

UNIVERSITY OF CAPE COAST

PERCEPTIONS ABOUT THE EFFECTS OF ORGANIZATION HEALTH AND  
SAFETY POLICIES ON EMPLOYEE PERFORMANCE IN KINTAMPO -  
NORTH MUNICIPAL HOSPITAL

BY

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## DECLARATION

### Candidate's Declaration

I hereby declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Name: Eric Tukuu

Signature: .....

Date .....

### Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's Name: Mrs. Abigail Opoku Mensah

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## ABSTRACT

The study was conducted with the broad objective of finding out the relationship between employee's health and safety and performance using Kintampo-North Municipal Hospital as study area. Relevant literature on health and safety were reviewed. Questionnaire was the main tool for data collection. Data was analysed using descriptive statistics. Proportions were used to summarise variables that were categorical in nature. The dependent variable in this study was binary in nature, therefore, the logistic regression was used to determine the relationship between the dependent variable and other explanatory variables in the study. The sample size for the study included all 75 nurses at the Kintampo hospital. The research identified employees' health and safety as associated with the availability of resources such as access to welfare facilities. Majority of the respondents said management has been organising periodic health and safety discussions with them. Effective health and safety management have been discovered to have positive correlation with the increased organisational performance and profitability.

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**DEDICATION**

To my family, mother, wife and children

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## CHAPTER ONE

### INTRODUCTION

#### **Background to the study**

Workers constitute a large and important population. The World Health Organization (WHO) estimated in 2007 that the Global Labour Force was half of the World's population (about 3300 million, WHO 2007). The officially registered working population includes 60-70 percent of the world's adult males and 30-60 percent of adult females. Most people between the ages of 22 and 65 spend approximately 40 percent of their working hours at work (James Leigh, Petra Macaskill, Eeva Kuosma and John Mandryk – Global Burden of Disease and Injury Due to Occupational Factors, 1997).

Occupational health, as defined by a joint committee of the WHO and the International Labour Organization, involves the promotion and maintenance of the highest degree of physical, mental and social well - being of workers in all occupations (Forsman, 1983). This definition emphasizes the term health rather than disease, and further implies a multidisciplinary responsibility as well as a mechanism for the provision of health services for the working population. As practiced today, the cornerstones of occupational health practice are health protection and health promotion of those who work. In many countries, such activities extend beyond the worker to include his or her family members.

Health and safety policies in an organization also commonly referred to as occupational health and safety or workplace health and safety is an area concerned with protecting the safety, health and welfare of people engaged in work or employment. A number of organizations promulgate health and safety policies. Occupational health and safety policies include fostering a safe and healthy working environment. Health and safety policies may also protect co-workers, family members, employers, customers and many others who might be affected by the work place environment.

Health and safety policies can be important for moral, legal and financial reasons. All organizations have a duty of care to ensure that employees and any other person who may be affected by the organizations' undertaking remain safe at all times. Moral obligations would involve the protection of employees' lives and health. Legal reasons for health and safety policies relate to the preventive, punitive and compensatory effects of laws that protect workers' safety and health. Health and safety policies can reduce employee injury and illness related costs, including medical care, sick leave and disability benefit costs.

Employee performance is one of the most widely used variables in organizational behaviour. Employee performance is defined as a process for establishing a shared work force understanding about what is to be achieved at an organization level. It is about aligning the organizational objectives with the employees' agreed measures, skills, competency requirements, development plans and the delivery of results. The emphasis is on improvement, learning and

development in order to achieve the overall business strategy and to create a high performance workforce.

The working environment has been described as the aggregate of all living and working conditions that may influence the life and health of the workers. It includes; lifestyle, culture, values, beliefs, perceptions of quality, stakeholders, perception of value for money, current situation, changes, benefits or risks of those changes and health promotion strategies. The work environment consists of various factors which introduce new dimensions to health, causing disease and injuries which include work accidents and exposure to hazards. “High level of worker productivity are critical to the success of all sorts of organizations, whether for profit, government or non-profit. As a result, health and safety risks and productivity is being discussed within corporate medical department, executive suite, academic centers, and Government Agencies around the World” (Brandt, Hornschemeier, Alexander, Garmire, Schnider, Broos, Townsley, Bautz, Felgelson, and Griffiths 2001).

Improving the fit between humans and tools inherently means a more effective match between health and safety and performance. Good design permits more output with less human effort. Health and safety is an inevitable aspect of health care delivery and this is because the only time an employee will perform his duties is when the employee is in good health and is sure of safe working conditions. This boils to the fact that a worker will perform his duties to the fullest only when he is sure that even when an accident occurs he will be taken good care of. One of the most important things that an employer should provide to his

employees is safety even at a low risk site. Health concerns of an employee ought to be valued more than any other thing in an organization, there is an adage that says “Health is Wealth.” All other factors involved in the running of an organization depend on man; money, material and machines are to be spent, utilized and controlled by man” (Mac lead, 1995:19).

According to Webb (1989), a central belief in most of the occupational medicine / health promotion literature is that people perform better when they are physically and emotionally able to work and want to work which in turn leads to higher productivity and profits.

Safety constitutes one of the essential human needs, as postulated by Abraham Maslow in his theory of needs hierarchy. Feeling safe at work ranked as a very important factor in job satisfaction, (Kreitner, 2007). In attempt to satisfy this need, certain organizations incorporate into their policy thrusts, guaranteeing workers safe work execution under a condition of being safe from undergoing or causing hurt, injuries or loss. Hence, safety policies may encompass activities directed at either reducing or complete removal of hazardous conditions capable of causing bodily injuries. Organizational safety policy according to Aswathappa (2004), specifies the company’s safety goals and designates the responsibilities and authority for their achievement.

### **Statement of the problem**

Health care workers are known to be at a higher risk of infection from blood – borne pathogens than the general population. Those mostly at risk are those whose activities entail exposure to blood and blood products. Important

blood - borne pathogens in this regard include Hepatitis B (HBV), Hepatitis C (HCV) and HIV /AIDS. (Occupational Health and Safety Policy and Guidelines for the Health Sector, June 2010).

The World Health Organization (WHO) estimates that sharps injuries contribute 30% of new cases of HIV among health care workers in Sub-Saharan Africa (WHR 2002). Important predisposing factors found to account for these trends according to WHO include needle stick injuries resulting from recapping of needles with two hands and contributory factors such as an over use of injections. Other patient and health care worker behaviours also contribute to sharps injuries.

