission, for undertaking the study and approaching participants was obtained from the hospital authorities (Appendix 3). Confidentiality and personal anonymity to all group participants (including the pilot group) was assured through a specifically designed interview consent form (Appendix 2) that followed a verbal explanation of what the research entitled and what was expected of them as participants. Their rights as participants were also addressed as suggested by Ford & Reutter (1990), the right to refuse to participate, the option to withdraw whenever pleased and the right to withhold information.

3.4.5 Data processing and analysis.

Although computer software such as NUD*IST, Hyper RESEARCH and AQUAD for qualitative data processing and analysis are presently in use however several problems associated with using such programs is highly recognised (Catterall & Maclaran, 1997). The main problems as outlined by Barry (1998) are that such programs distance researchers from their data, may lead to qualitative data being analysed quantitatively and increase homogeneity in methods of data analysis. In view of such findings a manual approach for data processing and analysis was chosen. The selected method, known as framework approach has been developed in Britain specifically for applied or policy relevant research.
The transcription process is followed by five stages of analysis known as familiarisation, thematic framework identification, indexing, charting, mapping and interpretation. Table 7 explains these stages of analysis in further detail.

### Table 7 The five stages of data analysis using the framework approach

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Familiarisation</th>
<th>Immersing in the raw data by listening to tapes, reading transcripts, studying notes and so on in order to list key ideas and recurrent themes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Thematic framework identification</td>
<td>Identifying all key issues, concepts and themes by which the data can be examined and referenced. The end product of this stage is a detailed index of the data, which labels the data into manageable chunks for subsequent retrieval and exploration.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Indexing</td>
<td>Applying the thematic framework or index systematically to all data in textual form by annotating the transcripts with numerical codes from the index.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Charting</td>
<td>Rearranging the data according to the appropriate part of the thematic framework to which they relate and forming charts.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Mapping &amp; interpretation</td>
<td>Using the charts, map the range and nature of phenomena, create typologies and find associations between themes.</td>
</tr>
</tbody>
</table>


### 3.5 Part 2 (Document analysis).

Document analysis in workplace safety intervention assessment can offer
evidence on intervention implementation and any subsequent barriers inherent within the process (National Institute for Occupational Safety and Health, 2002). Documents available at St. Luke's Hospital relevant to occupational health and safety issues were sought and obtained for analysis. The analysis dealt with aspects relating to the actual content of the policy, detail and presentation.

3.6 Validity and reliability.

Issues relating to validity and reliability in qualitative research are more appropriately assessed by the criteria of truth value, applicability, consistency and neutrality (Lincoln & Cuba, 1985).

3.6.1 Truth Value and applicability.

'Truth value' and 'applicability' issues in qualitative research are the alternative measures dealing with aspects of internal and external validity in quantitative research (Lincoln & Cuba, 1985). Measures to establish truth value (credibility) and applicability (transferability) of the findings were applied as possible.

The researcher performed informal 'member checking' with the interviewees following each interview. At the end of the interviews, the researcher summarised the main points of view and asked the participants whether the perceptions were
accurate, as suggested by Krueger (1994). Such technique gives the participant an immediate opportunity to correct errors of fact and challenge the researcher what could possibly be viewed as wrong interpretations (Lincoln & Cuba, 1985). In the subsequent analysis, the researcher referred back to the interview transcripts and performed validation of themes.

Another technique used to enhance ‘truth value’ is that described as ‘referential adequacy’ (Lincoln & Cuba, 1985). The recorded material (voice tape recording) are kept by the researcher to provide benchmarking against which later data analysis and interpretation can be tested for adequacy, as suggested by Lincoln & Cuba (1985).

The scope of the research does not justify generalisation. The purpose of the research is to grasp an accurate and detailed description of the employees’ and managers’ point of view on health and safety practices in the hospital. Lincoln & Cuba (1985) argue that in these circumstances it is more appropriate to see the fittingness of the data rather then the generalisability.

3.6.2 Consistency.

Following the first few interviews, minor adjustments were made to the interview guide increasing the consistency of the data collected. The degree of
consistency of the analysis was enhanced since the researcher was personally involved in the actual data collection.

3.6.3 Neutrality.

During the data collection, the researcher was immersed in the natural setting and intensely interacting with the participants. The researcher himself was part of the population under study and some personal characteristics and knowledge may have became an integral part of the research. The relationship with the study participants was close and intense and as a result, an element of subjectivity has to be incorporated in the research. The researcher’s own expectancies could have further biased the data in a way that reflected the researcher’s own beliefs. The researcher tried to overcome this by adopting a neutral stance and not presenting his perceptions during data collection. Also the interview transcripts were translated from Maltese into English rendering a possible bias and change of meaning during the translation.

At the data analysis stage the technique of ‘multiple coding’ as suggested by Barbour (2001) was adopted to enhance neutrality. ‘Multiple coding’ does not necessitate complete replication of results but involves the cross checking of coding strategies and data interpretation by independent researchers (Barbour, 2001). The researcher asked an expert (independent of the study) in qualitative
research in order to review the transcripts and generate his own coding framework. Categories generated in this way were then compared and discussed with those formulated by the researcher giving a similar coding structure.
CHAPTER FOUR
4.0 Results

4.1 Introduction.

This chapter presents the findings from this study. The findings feature aspects from the data collected following the focus group and personal interviews conducted with St. Luke's Hospital personnel in part 1. To enhance analysis and presentation both type of interviews were analysed and presented together. Part 2 tackles the analysis of policy documents available in the hospital.

The interview data is subdivided into five categories emerging from themes used in the topic guide falling under the general headings of:

- General knowledge/ perceptions.
- Safety policy.
- Reporting and documentation.
- Training.
- Safety culture.

The chapter ends with some general comments on the experience felt by the researcher during the data collection process in a naturalistic setting.
4.2 Part 1 (focus group and personal interviews).

4.2.1 General knowledge/ perceptions.

In the first part of the interview participants were asked to share their respective ideas on the following three main areas:

- Meaning of occupational health and safety.
- Legal duties and responsibilities.
- General situation at the hospital regarding health and safety.