The reality of Ebola virus disease occurring in Ghana has been heightened by the relentless spread of the disease and its associated high case fatality rate as seen in the initial three countries: Guinea, Sierra Leone and Liberia. Nigeria and Senegal have also acquired cases through importation from the index countries. The high case fatality rate is associated with an apparent paralysis of the disease of the health systems to adequately respond to the epidemic and the deaths of health care workers have heightened the state of apprehension.

The prospect has been fuelled by the State of (un) preparedness in Ghana and the inability to control the spread of the epidemic, should it occur. Reactions to the outbreak are reflected in psychological, socio cultural, economic and above all health systems responses. There is the need to design and implement appropriate information and communication approaches to address these concerns. A striking observation is the weakness in the health systems of the three index countries that have recent histories of social disablement through conflict. The

above statements reflect that compliance with occupational safety and health policy standards is taken for granted, but that is often meant to be the starting point for safety.

Monthly returns on occupational health and safety from Kintampo Municipal Hospital have consistently not been entered on the DHIMS (District Health Information and Management Services) even though the Regional Health Directorate made provision for monthly returns. This makes it difficult to figure out the number and nature of injuries at the Hospital so as to put measures in place to prevent their reoccurrence.

These problems have therefore provoked a study on the Effects of Occupational Health and Safety Policies on Employee Performance; A Study of Kintampo Municipal Hospital.

### **Objectives of the study**

The study was conducted with the broad objective of finding out the relationship between employees' health and safety and performance using Kintampo - North Municipal Hospital as study area.

The specific objectives include:

1. To identify the health and safety policies and programmes for employees of Ghana Health Service in Kintampo- North Municipal Hospital
2. To establish the relationship between health and safety and employee performance



3. To identify some of the challenges of health and safety in Ghana Health Service in Kintampo- North Municipal Hospital.

### **Research questions**

1. What are some of the health and safety policies in Ghana Health Service?
2. Is there a relationship between employees' health and safety and their level of performance?
3. What are the challenges facing management in the formulation and implementation of health and safety policies in Kintampo Municipal Hospital?

### **Hypothesis**

H<sub>1</sub> Employees who are satisfied with the health and safety policies are committed to the service goals.

### **Significance of the study**

Under section 19 (1) of the Work Health and Safety Act, 2011 (WHS ACT), a Person Conducting a Business or Undertaking (PCBUs) must ensure the health and safety of workers at work in the business or undertaking; so far as it is reasonably practicable. Additionally, section 19 (2) requires PCBUs to ensure that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking, so far as it is reasonably practicable (2011Act No.137).

“A cultural shift is gradually occurring in Australia. Employers, health systems payers and individuals are increasingly seeing the benefit of the workplace as a setting for optimizing physical, psychological and social health” (Price Water House Coopers, 2010).

Brenner (2004) asserted that the ability of employees within an organization to share knowledge throughout the system depends on the conditions of their work environment. The study adds to existing literature. It also provides basis of informing management of Kintampo Municipal Hospital on the extent to which occupational health and safety could go in adding more value to the image of the service, its activities and turnover. The study aims at alternative means of getting things done in a new way. The dangers of not having a health and safety policy in any organization / service shall also be examined.

### **Delimitation**

Delimitations refer to choices that the researcher makes for the study that are under the control of researcher according to Baltimore County Public Schools. The researcher must rationalize these decisions. Delimitations include the population of the study, variables, statistical analysis and focus of the research. This helps the researcher maintain objectivity in the study. It also helps other researchers reconstruct a study or advance future research on the same topic ([www.bcps.org](http://www.bcps.org)).

The study is limited to Kintampo - North Municipal Hospital. Although hospitals exists in all the Districts, Municipalities and Metropolis throughout

Ghana, time constrain, cost and the large structure of hospitals are some of the reasons why all the hospitals would not be covered. Kintampo - North Municipal Hospital has been chosen because of the relatively large presence of health workers and the inability of management to report on occupational health and safety up till June 2015 on the District Health Information Management Systems (DHIMS). Accessibility of staff unlike other Districts, Municipalities and Metropolitan Hospitals was also not a challenge.

The study limit its sample population to the seventy five (75) total number of nurses of all categories in Kintampo - North Municipal Hospital where the sample size was selected as the representative of the total employees of the hospital.

### **Limitations**

Limitations are influences that the researcher cannot control. They are the shortcomings, conditions or influences that cannot be controlled by the researcher and place restrictions on your methodology and conclusions.

One limitation of the study was the inability to use a larger sample size. This was not possible because of time limitation and also because of the objective of finding out the relationship between occupational health and safety and performance on workers who are directly affected by occupational hazards in the hospital such as the nurses. That notwithstanding, the sample size used was reasonably large, the findings can be generalized for the entire Ghana Health Service, with caution.

Another limitation of the study was the inability to have enough access to literature from which to draw the desired conclusions. It is a well –known fact that because of the oath of secrecy that public servants swear, they seldom release information to the public and this leads to a low response rate to the administration of the questionnaire. This was minimized by assuring respondents of the purpose of the study and the enforcement of confidentiality.

### **Definition of Some Key Terms**

**Risk:** Exposure to danger or loss

**Hazard:** Something that can cause harm if not controlled

**Employee:** A person who is hired to provide services on a regular basis in exchange for compensation and who does not provide these services as part of an independent business.

**Accident:** An unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.

**Health:** is the art and science of preventing disease, prolonging life, promoting physical and mental health, sanitation and personal hygiene, control of infections and organization of health services.

**Organization:** A social unit of people systematically structured and managed to meet a need or pursue collective goals on a continuing basis.

**Performance:** The accomplishment of a given task measured against preset known standards of accuracy, completeness, cost and speed. In a contract, performance is deemed to be the fulfilment of an obligation, in a manner that releases the performer from all liabilities under the contract.

**Policy:** The set of basic principles and associated guidelines formulated and enforced by the governing body of an organization, to direct and limit its actions in pursuit of long – term goals.

**Safety:** Relative freedom from danger, risk or threat of harm, injury, or loss to employee and/ or property, whether caused deliberately or by accident.

**Workplace:** Establishment or facility at a particular location containing one or more work areas.

### **Organization of the study**

Chapter one is the introduction. This includes the background to the study, the statement of the problem, research questions and objectives of the study, hypothesis, and significance of the study, delimitation of the study and definition of some keywords. Chapter two covers the review of literature on organizational health and safety. It enumerates theories and concepts available on organizational health and safety. Chapter three deals with the methods used and how the data for the study will be analyzed and presented. Chapter four provides historical overview of the health system in Kintampo and centre on data presentation, analysis and discussion of findings. Chapter five summarizes, conclude and make recommendations for the study and suggested areas for further study.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Despite the existence of protective legislation in many countries, the burden of injury and illness on workers remain significant. It is essential for medical practitioners and public health programmes to recognize, prevent, and manage work-related injuries and illnesses. There is need for International coordination of occupational health protection for workers, given the increasing globalization of the World economy. Several approaches have been proposed to address this issue. For example, there should be harmonization of health, safety, and environmental standards in a way that does not unfairly impose a competitive disadvantage on the newly industrialized Nations. Government and Multinational Corporations should share the most advanced technologies and resources. Rather than allowing companies to manufacture products banned for use in their own countries, governments in Developed Nations should provide financial incentives for their industries to develop and export safer products and technologies. At a minimum, International systems should be established to ensure complete notification of potential hazard, including labelling the contents of raw materials and products.

The practice of occupational health has extended beyond the domain of the workplace, into the general environment. Hence, the term “occupational and environmental health” might accurately describe this important aspect of public health.

## **Theoretical Framework**

Safety constitutes one of the essential human needs, as postulated by Abraham Maslow in his theory of needs hierarchy. Feeling safe at work ranks as a very important factor in job satisfaction, (Kreitner, 2007). In attempt to satisfy this need, certain organizations incorporate into their policy thrusts, guaranteeing workers' safe work execution under a climate capable of enhancing the physical, mental and emotional conditions. Organizational policy of this nature is often categorized under health and safety.

Under work environment, Hall and Goodale (1986) describe employee health as the absence of illness or disease resulting from the interaction of employees and the work environment. In general term, health means a state of complete physical, emotional, mental, and social ability of an individual to cope with his environment, and not merely the absence of disease or infirmity (Hippocrates,1981). Health is the science and art of preventing disease, prolonging life, promoting physical and mental health, sanitation and personal hygiene, control of infections and organization of health services (Lucas, 2001).

On the other hand, safety means freedom from the occurrence or risk of injury or loss (Aswathapa, 2004). He described industrial, occupational or employee safety as the protection of workers from the dangers of industrial accidents. Safety can as well be referred to as the absence of injuries due to the interaction of the employee and the work environment (Lucas, 2001). In a general perspective, safety means condition of being safe from undergoing or causing hurt, injuries or loss. Hence safety policies may encompass activities directed at either

reducing or complete removal of hazardous conditions capable of causing bodily injuries. Organizational safety policy, according to Aswathapa (2004), specifies the company's safety goals and designated the responsibilities and authority for their achievement. According to him, such policy statement must emphatically declare four fundamental points;

The safety of employees and the public,

Safety taking precedence over expediency,

Every effort made to involve all managers', supervisors and employees in the development and implementation of Safety procedures.

Organizational Health and Safety in the context of this research work is concerned with the health and safety of workers which Annah (2004) described as part and parcel of human security and as a basic right.

According to ILO (2005) Organizational health and safety focuses on the development of specific measures and programmes, aimed at protecting employees in the course of performing their duties to maximize productivity and improve the overall organizational performance.

### **The industrial revolution and occupational health**

The major event that profoundly influences the development of occupational health was the industrial revolution in the eighteenth century. Dramatic social change during this period occurred in the Western World. These transformations related to newly introduced industrial processes and the setting up of factories, which in turn set in motion a variety of social changes. Previously,



most work was done by craftsmen in rural cottage industries. The industrial revolution resulted in work being carried out in factories in urban centres.

Effects were seen both within the community, as well as in the individual worker. Family life was disrupted, with men leaving their families and moving to work in new industrial areas. In industrial areas, health and social problems emerged – such as poor housing and sanitation, alcoholism, prostitution and poverty. Inside factories, individuals were exposed to long hours of work and uncontrolled occupational hazards; and faced the risk of accidents at work. Child labour and apprenticeship of young children were common place, and there was absence of labour legislation.

As problems of industrialization grew, people of influence and political power campaign to improve working conditions. Occupational health legislation appeared towards the end of the eighteenth century and progressively developed to protect the health and rights of workers.

Today, the same phenomenon seen, during the industrial revolution are being replicated in some developing Nations. Even in industrial nations, the similar problems are still being encountered by migrant workers and other deprived sectors of the society.

### **History of Health and Safety in the Workplace in Ghana**

In 1833, the Factories Act led to the creation of the First Factory Inspectors. Initially charged only with preventing injury among child labourers, they came to exercise considerable legislative influence.

Between 1860 to 1871, their jurisdiction was extended to almost all workplaces; no longer simply observers, they became technical advisers and enforcers in their own right. As the culture of the workplace inspection blossomed, so other industries came to respect minimum standards. Public outcry over the brutal treatment of miners resulted in Mines Act of 1842. In 1895 the Quarry Inspectorate was formed and, from 1956, the Agricultural Sector began to face regulation.

The piecemeal reform came to a head with the passage of 1974's seminal health and safety at work etc Act. Ironically, given the didactic tendencies all-too-often associated with "Elf and Safety" today, the Act in fact promoted a less prescriptive system than existing regulation allowed. For the first time, employers and employees were consulted. Codes of practice and guidance became readily available. The Health and Safety Commission (HSC) was established to propose new regulation, provide information and conduct research. In 1976, the first of their Annual Reports into Workplace Standards was published.

Increasingly, the HSC began to take into account the long-term wellbeing of employees. From 1980, it became incumbent upon employers to keep records of accidents in the workplace and from 1981, to provide adequate first aid facilities. A series of laws regulated the treatment of those exposed to lead at work and in 1983, the set of asbestos regulations came into force.

Exposure to genetically modified organisms, pesticides, radiation, excessive noise and carbon monoxide – both at work and in the home – were all subject to jurisdiction. In 1992, the so called "six pack" regulation established the office-based health and safety with which we are familiar now. Employers were

charged with carrying out assessments, health surveillance and providing information protective measures to staff. Computer screens, space, lighting and seating arrangements were all subject to guidance.