4.2.1.1 Meaning of occupational health and safety.

When focus group participants were asked to share their views on the meaning of occupational health and safety various answers were given reflecting particular employee group category characteristics. Following review of the transcripts, a list of significant statements was extracted and later aggregated and clustered into 4 main themes. Table 8 gives detail of the significant statements extracted after being clustered into four main themes. Duplicate statements have at this stage been eliminated.
Table 8  Meaning of occupational health and safety

<table>
<thead>
<tr>
<th>Theme</th>
<th>Significant statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe working environment</td>
<td>• The discipline involved with making the working environment as safe as possible.</td>
</tr>
<tr>
<td></td>
<td>• The place where you are working is safe as regards safety and hygiene.</td>
</tr>
<tr>
<td></td>
<td>• Smoking in corridors is another aspect.</td>
</tr>
<tr>
<td></td>
<td>• Safety from hazards at the workplace.</td>
</tr>
<tr>
<td></td>
<td>• Health and safety at the place of work.</td>
</tr>
<tr>
<td></td>
<td>• A safe working environment.</td>
</tr>
<tr>
<td>Safety of employees, patients and third parties</td>
<td>• In the hospital there are so many disciplines that it is very vast.</td>
</tr>
<tr>
<td></td>
<td>• As regards the patients you have the machinery and instruments.</td>
</tr>
<tr>
<td></td>
<td>• Patients definitely should not be exposed as much as possible.</td>
</tr>
<tr>
<td></td>
<td>• Every individual that comes in the premises can be exposed to different risks.</td>
</tr>
<tr>
<td></td>
<td>• Looking at the health and safety of everyone that enters the hospital.</td>
</tr>
<tr>
<td></td>
<td>• Seeing that I don't get hurt, don't hurt my colleagues and the patients as well.</td>
</tr>
<tr>
<td></td>
<td>• Even hospital visitors have to be safeguarded.</td>
</tr>
<tr>
<td></td>
<td>• Explain to the patient and not assume that he knows everything.</td>
</tr>
<tr>
<td></td>
<td>• The damage that may even be caused to the employees' family.</td>
</tr>
<tr>
<td></td>
<td>• A safe environment for the patients as well.</td>
</tr>
<tr>
<td>Good physical and mental health</td>
<td>• Taking care of the occupational side and the mental side of work.</td>
</tr>
<tr>
<td></td>
<td>• Psychological stress specifically in our job is very important.</td>
</tr>
<tr>
<td></td>
<td>• The mental health is very important.</td>
</tr>
<tr>
<td></td>
<td>• If you are overworked it is just as bad.</td>
</tr>
<tr>
<td>Adopting a proactive attitude</td>
<td>• Exclude preventative accidents.</td>
</tr>
<tr>
<td></td>
<td>• Minimising risks inherent to the job.</td>
</tr>
<tr>
<td></td>
<td>• Following a set of guidelines or rules.</td>
</tr>
<tr>
<td></td>
<td>• Trying to avoid dangers.</td>
</tr>
<tr>
<td></td>
<td>• See that all is safe before starting a job.</td>
</tr>
<tr>
<td></td>
<td>• Involving employees in an integrated team approach.</td>
</tr>
</tbody>
</table>

Data source: Complied by the author on data collected from interviews.
Participants from the groups of doctors, managers, nurses and paramedical professionals gave definitions falling under all four major categories showing a holistic view of occupational health and safety. On the other hand, responses from the support workers, domiciliary staff and workers in technical grades were mostly focused on aspects relating to the work environment and measures for preventing accidents on the job.

4.2.1.2 Legal duties and responsibilities.

Mixed reactions were encountered when the focus group participants were asked to answer the question "In your own personal opinion, who has the duty and responsibility to foresee that health and safety issues are being tackled and adhered too; the employer, the employees or both have their own respective responsibilities?" Whilst conducting the interviews with support workers, domiciliary staff and workers in technical grades arguments started to heat up between participants at this stage. Some interviewees expressed the first idea that came to their mind whilst others reflected before giving their answer.

70% of those interviewed highlighted the fact that both the employees and the employers (together with the management) have their own respective legal duties and obligations. Only managers agreed immediately that both employers and employees have their part to play in relation to occupational health and safety. As regards the rest of the focus groups, there were mixed responses and no
particular pattern related to any employee category could be noted. Some participants changed their ideas during the discussion showing that they were not entirely convinced of their initial opinion. This phenomenon presented some difficulty for classification during data analysis, as it was difficult to understand clearly what particular respondents actually believe.

Table 9 gives a few selected verbatim excerpts from the transcriptions of the views expressed.

Table 9   Health and safety duties and responsibilities (verbatim excerpts)

Employers and employees have their respective duties and responsibilities:

"I think that for the employees there are certain guidelines which were taught that make sense, like needlestick injury...On the other hand I agree that the employer has to provide the framework in which these work..." (doctor).

"Management should make it easy for the employee to follow the rules" (nurse).

"The employee has a duty but it lies mostly on the employer" (midwife).

"I believe that the responsibility lies on everybody and at present the input unions can give on the subject is very important" (nurse).

"We believe that the responsibility lies on the employee, the employer and the union" (union rep.)

"On this subject we should be working as a team" (manager).

"If you see something wrong you have to report and to whom you report has the responsibility to take action" (health assistant).

"Of the management and the employees" (health assistant).
Responsibility is of the employer only:

"Responsibility lies on those on top always" (elect. tech.).

"What can the employee do? Say I don't want to work if I don't have health and safety" (cleaner).

"There is the element of lack of interest from the management" (nurse).

"The employee has to work with whatever is available" (nurse).

"I believe that it falls mostly on the management" (nurse).

"The employer should guarantee it." (doctor).

"Always the employer has to take care" (elect. Tech.)

"Responsibility is always on top people" (elect. Tech.)

"The employer is responsible" (HVAC tech.)

Data source: Complied by the author on data collected from interviews.

4.2.1.3 General situation at the hospital regarding health and safety.

When asked to express their perception regarding the general situation on occupational health and safety within the hospital, the answers received were of an extremely negative nature (see table 10). The general feeling is that there is still a lot to be done within the area and all the credit for the little effort acknowledged was given to the Infection Control Unit. Such views have been
expressed in all interviews. Some positive comments on the work being done by the unit worth mentioning are:

"The only thing being tackled is infection control" (doctor).

"I think the infection control unit has helped. We see more containers were before we used to use water bottles. Gloves are available….we’ve seen changes in that respect" (doctor).

"There is the infection control unit that is doing a lot of good work” (manager).

"As regards infection control issues we have definitely made progress” (nurse).

"A good relationship exists between our unit and infection control. They are quite helpful” (physiotherapist).

"The infection control unit is definitely doing a lot of work that has to do with health and safety. We have to build on what has been done by the infection control unit. We need to have more resources both human and financial so that we can do more expansive work as regards health and safety” (HR Director, Mater Dei Hospital).

The interview with the infection control officer confirmed that the unit is tackling some health and safety issues however the unit’s resources are limited and can be focused on few specific issues. Aspects being tackled by the Infection Control Unit as outlined by the officer are those relating to needlestick injury,
prevention from disease and body fluid contamination and the problem of latex allergy.