In the wake of the six pack regulations, simplifying health and safety legislation has become a priority. In 1941 a major review of regulation recommended that 100 laws be removed. Since then, a variety of strategies have been launched purporting to make health and safety less bureaucratic, ranging from 2000's "Revitalizing Health and Safety to Lord Young's "common sense – common safety" last year. (Source: [http://www. Occupational safety and health](http://www.OccupationalSafetyandHealth.gov) dated 28th September 2014).

### **Occupational Health Legislation**

The first environmental cancer was described by Percival Pott over 200 years ago. This cancer – scrotal skin cancer – occurred in chimney sweeps, and was caused by exposure to polycyclic aromatic hydrocarbon compounds in soot. An early piece of English legislation was the Act for Better Regulations of chimney sweeps and their apprentices, 1788. This Act stipulated a minimum age of eight (8) years for Chimney sweeps; provided for inspections and hearing of complaints, required that the master not "misuse or evil treat" the apprentice and stated that the master "shall at least once in every week, cause the said apprentice to be thoroughly washed and cleansed from soot and dirt".

The Health and Morals of Apprentices Act, 1802 applied to apprentices in the cotton and woollen industry. It limited work to 12 hours a day, specified work factory walls to be washed and rooms to be ventilated, and allowed voluntary

factory inspections by visitors. The Factory Act, 1819 set nine years as a minimum age for the worker and limited work hours. Other work environments were covered by other legislations, such as the Mines Act, 1842, which prohibited females from working in Mines, and allowed for Government inspection.

Many countries today have comprehensive occupational health legislation, for example in the United States, the occupational safety and health Act was passed by congress in 1970. It's goal was to assure as far as possible every working man and woman in the Nation safe and healthful working conditions.” The health and safety at work Act, enacted in 1974 in the United Kingdom, provides a broad legislative framework for the protection of workers through specific regulation. The European Union (EU) adopted a policy in 1989 on the “fundamental social rights of workers” emphasizing the need for safety and health protection in the work place, improvements in living and working conditions and provisions of social protection for workers.

Another recent development of occupational health legislation aims to ensure that employers do not discriminate against applications and employees with disabilities. One example of this type of legislation is the Disability Discrimination Act, 1995 in the United Kingdom. Employers should also make reasonable accommodations for a known impairment, unless it would cause undue hardship such as incurring significant difficulty or expense.

### **Estimates of Cost and Economic Loss**

Total economic losses due to occupational injuries and illnesses are large. The International Labour Organization (ILO) estimated that overall economic

losses from work-related injuries and illnesses in 1997 were approximately four (4) percent of the world's Gross National Product (GNP). According to recent estimates, the cost of work related health loss and associated productivity loss may amount to several percent of total GNP of a country. For example, the Health and Safety Executive (HSE) has estimated the cost of occupational illness and injury to the British economy to be between £13.1 billion to £22.2 billion in 2001 - 2002 (HSE 2004)

In the United States, the direct cost of workplace injuries and illnesses was estimated to be US\$45.8 billion and the indirect cost ranging from US\$ 137.4 to US\$ 229 billion. In addition, employer cost for providing workers' compensation rose from US\$52.8 to US\$72.9 billion between 1998 and 2002 (NIOSH, 2005).

### **Under- Recognition of Occupational Ill Health**

Although recording of workplace injuries is reasonably accurate in most developed countries, surveillance systems generally result in substantial under-estimates of actual cases of occupational illnesses. One explanation for under-recognition of occupational disease is the inherent difficulty in diagnosing occupational diseases and in establishing cause and effect relationships. The link between occupation and disease are not distinct clinically and pathologically from disease associated with non occupational aetiologies. For example, skin cancer caused by polycyclic aromatic hydro carbons is similar in appearance to that caused by sunlight. (Selikoff et al, 1964).

Another course of under-recognition of occupational disease is that the majority of chemicals in commerce have never been evaluated with regard to their

potential toxicity. Only (7) Seven percent of approximately 8000 chemicals commonly used in industry have been studied thoroughly (La Dou, 2007). Such toxicity testing often concentrates primarily on high dose, acute effects, and on the long term risk of cancer.

The long latency which typically elapses between occupational exposure and onset of illness is a third factor which may obscure the occupational aetiology of chronic disease. For example, few occupational cancers appear within 10 or even 20 years of first exposure. Similarly, chronic neurotoxic effects of solvents may become evident only after decades of exposure. In such instances, it is unlikely that the worker will be diagnosed as having diseases of occupational origin.

Lack of awareness among health practitioners about the hazards found at work is a fourth cause of underestimation of occupational disease, reflecting the fact that most physicians are not adequately trained to suspect work as a cause of disease (Institute of Medicine 1988, Barry M. Goldman, Barbara A. Gutek, Jordan H. Stein and Kyle Lewis, 1999). Very little time is devoted in most medical schools to teaching physicians to take a proper occupational history to recognize symptoms of common Industrial toxins, or to recall known associations between occupational exposures and disease.

Compounding this lack of medical awareness is the limited ability of many workers to provide an accurate report of their exposures. Workers may have had multiple toxic exposures in a variety of jobs over a working lifetime. In most countries, there are no requirements to inform workers of the hazards of the

materials with which they work. In many instances, a patient may not know about all his or her post occupational exposures.

Finally, given the potential financial liability associated with the finding that a disease is of occupational origin, employers may be resistant to recognizing the work - relatedness of a disorder, especially in cases where personal habits or non occupational pursuits are possible contributory factors. Since employers are often in the best position to recognize causal association between workplace exposures and disease, this conflict of interest represent an obstacle to obtaining accurate estimates of the burden of occupational illness.

### **Managing the risk of Work**

Prevention of occupational disease can take place at various levels such as at the National level or at the level of the workplace itself. The aim is to reduce the occurrence of occupational disease by eliminating the cause or by controlling exposure to safe level in order to prevent damage to the health of workers. Customarily, several levels of prevention are recognized.

Primary prevention aims to reduce the occurrence of disease by eliminating the cause of disease or reducing exposure to safe levels that prevent it from causing damage, for example, banning the use of asbestos or reduction of noise at its source to levels that do not cause noise- induced deafness. Primary prevention with regards to chemical requires either elimination of toxic materials and their replacement by less hazardous substitutes or Use of tight processes and controls, such as complete enclosure or ventilating the source of aerosol generation.

Secondary prevention aims to detect situations of early effects of disease before they manifest as clinical symptoms and signs in order to take corrective action for example, regular monitoring of blood lead (BPb) levels among exposed workers or regular audiograms among noise – exposed workers. Successful secondary prevention depends on the ability to identify work related illness efficiently and effectively through screening workers at high risk for occupational disease.

Tertiary prevention aims to minimize the consequences in persons who already have disease. This activity is largely a curative and rehabilitative procedure and depends on proper and appropriate treatment. Tertiary prevention depends on the development and wide application of appropriate diagnostic techniques for identification of persons with already established occupational illness.

Prevention on all three levels require information on the potential effects of specific occupational exposures, as well as data on the industries, occupations, and geographical areas in which hazardous substances are used. The hierarchy of strategies for preventing occupational disease is as follows:

**A. Primary Prevention Include**

Elimination of the hazard

Substitution with a safer alternative

Engineering controls

Redesign of the work station or process



Administrative controls

Education of workers

Improved and safer work practice

Use of personal protective equipment

Personal hygiene

Pre-employment or Pre-placement examinations

### **Secondary Prevention Include**

Periodic health monitoring

Detection of evidence of excessive exposure

Biological tests of early effect

### **Tertiary Prevention Include**

Planning for emergency response

Rehabilitation and return to work

Workers compensation

### **Infection Prevention and Control**

**Infection:** it is an invasion of body tissue by micro-organisms and their proliferation there. Nurses are directly involved in providing a biologically safe environment and promoting health.

Micro-organisms are found everywhere in the environment: in water, soil and on body surfaces such as the skin, intestinal tract, and other areas open to the outside like mouth, upper respiratory tract, vagina, and lower urinary tract.

Most micro-organisms are harmless, and some are even beneficial to the body.

## **Division of Micro-Organisms**

**Pathogenic:** Disease causing micro-Organism

**Non Pathogenic** (Normal Flora) example, escherichia coli in the large intestine

**Opportunistic Pathogens:** They cause disease in only susceptible individuals.

## **Types of Micro- Organisms Include**

Types of Micro-Organisms include Bacteria, Viruses, Fungi, protozoa and Rickettsia.

## **Components of Infection Prevention and Control**

The components of Infection Prevention and Control include the use of Protective Clothing, Hand Wash, Proper use and disposable of sharps, instrument processing, decontamination, cleaning, sterilization or high level disinfection, storage and house - keeping and waste disposal.

## **Hand Washing**

This is important in every health care setting. It is considered one of the most effective infection control measures. Any client may harbour micro-organisms that are harmless to the client, but harmful to another client or the care giver. It is therefore necessary that the staff wash their hands frequently and when necessary. Hands should be held down when they are soiled with body substances and held up after hand washing and before cleaning with clean towel.

## **Purpose of Hand Washing**

- To reduce the number of micro-organisms on the hands.

- To reduce the risk of transmission of micro-organisms.
- To reduce the risk of cross - contamination among clients.
- To reduce the risk of transmission of infectious organisms to one self

### **Requirements for Hand Washing**

Requirements for hand washing are soap in soap dish, Towel, Water, Sink or bowl, veronica bucket, hand brush, two small buckets with lids for cleaning and dirty towels and cup.

### **Steps in Hand Washing**

The steps in Hand Washing Processing are Preparation and assessing of the hands through the following:

- Cutting fingernails short
- Checking hands for break in the skin
- Turn on the water and adjust the flow
- Use elbow to open the tap and adjust the flow
- Wet the hands thoroughly by holding them under the running water.
- Apply the soap to the hands and allow it to lather
- Hold the hands lower than the elbow

Thoroughly wash hands through using firm, rubbing, and circular movements, Washing the palm in between fingers, fingernails, thumbs and back of the hand. Moving the hands back and forth, wash the hands for ten (10) seconds, wash hands up to the elbow, Rinse the hands, thoroughly rinse the hands through lifting the hands and allow the water to drain from the elbow, drying the hands

with dryer or clean towel. Drying the hands in a rotating motion from the fingers to elbow, using a different towel to clean each hand and arm, discarding the towel.

### **When to Wash Hands**

After touching blood, body fluids, secretions, excretions and contaminated items, before and after wearing gloves, before and after every procedure, after cleaning, dusting and mopping, after handling waste, after serving bedpan, when you arrived at work, before leaving the ward, after touching anything that might be contaminated, after handling specimens, after using the toilet.

### **Types of Hand Washing**

In health care there are three types of hand washes and are referred to as: Social Hand Wash, Clinical Hand Wash and Surgical Hand Wash. The basic principle of hand washing is to remove transient micro-organisms from the skin. This is achieved by using soap, water and a vigorous rubbing action. Transient micro-organisms can be picked up through contact with people, objects, and the environment and may be transferred to others.

### **Social Hand Wash**

A social hand wash is a hand washing technique recommended following social type contact with clients, after a cough or sneeze. A plain liquid soap is often used. Below are steps in social hand washing;

- Using warm water wet your hands thoroughly including palms and back of the hands.

- Dispense soap into the palm of your hand. Lather the hands with soap. Vigorously rub your hands together cleaning palms, fingers, and between fingers and the back of your hands, thumbs and wrists for at least 15 seconds .
- Thoroughly rinse off the soap.
- Turn off the taps using the elbow, or electronic controls. If the tap has only a normal tap handle and paper towels are available use paper towel to turn the taps off.
- Pat dry your hands with a disposable paper towel or a clean cloth towel.
- In areas where there is a cloth roll towel, make sure you are using a clean section of the towel.
- Make sure your hands are dried well to prevent chafing.
- If using disposable paper towel, place the used paper towel in the appropriate waste bin.

### **Clinical Hand Wash**

A clinical hand wash is used before clinical procedures on clients, when a client is being managed in isolation, or in outbreak situations. Anti-microbial soap, containing an antiseptic agent is used. Staff that have to perform clinical hand washes are usually shown the procedure and assessed during training, orientation or in-service steps.

- Remove rings, watches and wrist jewellery;
- Using warm water wet your hands thoroughly, including palms and backs of the hands;
- Dispense anti-microbial soap into the palm of your hand.
- Lather the hands with soap.
- Vigorously rub your hands together cleaning palms, fingers, between fingers, the back of your hands, thumbs and wrists for at least 15 Seconds.
- Rinse the soap off thoroughly
- Keep the hands in a raised position higher than the elbows and let the excess water drip off your hands and arms.
- Turn off the taps using the elbow, foot or electronic controls. If the tap has only a normal tap handle use a paper towel to turn the taps off.
- Pat dry your hands with a disposable paper towel.
- Cloth roll towels should not be used for a clinical hand wash.  
  