**Table 10**  Significant statements on the health and safety situation at SLH

- No health and safety unit to refer to.
- Need for a whole structure.
- No patient lifters.
- Inadequate showering facilities for patients.
- Lack of protective equipment to use with hazardous material.
- Structural problems.
- Rooms with no fire escape.
- Insufficient ventilation in some unit.
- Airconditioners not functioning well.
- Some units still have asbestos fittings.
- Very slight improvement only in certain aspects.
- Certain initiatives start and then stop after some time.
- Still a lot to be done.
- An issue on which the department still has a lot to work upon.
- Health and safety is not being given its due importance within the hospital.
- Complaints and suggestions fall on deaf ears.
- If something is to be achieved, the union has to be involved.
- You need to fight for your own rights.
- It's just a *makeup*, nothing is really being done.

*Data source:* Complied by the author on data collected from interviews.
During the personal interview, the researcher confronted the Human Resources Director (Mater Dei Hospital) with the negative comments on the present situation as expressed by the employees. Positive comments for a brighter future were received stating that:

"Health and safety is going to be one of the departments within the human resources directorate. Health and safety is going to include the physical aspects, the physical hazards whilst taking a wider view of the employee's requirements like employee welfare, counseling for the staff regarding stress management. These are the aspects that are going to be included within the health and safety department".

4.2.2 Safety policy.

Selected questions were targeted both at the focus groups and in the personal interviews to find out about knowledge on already existing policies and check on channels of how these are being communicated. There seems to be quite a lack of policy documentation regarding health and safety issues within the hospital and the few policies referred to were those issued by the Infection Control Unit.

4.2.2.1 Knowledge on existing policies.

Only five participants (3 nurses and 2 managers) have been able to mention a couple of existing policies by their respective names. Worth noting is the fact
that the two managers who mentioned some policies came also from the nursing profession. Another six participants (1 doctor, 1 nurse, 2 managers, 1 laboratory technician and 1 physiotherapist) stated that they know that there are some policies issued by the Infection Control Unit but could not remember exactly to what they related. The rest of the employees interviewed replied that they never heard of any policies or said that they heard that some policies exist but do not actually know anything about them. Some comments given from the respondents that did not know about any such policies were:

"I never even heard of them" (doctor).

"Here I don't know of anything to look on" (cleaner).

"I don't know that these exist and as a managers we would like them to be there together with a structure that takes care of health and safety" (manager).

"I don't know if there are any and if there are I don't know about them" (nurse).

"Could be that there are but I never saw them" (Radiographer).

The issue of policies was also tackled in the personal interviews. When the HR Director (Mater Dei hospital) was told that there is a general lack of knowledge amongst hospital employees as regards health and safety policies, the interviewee did not seem so surprised at all. A strategy to tackle such problems in the near future was explained. Two interesting points on this subject related to the publishing and distribution of an employee handbook including various
policies and procedures and the introduction of an induction period for all employees that shall include health and safety training was discussed.

The interview with the infection control unit officer took place before such a negative trend was noticed in the interviews by the researcher and thus the interviewee was not confronted to comment on such findings. A remark worth mentioning during the interview was “I believe that the policy is quite accessible but depends on the interest of the specific individual” (Infection Control Unit Officer). Later on in the same interview the respondent commented that the unit often receives calls from employees questioning on certain procedures to be carried out that are documented and published by the unit. From such calls the interviewee noted that they “can easily detect the fact that the employee has surely not read the policy”. This contrasts with the above mentioned findings from the group interviews and could probably be outlined as a reason for the resultant lack of knowledge on existing polices.

4.2.2.2 Communication of policies.

The Infection Control Unit officer was very affirmative on the fact that all policies issued from the unit are quite easily accessible to the hospital employees by saying:

“As regards accessibility, nowadays all wards and units have access to the hospital’s intranet service whereby we have our own space as a unit and there one can find, read and print the policy. So I believe that the policy is quite accessible…………… Besides this facility, any employee can come to our unit and will be provided with a printed copy”.

70
In contrast to such a statement, the majority of those interviewed did not know were to find such policies and how copies can be obtained. The main reasons outlined by the employees for such a communication problem were:

- Lack of knowledge where to find the policies.
- Forbidden access to the use of computers at ward/unit level by respective managers.
- Policies are being received by ward/unit managers but left on the desks and not disseminated.

On a positive note, in the interview held with the Human Resources Director, the issue of policies and how they should be communicated seems to be quite understood. The importance to the necessity of issuing specific policies on all health and safety aspects in the hospital has been highlighted in the interview together with the fact that an effective communication strategy is to be formulated and adopted.

4.2.3 Reporting and documentation.

Accident reporting and documentation is an essential part of any health and
safety management system. Knowledge on how to go through proper reporting channels within the hospital were assessed by direct questions to the participants on how they are used to go about following an accident at their respective place of work. 70% of the participants said that they never had an accident and therefore admitted the fact of not knowing any specific procedure to be followed. A few others commented on their personal experiences and the channels used in such particular case. The answers received are grouped in table 11 according to the comment and who gave the response.

The fact that there is no health and safety unit or department within the hospital has emerged as a main issue of concern throughout the groups. One of the comments from a doctor was "I know of no other structure where you can actually... contact a specific person. Don't tell me there is this department, give me a name; this is your contact person or persons. If there is a problem these are the people to contact". As commented by a union representative present within the pilot focus group, the represented union had already put some pressures on the division for the setting up of such a unit within the hospital but no action has been taken. Further on the same individual also noted that this is a serious matter and if neglected "it might affect the way in which the hospital operates as we might have a number of employees that are unhealthy to carry out their duties".

Although general documentation standards and procedures were found to be lacking within the hospital, the same comment cannot be expressed when it comes to needlestick injuries. The work being done by the infection control unit
team has been found to be quite remarkable and up to date documentation is kept throughout the year. The documentation collated by the unit is scrutinised in order not to disclose any personal data concerning employees, however it is well presented in general form and available for research use and analysis following necessary permission for access.

**Table 11** Channel and documentation used for accident reporting.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Responses</th>
<th>Respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital administrator</td>
<td>3</td>
<td>Doctor</td>
</tr>
<tr>
<td>Filling of NI30 form</td>
<td>2</td>
<td>Health Assistant Maintenance tech.</td>
</tr>
<tr>
<td>Person in charge of ward/unit</td>
<td>9</td>
<td>Cleaner X 2 Health Assistant Enrolled Nurse Radiographer Physiotherapist Manager X 3</td>
</tr>
<tr>
<td>Go to A&amp;E department and fill NI30</td>
<td>2</td>
<td>Registered Nurse Maintenance tech.</td>
</tr>
<tr>
<td>Infection control unit</td>
<td>3</td>
<td>Enrolled Nurse X 1 Registered Nurse x 1 Midwife</td>
</tr>
<tr>
<td>Senior Nursing Officer or manager</td>
<td>2</td>
<td>Registered Nurse x 2</td>
</tr>
</tbody>
</table>

**Data source:** Compiled by the author on data collected from interviews.
4.2.4 Training.

Participants were asked about any training regarding health and safety which they have subsequently received since being employed with the hospital. Details of the answers given are represented in table 12.

The responses indicate that as regards training there is still considerable ground to be covered. Courses or lectures organised by the Infection Control Unit have been noted to be quite diffuse and well attended amongst the nursing staff and health assistants, however there seems to be a vacuum as regards training on other health and safety issues. The infection control officer interviewed noted that recently the unit started giving some training to newly qualified doctors and a credit on the subject has also been introduced for student nurses at the Institute of Health Care. An annual conference was also mentioned amongst other strategies being adopted by the unit. However there seems to be a lack of participation from most of the medical and paramedical sector to such initiatives as "usually 90 % are nurses and the other 10% are other health professionals" (Infection Control Officer).

A nurse, highly frustrated with the lack of training initiatives expressed concerns that at times problems arise when employees apply to attend some form of training initiative. A verbatim transcription of his comments goes:
"When you see something like health and safety and you apply for it, you either have a problem with your manager or else you have to take it from your own leave. Instead of helping you in such situations so that you learn something you find a lot of things against you, obstacles. They do not even try to help you from their behalf.”

Table 12  Health and safety training received.

<table>
<thead>
<tr>
<th>Type of training</th>
<th>No. of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>17</td>
</tr>
<tr>
<td>Infection control related</td>
<td>12</td>
</tr>
<tr>
<td>Fire safety training</td>
<td>3</td>
</tr>
<tr>
<td>Learning through practice</td>
<td>2</td>
</tr>
<tr>
<td>Bacteriology behind sterilisation and disinfection</td>
<td>1</td>
</tr>
</tbody>
</table>

Data source: Complied by the author on data collected from interviews.

On this same topic the participants were asked “when a new piece of equipment is introduced in your department, do you get any training related to safe use of the specific equipment and are its potential hazards explained to you; if yes how and by whom?” Various answers were given showing that there is a
difference in practice that could be related to the unit/ward from where the employee derived. Some mentioned the fact that at times, a company representative goes to give a brief explanation however it is not always sufficient. Others commented that the usual trend is to learn by practice and through trial and error expressing serious concerns for the safety of the user and the patients involved.

Statements from the Human Resources Director (Mater Dei Hospital) were quite encouraging in relation to training vis-à-vis the health and safety aspect as it was claimed that money is already being allocated within budget plans for such issues. A comment worth mentioning from the same interviewee was:

"You can never be held accountable for something that you don't know about but if you know about it and you have been trained for it you can be held accountable for it".

4.2.5 Safety culture.

The general culture towards occupational health and safety in the hospital was discussed both within the focus group sessions and in the personal interviews. A general negative feeling as regards cultural issues concerning health and safety could be felt throughout the whole of the data collection exercise amongst all spheres of participants. Everyone tried to give his/her personal opinion for the reasons behind such negative feelings but interestingly
enough some much-unexpected points emerged during the discussions. The idea of having more enforcement and if necessary even to the extent of the particularly expressed policing phenomenon shows that there is definitely room for collaboration between all parties involved i.e. employees and management. From behalf of the employees it is clear that the majority agree that there should be adequate enforcement coming form competent authorities and as stated the idea of punishment against non compliers would be accepted when necessary.

Two main issues emerged that need to be considered into further detail are:

1. Imposing/ policing.
2. Laissez faire attitude.

4.2.5.1 Imposing/ policing

As already stated the imposing/policing phenomenon highly dominated in all interviews. Some comments worth mentioning from behalf of different participants are quoted hereunder:

"I believe that our culture necessitates that there will be enforcement of the laws so things would be done better" (nurse).

"It should be something that should be imposed on you not just you’re told about it .. it should be imposed on you" (doctor).
"With the culture being what it is you have to keep on reminding and keep on pushing safety measures" (doctor).

"I believe that the culture amongst workers within this hospital is very similar to that of other employees in Malta" (union).

"I believe that the management should enforce health and safety issues amongst the hospital employees" (nurse).

"Enforcement is a new concept for some areas of St. Luke's so we have to get there as well...but definitely enforcement is important in this aspect as well because we are finally responsible for the employee" (HR Director- Mater Dei Hospital).

One of the reasons behind such statements could be the fact that the issue concerns the employees' own personal health and it is very much likely that everyone wants to remain as healthy as possible.

4.2.5.2 Laissez faire attitude.

The laissez faire attitude as described by some participants is much associated to the "I don't care less" (actual words from transcripts) phenomenon. All those who mentioned such cultural tendencies amongst the employees noted that it was never them who adopted such a position but always referred to some of their
colleagues. This point need be taken into further consideration, as although most of the respondents seemed genuine in their thoughts and expressions there seems to be the fact that nobody actually admits that he/she could be pertaining to such a group. Having a considerable number of such employees might require specific attention whilst planning the required strategy.

4.3 Part 2 (Policy document analysis).

A search has been conducted by the researcher in order to try and establish which form of policies related to health and safety issues are published and available within the hospital. The search revealed that there are a few policies issued by the Infection Control Unit Committee St. Luke’s Hospital supporting comments made in the interview with the respective unit officer. These were available for downloading from the hospital’s intranet service or through the internet. The downloaded policies are:

1. Gloves use policy for the government health services (Issued 2002).


3. Isolation guidelines for patients suffering from communicable disease (Issued 1994).
4.3.1 Gloves use policy for the government health services.

This is a two-page document focusing on the use of gloves within all government health services. The document gives a very brief introduction regarding the necessity to use gloves and seems as if it is solely aimed to instruct employees which type of gloves they should be wearing whilst carrying out specific procedures. The whole policy document rather gives the impression that it is specifically intended to raise employee awareness on the use of sterile vs non-sterile gloves due to the financial implications surrounding the issue.

4.3.2 Needlestick injury & body fluid exposure policy.

The five-page document is mainly divided into four distinctive and well presented sub headings named:

1. Universal precautions.

2. Needlestick injuries.

3. Disposal of sharps.

4. Injury procedure.

In general the document is quite well presented and it seems that the policy makers involved into drawing up such a document have put quite a considerable
effort. All sections of the policy are detailed and clear especially when it comes to the instructions to be followed within the injury procedure section. A good explanation on what type of documentation should be recorded and maintained is present in which case giving the sufferer a solid point of reference.