Make sure your hands are dried well to prevent chafing.
- Place the used paper towel in the appropriate general waste bin.

### **Surgical Hand Wash**

A surgical hand wash is required before any invasive or surgical procedure requiring the use of sterile gloves. An antimicrobial skin cleanser, usually

containing chlorhexidine or detergent- based povidone -iodine is used. Staff need to be trained and assessed in surgical hand washing technique.

### **Universal Precaution of Infection Prevention**

Wear mask and protective eye wear in situations such as wound irrigation where droplets of blood or other body fluids are likely to spray on your face.

Wear gloves when in contact with blood or other body fluids. Change gloves after each client or contact. Wear gowns in situations where it is likely that droplet of blood or body fluids will be sprayed. Wash your hands before and after every procedure. Dispose off all sharp objects into punctured resistant container that has a secured lid. Do not recap, break or bend needles after use. Do not provide care for clients when you have open wounds.

### **Training and Development for Health Employees**

Training for health professionals is a process whereby employees acquire capabilities to aid in the achievement of the services purposes. Training can be viewed either normally or broadly. In a limited sense, training provides employees with scientific, identifiable knowledge and skills for use in their present jobs. Sometimes a distinction is drawn between training and development with development being broader in scope, and focusing on individuals gaining new capabilities useful for both present and future jobs.

## **The Role of Training and Development for Health Employees**

Training and development play important roles in the effectiveness of organisations and to the experiences of people in work. Training has implications for productivity, health and safety at work and personal development.

All organisations employing people need to train and develop their staff. Most organisations are cognisant of this requirement and invest effort and other resources in training and development. Such investment can take the form of employing specialist training and development staff and paying salaries to staff undergoing training and development. Investment in training and development entails obtaining and maintaining space and equipment. It also means that operational personnel, employed in the organisations main business functions such as production, maintenance, sales marketing and management support must also direct their attention and effort from time to time towards supporting training development and delivery. This means they are required to give less attention to activities that are obviously more productive in terms of the organisations main business. However, investment in training and development is generally regarded as good management practice to maintain appropriate expertise now and in the future.

## **The Relevance of Occupational Psychology to Training and Development**

Contributing to training has long been one of the main concerns of occupational psychology- this is not surprising given that training involves learning and that learning is a central issue in psychology. Training is one of the core skills of occupational psychology. People with qualifications in and



experience of occupational psychology have been employed in different capacities in training and development roles in government organisation, private companies and consultancy groups.

The discipline offers many benefits and perspectives to help resolve training issues and problems and has also been at the root of many methods and techniques that have now become. “Part of the routine practices within human resource management. Training specialist must be alert to the wider issues regarding the problems presented to them and need the skills and confidence to deal with them. They must understand how training fits into the wider organisational context”. Ruth Mayhew StudioD, (1985). An occupational psychology perspective is extremely beneficial in helping the practitioner to understand how training relates to other interventions aimed at improving job performance.

### **Opportunities of Employment in Training and Development**

Governments have traditionally played a significant role in the promotion and development of occupational psychology with regard to training, because of their responsibilities for employment, military, health and other services. People with an occupational psychology background have been employed directly by governments in areas such as job training, military training and health and safety. Government agencies have also been a major sponsor of training research and development; such investment has often provided the major underpinning of developments in this area.

Governments can also affect the impetus for change in organisations through legislation, taxation, and the general health of the economy, which in turn can create more disposable income to create new demands for products and services, affect the supply of raw materials and services, or put such pressure on consumers that markets are adversely affected. Also, government initiatives can affect health and safety requirements, fiscal issues, competition laws, and ecological concerns, working with new technology and employment practices. Such changes prompt new ways of organising and delivering these products and services, creating new training needs.

The other major source of employment and funding in training and development, where occupational psychology plays a specialist role, is private companies. Specialists might be employed directly within an organisation's training and development functions or in consultancy offering services to clients. Organisations often employ their own specialist training and development staff who have been recruited from the organisation's own ranks. Organisations often prefer this approach because they feel it is more appropriate for their training staff to have operational and business experience than for them to be experts in training or occupational psychology. It is often assumed that training is simply a matter of following well-established procedures and principles. This is an ill-informed view because often training cannot always proceed simply by application of standard methods. It is often necessary to understand variations that have not been responsive to the standard procedures. This entails understanding how people learn and how training can support this learning.

Training and development staff are generally responsible for maintaining company training and development systems, to judge training needs and to organise the delivery of training and development. Practitioners with an occupational psychology background may be encountered in departments concerned with organisational development where they are engaged with the processes of organisational change of which training and development is a part. It is impossible to be more specific than this. Opportunities for occupational psychology specialists to become engaged in training arise in different contexts and circumstances. It is important to remain alert to where these opportunities might occur and be adaptive and constructive in responding to opportunities.

### **Research into the Psychology of Training and Development**

There is substantial literature concerned with the psychology of training and development, much of which has emerged from past government and military funding initiatives. Some has been funded from the commercial sector. Applied training and development research is less likely to have been funded by research councils, who tend to focus instead on pure rather than applied science.

Research into training generally requires substantial funding and opportunity for access to real situations. Without funding or access, it is difficult for applied psychologists to contribute effectively to this area or for their findings to be accepted as credible. In university research it is possible to set up and run basic laboratory or small-scale studies in human learning and social interaction with minimal resources as a basis for publication and for theory development, but these do not match the complexity that needs to be addressed to resolve practical

training issues in a rigorous way. Some comparatively inexpensive laboratory studies in areas of training and instruction have been important in clarifying issues and demonstrating the potential benefits of applying different principles to training. But laboratory studies are limited in this field because research findings may be confined to the laboratory context and not deal effectively with practical issues when the complexities of the real situation are encountered.

This means that there is no wholly reliable body of research to enable training decisions to be made with complete confidence. This may sound like a weakness, but it is a reflection of the fact that new operational contexts can change the applicability of research findings that were obtained in a different operational context. It also makes for more interesting work, because problems generally have to be investigated, solved and then outcomes tested, rather than simply following a simple recipe.

Knowledge of occupational psychology can contribute towards helping solve practical problems of training in an effective way.