4.3.3 Isolation guidelines for patients suffering from communicable disease.

The thirteen-page document goes into quite some detail related to the precautions to be taken if a patient is suffering from a list of sixty four mentioned type of infections. Although as already said there is quite an amount of infections covered, the way how these are presented into a table format makes it a quite easy and user friendly reference guide. For each of the infections listed there are recommendations on whether there is need for isolation, isolation site, mask/ gown/ gloves use, what body material is infective, length of isolation and precautions required. As with the Needlestick injury & body fluid exposure policy it is also gives a very good point of reference for all the hospital health care employees whilst a considerable amount of effort must have also been put in its planning stage.

Besides these three mentioned policy documents one could find a few health and safety related documents at individual ward/ unit level that are not specifically
designed but rather bought or obtained from some libraries or foreign hospitals. Some of the documents found related to the use of LASER beams in the operating theatres and general health and safety guidelines. The documents can undoubtedly provide some information to the employees however at times it tends to be misleading due to different contextual factors whereby these would have been written.

4.4 Summary notes from the interviewing experience.

It was quite felt that the majority of participants involved appreciated the fact that they have been given the chance to express their personal opinion and views regarding health and safety issues within the hospital. From a researchers' point of view it seems that there have not been much attempts and discussions on the subject with the employees themselves prior to this project. It was also noted that the participants were not used to such methods of data collection (group interviews) and at first they were very sceptic about the process used.

As regards the managers involved there was also a considerable effort to try and find time to fit with the interview schedule showing signs of willingness from behalf of such category that they really want to improve the situation. In one instance following the group interview with the technical grade workers, a maintenance technician approached the researcher and commented on the fact
that he really hopes that following this project finally something will be done. The comments passed on a personal basis (which the participant did not want included within the transcripts) showed real frustration regarding the present situation and served as a point of encouragement for the researcher.

4.5 Conclusion.

Both parts of the results collected within the project gave interesting findings shedding further light on the present situation regarding occupational health and safety at Malta's main general public hospital. The findings will be further discussed within the next chapter of the project.
CHAPTER FIVE

5.0 Discussion

5.1 Introduction.

Chapter five presents a discussion of the findings. The findings will be analysed and discussed in the following sequence:

- Safety culture.
- Occupational health and safety training.
- Employees' knowledge and perceptions on health and safety.
- Safety policy, reporting and documentation procedures.

These sub-headings were chosen on the basis of their importance for the development of an occupational health and safety management system. Main findings from this study are consistent with findings found in other organisations in Malta as reported in ‘Perceptions of health and Safety in Malta’ (Occupational Health and Safety Authority, 2002).
5.2 Safety culture.

As already stated in the literature review, Spears and Johnson (2002) describe the term safety culture as "a common shared emphasis on safety and a common valuation of safe working" within an organisation. It is this common shared set of values that makes the difference between having a defined type of culture or another. Looking at the answers received from different categories of employees it seems that they are not very happy with the present state of affairs as regards occupational health and safety and wish that the system is improved. The negative feeling expressed by the employees accompanied by the resultant lack of training initiatives, policies and health and safety management structures in the hospital, all point to a weak organisational safety culture. This is in line with the arguments of Bottomley (1999) suggesting that a positive link exists between the organisational approach to occupational health and safety, the employees' perception on the situation and organisational culture.

In all the interviews, employees acknowledged the fact that something needs to be done in order to arrange the present state of affairs. However, an unexpected feature that emerged was that the employees themselves agreed that health and safety measures should be imposed and policed by the management. Such phenomenon leads to the conclusion that the employees themselves are saying that they are eager for the change towards such initiatives and it might be an important factor that could make the process easier to accomplish.
At this point it is quite relevant to mention the comment made by the Human Resources Director (Mater Dei Hospital) regarding enforcement and commitment to health and safety issues within the new hospital. Having top management understand and believe such ideologies is quite necessary as commitment has to be seen coming from the top at all times. This is reflected in the works of Peterson (1998) and Hopkins (2002), suggesting that a degree of top management focus and commitment makes the employees feel positive and helps to achieve a strong safety culture. Seen in the light of such statements from the employees, there seems to be sufficient ground to adopt a proactive, systematic management approach to health and safety as suggested by Bottomley (1999).

Although at face value such comments made from the majority of employees seem to be very encouraging, some caution is required as there might be quite a difference from what the participants said as compared to the facts when put into practice.

The main point of discussion here lays on how to deal with the segment of employees labelled as the ones pertaining to those adopting an "I don't care less" attitude. Such individual type characteristics have also been noted in a study involving other sectors of the Maltese working population (Occupational Health and Safety Authority, 2002). It could be that such characteristics are ingrained in some segments of the local workforce and not solely attributed to the population under study. These can never be ignored and when put into the whole picture might prove to be a threat within the adoption and implementation
phases of the system. As none of the individuals interviewed expressed the fact that they pertain to such a group it is rather difficult at such a stage to estimate the actual dimension of such negative cultural behavior.

5.3 Occupational health and safety training.

As expected, a vast range of training initiatives related to health and safety are undoubtedly lacking within the hospital at present (this can be seen from table 12). Apparently such a problem is not confined to the setting under study as similar situations have been found within several other local organisations (Occupational Health and Safety Authority, 2002). Under current Maltese legislation provision of appropriate health and safety training is the responsibility of the employer (Laws of Malta, 2002).

The most positive type of training initiatives outlined throughout the whole data collection process seem to be coming from the hospitals' Infection Control Unit and it seems that these are gaining considerable popularity amongst some employees. All of the respondents who said that they have attended training related to infection control pertained to the nursing profession. Such findings need also be viewed in the light of the statement that when organising the annual infection control conference "usually 90% are nurses and the other 10% are other health professionals" (Infection Control Officer). Studies conducted amongst NHS hospital staff in the UK revealed similar trends whereby nurses
emerged as the most likely staff to attend health and safety training with the doctors being the least likely to attend (National Audit Office, 2003). Whether there is a lack of interest from other worker categories or simply that they do not know of such initiatives has not actually come out during the interviews and thus a point for further questioning remains on the willingness to attend for training.

As can be seen from table 12, there were a few participants \((n=3)\) that mentioned fire safety training. This relatively small number of employees who have received such training gives the idea that the initiative might have been carried out solely through the effort of the workers involved and their respective unit/ward manager. In the case of hospitals, fire training is very important for the safety of employees, patients and any third parties involved such as visitors or relatives within the premises.

Although only 2 persons within the focus group session stated that they believe that the little knowledge possessed regarding health and safety issues has been gained through practice, their statements could not be neglected. It could be that what they learn through practice might not be the ideal situation or procedure to be carried out therefore imposing unnecessary risk to the individual. As stated within the literature reviewed hospitals present the workers with a myriad of potential health and safety hazards (National Institute for Occupational Safety and Health, 1988), thus requiring a solid training program for all those involved within the organisation.

On a positive note it seems that plans are already underway to enhance such training initiatives as was stated by the Human Resources Director (Mater Dei
Hospital) and therefore the existent gap on such sphere could be narrowed in the near future.

A concluding remark to the topic of training goes on the emphasis for further education in occupational health and safety to managers. Daily management decisions have a critical impact on employee safety and health (Hecker, 1998). Further efforts to make education on such issues more widespread amongst such category of personnel are crucial within a health and safety management framework.

5.4 Employees’ knowledge and perceptions on health and safety.

5.4.1 Meaning of health and safety.

When participants were asked as to what do they understand by the term occupational health and safety, a number of individual definitions have been given. The various definitions were assimilated and sub divided into four main categories or themes (see table 8). The four categories that emerged cover all aspects of health and safety giving the idea that some of the participants are quite informed about the subject and in general know what they are talking about. From the answers received one can see that it is not just the physical aspect that is mentioned but also the psychological well-being. Physical and psychological stress featured within a number of interviews showing signs of concern from doctors, nurses, the union representative in the pilot focus group.
and even amongst management personnel. This is in line with statements by Menzies (1970) and Revans (1976) saying that hospitals are anxiety producing, stressful organizations. The subsequent effect on quality of care due to stress was also mentioned by one of the participating doctors whose comment matches with findings by Firth-Cozens & Moss (1998).

Another important factor that emerged was the fact that it is not just the health and safety of the employees themselves that need be safeguarded but also that of the patients and third parties entering within the hospital's boundaries. This shows an element of concern on behalf of the employees themselves to their respective present and potential clients emphasizing on the need to tackle health and safety management issues from various angles and perspectives.

5.4.2 Legal duties and obligations.

With reference to local legislation, the Health and Safety Authority act states that both the employer and the employees have their respective duties to abide with and follow (Laws of Malta, 2002). When such aspect was discussed in the interviews mixed reactions were encountered. As can be seen from the results, only the managers unanimously agreed that both sides (employers and employees) have their respective part to play. Such findings can be seen as positive, however the results obtained from the rest of the focus groups were quite unexpected.
The employees who said that responsibility lays solely on the management were openly criticised by fellow participants within their respective group and following some discussion it appears that they have taken a different stance on the matter. The fact why these few individuals had taken such a stance could be that they did not actually understand the way in which the question was posed or perhaps might have had some very negative experience with the management themselves.

5.4.3 General health and safety situation at the hospital.

The general comments from behalf of the employees working at St. Luke's Hospital as regards the occupational health and safety situation were of a very negative nature (see table 10). The absence of a health and safety unit at hospital was mentioned and perhaps this should be one of the first things to set up to demonstrate that the issue is going to be tackled seriously. Findings regarding the general situation are in line with the report 'Perceptions of Health and Safety in Malta' (Occupational Health and Safety Authority, 2002), showing that health and safety at work is still being taken lightly in some organisations. The management personnel involved within the project were also of the same opinion, showing that there is a general consensus that a lot of ground need be covered in order to start moving forward.
5.5 Safety policy, reporting and documentation procedures.

5.5.1 Accident reporting and documentation.

An established accident reporting and documentation system is a key issue in health and safety management (ILO-OSH, 2001). Table 11 in the results section gives a picture of what channels are used in order to report an accident at St. Luke's Hospital. The answers given show that the employees themselves do not know the actual procedure and what documentation is to be filled. In case of an accident, the majority goes to their immediate superior for further guidance. The point of discussion here is whether the approached superior knows the actual procedure that need be followed him/herself or not. There seems to be no clearly set procedure to be followed in which case is leading to the fact that whoever has passed through some form of experience will learn through what has actually happened whether being the right or wrong approach to take.

The only sort of documentation mentioned was the NI30 form. None of the participants mentioned any kind of reporting that is of an internal (pertaining to the hospital) nature as the NI30 itself is not specific to the hospital. Within the content of the 'Needlestick injury & body fluid exposure policy' one can find a clear description of the reporting and documentation procedure in case of a needlestick injury. Within this particular policy, besides the NI30 another form is mentioned called the 'Blood and body fluid exposure notification form' that was never referred to by any of the interviewed employees. This could be due to the fact that the few existing policies are not well communicated as was found out...
within the data collected. The lack of communication of such procedures, policies and documentation is worrying and requires immediate action to be followed in order to try and improve the situation. It is not just a question of having the policies written down and documented but also providing efficient means for communicating such policies to all the people involved within the organisation that makes them useful and effective (ILO–OSH, 2001). Although the Infection Control Unit is doing a lot of good work, however it seems that the issue of how to communicate their respective policies is not being tackled well. The unit officer interviewed stated that the policies are on the intranet and all employees can access such policies, whilst results show that the majority of the workers do not even have real access to the ward/ unit's computer. Other means of communication should be sought and implemented in order to continue on with the good work already started and in place.

5.5.2 Safety policies.

As already discussed in other sections of this project there is no general health and safety policy within the hospital. The few general policies found are referred to within section 4.3 of the project. Although a lot of work is still to be done on this front however one of the three mentioned policies (i.e. Needlestick injury & body fluid exposure policy) is very well prepared and presented. In view of the interest showed from behalf of all employee categories involved in the study, an active worker participation approach to policy making (ILO-OSH, 2001) could be adopted within the hospital.
5.6 Limitations of the study.

It appears that although several measures have been taken to make the study as rigorous as possible, some limitations might still weaken the study. In a first qualitative research study attempt by the researcher there are bound to be many limitations, however efforts have been made in order to try and reduce them to their minimum possible. The following are the possible limitations elicited during the execution of the research project:

1. **The expert figure:** The qualitative approach (in the focus group interviews) cast the researcher as the expert within the field and created a relationship between the researcher and the participants involved.

2. **Interpretation bias:** The primary data collector has been an employee of the same hospital whereby the research was carried out for quite a considerable number of years. Although the researcher tried to enhance neutrality, the potential for selectivity of data collection as well as its interpretation always exists in a study of this nature, particularly when the researcher is an insider. Results depend on a subjective interpretation of the researcher, which may lead to personal views that may reflect the study outcome.
3. **Transferability of findings:** All study participants have been employed at St. Luke's Hospital. Findings emerging from this study need be tested in other public hospital settings to determine their relevance.

4. **Absence of quantitative data:** The lack of a quantitative part within the study might weaken validity of the findings.

5. **Time constraints:** Important points on the subject might have not come out during the focus group interviews leaving out unexploited areas of interest especially during the focus groups. Some of the interviewees were at times interrupted during the sessions due to duty commitments resulting in disruptions in the discussion.