## CHAPTER THREE

### METHODOLOGY

#### Introduction

A research method is a set of systematic procedures (plan) for conducting a study so as to get the most valid finding, (Kanna, 2004). Investigations or studies into the topic are aimed at “finding out” and the researcher needs to spell out the strategies or procedures to follow in order to properly carry out such investigation. These strategies or procedures may be termed research methods.

Basically, this chapter describes the methods and techniques that were adopted for data collection and analysis for this study and it includes; background of the study area, research design, sampling procedure, data collection methods, pretesting, field work/data management, field problems and ethical considerations. It is significant to note that a good research method produces the relevant data which in turn yields the expected results or findings. The research objectives will be addressed through empirical assessments that involve numerical measurements and analysis.

#### Background of the Study Area

The study was conducted in Kintampo - North Municipal Hospital of the Brong Ahafo Region of Ghana. The hospital is located near the geographical centre of Ghana (Kintampo old Police Station) and shares boundaries with the Kintampo Health Research Centre (KHRC), Kintampo Municipal Health

Directorate (KMHD) and the Kintampo Rural Health Training School (KRHTS), now College of Health and Well-Being.

This facility first started as a clinic somewhere around the 1940s. It later became a health centre probably as part of measures to meet the preventive and curative policies of the health service structure in Ghana. In 1994, the facility metamorphosed to attain the status of a District Hospital. In 2008, the hospital was further uplifted to attain the status of a Municipal Hospital. The hospital records a daily out-patients attendance of about 200 - 300, with an occasional rise hitting 400. It, however, has seven (7) sub-districts and about sixteen (16) community health planning and services (CHPS) zones to its credit. As a mother hospital and located at a very strategic point, that is to say, the centre of Ghana, the hospital serves as a referral point for the aforementioned sub-districts, CHPS zones and passengers who ply the Tamale -Kumasi trunk road. Kintampo- North Municipal Hospital also serves as a teaching institution for students of the College of Health and Well-Being.. Interestingly, the hospital partners the Kintampo Health Research Centre (KHRC) in the recruitment of participants for clinical trials. The hospital was given the mandate to run the National Health Insurance Scheme (NHIS) in 2003 as a way of relieving its numerous clients of the burden created by the then system, “out-of-pocket expenditure” (cash and carry) for healthcare services.

The management of the hospital comprises the medical superintendent (MS), deputy director of nursing service (DDNS), administrator, the pharmacist, an accountant and heads of the various units. The hospital offers a 24hour services

in paediatric, medical-surgical, maternity and a well dynamic and vibrant emergency services. The hospital also provides a functional 24hour records, pharmacy, x-ray and laboratory services.

Kintampo- North Municipal Hospital has a total bed capacity of 85 and staff strength of 196. The composition comprises six (6) medical doctors, one resident who is also the medical superintendent and one on further studies and the rest of the four (4) from the Kintampo Health Research Centre. The hospital has five (5) medical assistants, Three (3) pharmacists (1 on internship), seven-five (75) nurses of all category (15 rotational), and one Hundred and Fifteen (115) paramedics.

### **Profile of study area**

Kintampo - North Municipality is one of the twenty seven (27) districts in the Brong - Ahafo Region of Ghana. The district was created in 1988 by Legislative Instrument 1480 sequel to the Government's decentralization programme with Kintampo as its capital. Kintampo - North Municipality (KNM) is located between Latitudes 8°45'N and 7°45'N and Longitudes 1°20'W and 2°1'E and shares boundaries with five districts in the Country namely; Central Gonja district to the North; Bole district to the West; East Gonja district to the North-East (all in the Northern Region). Kintampo - South district to the south; and Pru district to the South- East (all in the Brong-Ahafo Region). The Municipal Capital, Kintampo, is about 130Km away by road from the Regional Capital, Sunyani, and lies East of the Brong-Ahafo Regional (BAR) Capital, Sunyani.

Kintampo North Municipality has a surface area of about 5,108km<sup>2</sup>, thus occupying a land area of about 12.9% of the total land area of BAR (39,557km<sup>2</sup>).

Due to its strategic location, centre of Ghana, it is easily identified as the “Centre of Ghana Hospital” and serves as a transit point between the northern and southern sectors of the country <http://kintamponorth.ghanadistricts.gov.gh/>. (01/09/14).

According to the Ghana Statistical Service (GSS), the 2010 Population and Housing Census (GSS, 2010), recorded for the Municipality a total population of 95,480 inhabitants, of which 47,302 (49.5%) are males and 48,178 (50.5%) are females. With an intercensal growth rate of 2.3%, Brong -Ahafo Region has a population density figure of 58 persons per square kilometre (km<sup>2</sup>) as against a national figure of 103 (GSS, 2010 PHC Report). Also as an agrarian society, majority of the inhabitants (70%) are engaged in farming while the women mostly engaged in trading activities.

Kintampo - North Municipality is blessed with health facilities; a government hospital, which serves a dual purpose for the main inhabitants and referrals from its six (6) other sub-districts and their catchment areas. As the only government hospital and located along a major transit, linking the northern and southern sectors of the country together, the hospital’s human and material resources become overburdened during sudden periods of mass casualty (Road Traffic Accidents, RTA,). Other facilities include; One (1) private health insurance accredited hospital, two (2) accredited private clinics, a private maternity clinic,



sixteen (16) CHPS compounds, four (4) health centres and a newly operating Non-Governmental Organizations (NGOs) hospital. Interestingly, the Municipality also has the following health related facilities worth reporting on; the Municipal Health Insurance Scheme, Kintampo Health Research Centre, and the College of Health and Well-Being where middle -level health professionals of all categories are trained.

### **Research design**

Once objectives are established in research, the issue of how these objectives can be met lead to a consideration of which research design will be most appropriate. A research design according to William “provides a frame work for the collection and analysis of data and subsequently indicates which research methods are appropriate” (William, 2006).

This study was quantitative in approach and explanatory in content. Quantitative methods emphasis objective measurements and numerical analysis of data collected through polls, questionnaires or surveys. Quantitative research focuses on gathering numerical data and generalizing it across groups of people (Babbie, Earl R. *The Practice of Social Research*, 12th ed. Belmont CA; Wadsworth Cengage, 2010)

It is aimed at finding out the relationship between organizational health and safety and employees performance. The over arching aim of the use of quantitative research study was to classify features, count them, and construct statistical models in an attempt to explain what is observed.