6. **Transcription:** The interview transcripts were translated from Maltese into English rendering a possible bias and change of meaning during the translation.

7. **Lack of experience:** Lack of interviewing experience from the researcher accompanied by a lack of opportunities for the participants to be involved into such initiatives might reflect on the quality of data collected.

8. **The group effect:** Although group participants have been homogenously selected to try and make them feel comfortable together the same idea
could have had a negative effect on the group dynamics. When conflicting issues arose between participants of the same grade or profession it was noticed that some hidden agendas were kept aside to reduce interpersonal conflict with colleagues.

9. **Dominant group participants:** Some specific individual characters have come out during some of the focus group interviews. Lack of experience from behalf of the researcher to control these individuals might have affected the group outcome as they dominated the group session leaving very limited time for other participants to express themselves.
CHAPTER SIX

6.0 Conclusion and recommendations

6.1 Conclusions.

In this study the author concluded that although some efforts are being made, however further progress is required to safeguard occupational health and safety within the public hospital under study. The following general conclusions on the situation require further attention and consideration:

- As expressed by several participants in the study there are several potential physical and psychological hazards in the hospital that need to be addressed and tackled in a coherent and systematic manner. Poor attention to health and safety issues is affecting staff retention and posing detrimental effects on the quality of care and staff morale as expressed by some employees themselves. Although the hospital is always expanding its services and offering an ever-increasing quality of specialised care to the respective clients, resources are not being channelled towards health and safety initiatives.

- Management of health and safety in the hospital is far from desired both as concerns the employees point of view as well as individuals in management positions. There is a general agreement that something need be done by all the
parties involved (management and employees). Encouraging signs for possible future collaboration and involvement between the management and staff have emerged from the study. Such positive findings could serve as an impetus for the management to start showing signs that the problem is going to be tackled and everyone giving his/her personal contribution. The employees seem to have quite a fair understanding of what occupational health and safety entails and what it is all about. Further exploiting such elements amongst the workforce will help for the success of the health and safety management system.

- There is a considerable lack of health and safety policies and guidelines in the hospital. General policies need be prepared touching various elements of occupational health and safety. Communication of the few existing policies is very poor and requires further attention. A strategy for effective means to communicating such policies should be found whilst units/wards need be helped and encouraged to develop specific departmental policies.

- There is a general lack of training initiatives on health and safety issues within the hospital. The few training initiatives being tackled concern elements of controlling physical risks (e.g. needlestick injury prevention, fire training etc.) and being tackled by the Infection Control Unit. Elements concerning psychological health and safety factors such as potential psychological effects of occupational stress, violence and excessive workload/working hours are not being tackled at
all. Such points have been outlined by the employees themselves showing that such problems do exist and are being faced on a daily basis.

- Certain elements inherent within the culture or personal individual traits have emerged that might need some further thought and consideration whilst planning for any changes regarding health and safety management. Such elements have also been previously confirmed in another study involving different sectors of the Maltese workforce. These negative elements should not discourage the majority of management and employees whom from their behalf would like to see a change into the right direction.

6.2 Recommendations.

With the aim of this study designed to investigate the health and safety situation at Malta's main general hospital in preparation to setting up a safety and health management system, the following recommendations could be forwarded for further consideration. The recommended strategy is divided into actions requiring immediate action and others requiring further consideration prior to medium term implementation.
Immediate strategy:

- Setting up of an Occupational Health and Safety Management Team with respective sub committees.

The setting up of a hospital ‘Occupational Health and Safety Management Team’ is an issue of primary importance. There is enough professional and intellectual background amongst already employed human resources to set up such a team. Tasks of the team shall include:

1) Revision of existent practices and systems in consultation with external health and safety advisors (help from the Occupational Health and Safety Authority is recommended).

2) Taking of immediate corrective measures in consultation with the Senior Hospital Management Team until an Occupational Health and Safety Unit is formed.

3) Commissioning of studies and evaluation reports on the negative effects due to inadequate health and safety measures that can be used for future cost-benefit analysis.

4) To serve as a main point of reference to management and hospital employees and take care of occupational health and safety issues until the Occupational Health and Safety Unit is set up.

The unit need focus on issues related to the workers, patients and other third parties that could happen to be within the hospital boundaries addressing both physical and psychological hazards.
Medium strategy:

The medium-term strategy shall include the setting up of an integrated occupational safety and health management system. Following the outcomes of this study it is recommended that the system be based on elements of innovative management and safe workplace oriented strategy as outlined by Gallagher (1997). Management will have a key role in occupational health and safety efforts with a high integration into broader management systems (e.g. quality) adopting a strategy focused on hazard identification, assessment and control at all stages. The recommended system can be developed in house with assistance from the Occupational Health and Safety Authority. Amongst the main elements requiring particular attention are:

- **Formulation of a hospital general health and safety policy document and review of existing policies.**

The formulation of a health and safety policy document is of utmost importance. Amongst the elements to be addressed by this document are issues related to management and employee responsibilities, training, discipline, monitoring arrangements, policies and guidelines and emergency plans and procedures. Policies need to support a clear, unambiguous reporting culture whereby staff understand the need for and are confident of making accurate and
timely incident reports. The policy is to be formulated in consultation with all parties involved adopting a tripartite approach.

- **Strategies for managing work related psychological problems.**

  Provision of specialised staff counselling and guidance clinics whereby workers can be directed to this specialised unit under strict confidential conditions. The unit will tackle various stress related problems such as work violence, bullying and increased workloads. The resources involved shall include the structural facilities, general running costs and salaries of staff required.

- **Adopt a strategic approach to induction and other training.**

  Development of a training program related to occupational health and safety topics (including infection control, manual handling, fire training etc.) provided to all existent and possible future clinical and support staff at the hospital. Responsibility for maintaining of staff training records at ward/unit level and at a central level need be clarified and records training kept up to date. Such training program can be developed in-house or sub-contracted to specialised health and safety consultancy firms following a detailed training needs assessment.

- **Introduction of an employment exit review system.**
The employment exit review system is aimed at identifying cases where staff leaves the hospital due to concerns about or experience of poor response to health and safety issues. Such concerns need be channelled and communicated to the hospital's health and safety unit to identify any shortcomings within existent health and safety concerns and subsequent further action as required.

6.3 Recommendations for further studies.

Whilst conducting this study the researcher felt that further work related to the topic could be carried out in order to help future management decisions. The following recommendations for further studies are henceforth forwarded for consideration:

- A study on the costs associated with absenteeism, time off work, psychological stress and staff turnover due to health and safety reasons would prove beneficial for future cost-benefit analysis of health and safety programmes.

- A benchmarking exercise with local private hospitals on the provision of occupational health services could assess standards with other local healthcare organisations. A benchmarking exercise can also be performed with a similar sized hospital on an international level (e.g. UK).

- A quantitative study involving a large sample of employees from all
employee categories in the hospital whereby findings can be compared to those elicited from this study.

- Data archived at the Department of Social Security in relation to sickness claims by hospital employees can be explored for major causes, trends and patterns of hospital work related injuries.

- A before and after design evaluation of the effectiveness of training organised by the infection control unit. Such evaluation could help to tune some program elements and help in the preparation of future hospital wide training programs.


APPENDIX 1

33, “Wild Orchid”
Triq il-Hortan
Marsascala
Malta ZBR 11

Date: .................. 2002

Dear Dr/Mr/ Mrs/ Mrs ............................................

In the following months I will be conducting a research on occupational health and safety in public hospitals. The study will form part of a management project that I shall present for my MSc in Health Services Management that I am reading at the Institute of Health Care. You have been selected to participate in a focus group/ personal interview concentrating on the subject matter.

I shall be conducting the interview myself. Please rest assured that your personal identity would be kept confidential during and after the study. Your personal participation and help is very much appreciated, however please do not hesitate to refuse to participate if you deem necessary.

The interview will take place as follows:

Date:

Venue:

Time:

Aprox. Duration of interview:

In case you feel the need to contact me for further details/ information on the interview, please kindly do so at your convenience on these contact numbers:
Home 21632233

Mobile 79703707

Work 2595 1575/6/7 (Karen Grech Operating Theatres)

Waiting to hear from you soon.

Sincerely

Neville Schembri
STUDY INTERVIEW CONSENT FORM

I ____________________________ (PARTICIPANT) HEREBY DECLARE THAT I AGREE TO TAKE PART AND RESERVE THE RIGHT TO OPT OUT AT ANY TIME FROM THE INTERVIEW CONDUCTED AS PART OF THE RESEARCH PROJECT ON OCCUPATIONAL SAFETY AND HEALTH MANAGEMENT SYSTEM FOR PUBLIC HOSPITALS.

I ____________________________ (RESEARCHER) DECLARE THAT THE IDENTITY OF THE ABOVE SIGNED PARTICIPANT IN MY RESEARCH PROJECT WILL REMAIN CONFIDENTIAL AT ALL TIMES DURING AND AFTER THE STUDY.

Participant's Signature: _______________________

Date: ________________

Researcher's Signature: _______________________

Date: ________________
July 7, 2002

Dr. F. Bartolo
Medical Superintendent
St. Luke’s Hospital
G’Mangia
Malta

Dear Dr. Bartolo,

As part fulfillment for my MSc in Health Services Management, which I am reading at the Institute of Health Care (Malta), I am in the process of carrying out a management project aimed at investigating the requirements to set up a health and safety system for public hospitals.

In this study I shall carry out a few focus group interviews involving some selected employees working at St. Luke’s and Karen Grech Hospitals. For such intervention anonymity of the selected employees shall be assured at all times. The participants will be given full details and information about the research with the option to consent to participate or opt out. All data collected will be represented in a collective form.

Before carrying out the study in your hospitals, your permission is kindly solicited.

Thanking you in advance.

Sincerely,

Neville Schembri

33 "Wild Orchid"
Triq il-Hortan
Marsascala
Malta ZBR 11
APPENDIX 4

Focus group interview question guide

General introduction:

In brief what does each of you understand by the term 'occupational health and safety'?

In your own personal opinion, who has the duty and responsibility to foresee that health and safety issues are being tackled and adhered too; the employer, the employees or both have their own respective responsibilities?

As employees, do you feel that the issue of health and safety is being tackled well or sufficiently enough within our hospital? (If yes expand).

IF NO

According to you what should be done in order to arrange the situation with regards to health and safety in the hospital? (Any suggestions).

Safety policy:

Do you know of any policies or guides relating to health and safety issues within the hospital or specific within your department?

During your duties within your respective department are there any health and safety issues, which in your opinion should be handled or tackled? (Expand).
Incident/accident reporting:

In case of an accident at the place of work what is the procedure usually carried out within your department? (Any specific data recording sheets e.g. incident report sheet)

If you compile an incident report regarding a workplace accident do you know what happens to it, do you follow to see what happens to your report and are you satisfied with the outcome? (Expand).

If you have any problem regarding health and safety at your place of work, who is/are the persons you usually first turn to and are you satisfied with their respective actions?

Training:

Before or when you started to work within your department was any sort of safety training carried out? (If yes how, by whom & where you satisfied).

When a new piece of equipment is introduced within your department do you get any training related to safe use of the specific equipment and are its potential hazards explained to you? (If yes how, by whom & where you satisfied).
Safety Culture:

Has anyone ever tried to introduce a safety practice within his/her respective department and if so what was the experience encountered? (Any support or resistance from workplace colleagues, superiors or people outside your department)

According to your own personal opinion are there any specific factors within the hospital or amongst employees that are might hinder the process to introduce further health and safety measures?

Anyone wishes to add something further to the topic?
APPENDIX 5

Accidents at work in Malta by occupation and gender (1999-2001)

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<td>Technicians &amp; associate professionals.</td>
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<td>Clerks.</td>
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<td>119</td>
<td>70</td>
<td>31</td>
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<tr>
<td>Service &amp; sales workers.</td>
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<td>15</td>
<td>164</td>
<td>220</td>
<td>27</td>
<td>247</td>
<td>172</td>
<td>30</td>
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<tr>
<td>Skilled agriculture &amp; fishery workers.</td>
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<td>44</td>
<td>32</td>
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<td>33</td>
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<td>-</td>
<td>18</td>
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<tr>
<td>Craft &amp; related trades.</td>
<td>1336</td>
<td>34</td>
<td>1370</td>
<td>1819</td>
<td>51</td>
<td>1870</td>
<td>984</td>
<td>22</td>
<td>1006</td>
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<tr>
<td>Plant, machine operators &amp; assemblers.</td>
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<td>8</td>
<td>194</td>
<td>227</td>
<td>9</td>
<td>236</td>
<td>192</td>
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<td>Elementary occupations.</td>
<td>2858</td>
<td>412</td>
<td>3270</td>
<td>1983</td>
<td>402</td>
<td>2385</td>
<td>2792</td>
<td>346</td>
<td>3138</td>
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<td>Total</td>
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<td>552</td>
<td>5265</td>
<td>4534</td>
<td>623</td>
<td>5157</td>
<td>4515</td>
<td>546</td>
<td>5061</td>
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M = Males

F= Females
APPENDIX 6

Fatal accidents at work in Malta (1993-2001)

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<th>Year</th>
<th>No. of Fatal accidents</th>
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<td>6</td>
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