Research design is very important in any study for various reasons. According to Johnson, et al (2001), it is a plan that guides the investigator in the process of collecting, analyzing and interpreting observations. It is a model of proof that allows the researcher to draw inferences concerning causal relations among the variable under investigation. Furthermore, the research design also defines the domain of generalize ability, that is, whether the obtained interpretations can be generalized to a larger population or to different situation.

### **Population**

Fraenkel & Wallen (1993) point out that, “Population is the group of interest to the research, the group to whom the researcher would like to generalize the results of the study” Jankowicz (1995) points out that in order to draw a sample; you have to know how many people are in the Population, and how this total is made up from people falling into various subgroups in which you might be interested.

The population of this study is made up of the entire nurses of all categories who number seventy- five (75). They run three shifts, morning, afternoon and night.

Although hospitals exist in all Districts, Municipalities and Metropolis through out Ghana, time constrain, cost and the large structure of hospitals are some of the reasons why all hospitals will not be covered, Kintampo – north hospital has been chosen because of the relatively large presence of health workers and the inability of management to report on occupational health and safety up till

June 2015 on the District Health Information Management Systems (DHIMS). Accessibility of Staff unlike other Districts, Municipalities and Metropolitan hospitals is not a challenge.

### **Sample size and sampling procedure**

Fraenkel & Wallen (1993) refer to a “sample” in a research study as any group from which information is obtained. Jankowicz (1995) defines sampling as the deliberate choice of a number of people; the sample provides data from which to draw conclusions about some larger group, the population, whom these people represent. Therefore not all the members of the study population were surveyed. Also, it is considered economically feasible to use part of the population. This enabled the research to be conducted within the limited time frame. In light of this, the researcher used seventy- five (75) subjects of the population.

Twumasi, (2001) mentions two types of sampling techniques used in various research studies. These are probability and non-probability sampling. He points out that in probability sampling, each and every unit within the population is given equal chance of being selected. In the selection of the sample size, a staff list of all nurses was obtained and the questionnaire served on them. Simple random sampling technique was used and all nurses had equal chances of selection. The sample was drawn from the nominal roll of the nurses.

### **Data collection procedure**

Twumasi, (2001) mentions that the selection of a particular method to collect data must be decided upon in the light of one’s problems. He further states

that in making this decision, the researcher must keep in mind the type of People he or she is dealing with, the nature of the social situation, the mood of the social environment and the psychology of the people. The study therefore applied quantitative methods to measure the fundamental connection between empirical observation and mathematical expression of quantitative relationships. Specific narrow questions were asked and the data collected analyzed with the help of statistics.

The data for the study was thus collected using questionnaires. The questionnaire consisted of mainly structured or close - ended questions were used to collect the primary data for the study. Close - ended questions are known to provide control over the participant's range of responses by providing specific response alternatives (Borden and Abbott; 2002). This makes it easier to summarize and analyze the responses.

The questionnaire for the staff had four (4) sections. Section A was on the socio demographic characteristics of the staff and also solicited information on the age, sex, educational level and department, rank and length of service of the staff. Section B of the questionnaire covered questions on availability of resources. Section C had questions on and employee performance skills. The last Section, Section D, dealt with Challenges of occupational health and safety. Questionnaire was mainly structured or close – ended questions with few open - ended questions.

The reasons for using the questionnaire method as an instrument of data collection was based on the fact that it provides a wider coverage of the sample

and also facilitates the collection of a large amount of data (Fraenkel and Wallen, 1993). Questionnaire method was appropriate in this study because all staff were literates.

First, the researcher collected introductory letter from department of management studies of the University of Cape Coast. This helped crave indulgence of the hospital and the staff for the data collection. In effect the consent of the hospital and staff were sought before the data collection.

The researcher personally gave out the questionnaires to the targeted staff to fill. The researcher personally collected all completed questionnaires from the staff at the point where the questionnaires were administered to them. Questionnaires were filled and the researcher ensured that the respondents answered all relevant questions. For staff who were not able to fill out their questionnaires on the first visit of the researcher, one week was usually allowed for them to do so for collection at a later date.

### **Data processing and analysis**

Microsoft Visual Foxpro version 9, data management software, was used to enter and check for inconsistencies in the data. STATA version 12, a statistical package, was used to clean and analyse the data. The questionnaires were analysed using descriptive statistics. Proportions were used to summarise variables that were categorical in nature. The dependent variable (presence of employees' health and safety policy in organisations) in this study was binary in nature, therefore, the logistic regression was used to determine the relationship between the dependent

variable and other explanatory variables in this study. All variables that were identified to be statistically significant were adjusted for in the multivariate regression to determine the effect of several explanatory variables on the dependent variable. All variables with p-value less than 0.05 were considered as statistically significant.

## CHAPTER FOUR

### RESULTS AND DISCUSSIONS

#### Introduction

This chapter presents analysis of the data gathered from the study of effects of organisational Health and safety policies on employee performance: a Study of Kintampo - North Municipal Hospital. Meanings and interpretations inferred from the results were presented in tabula form. These results were generated through frequency distribution and percentage. The chapter starts with the analysis of socio demographic characteristics of the respondents to reveal the background factors influencing the respondents understanding of the subject matter of the study. Following the analysis of respondents' socio- demographic characteristics was the analysis of respondents' opinion about the health and safety issues.

#### Socio- demographic characteristics of respondents

Out of a total of seventy five (75) nurses selected for the study, seventy two (72) were accessible while three (3) did not respond to the questionnaire. The response rate was 96% which is a fair representation of the population of study.

Majority of the nurses interviewed 58.3% were females whilst 41.7% were males. Over half 55.6% of those interviewed were aged between 30 to 39 years followed by 22.2% of them aged between 20-29 years. Most of the nurses (50.0%) were not married whilst 36.1% were married. More than half 51.4% of the nurses had Diploma as the highest educational level attained followed by 33.3% with Degrees. Most of the respondents (73.6%) had worked with the Kintampo

Municipal Hospital between 1 to 10 years whilst 20.8% had worked less than a year (Table 1).

**Table1: Demographic Analysis**

<b>Gender (N=72)</b>	<b>Number</b>	<b>Percentage</b>
Male	30	41.7
Female	42	58.3
<b>Age</b>		
< 20years	1	1.4
20-29years	16	22.2
30-39years	40	55.6
40-49years	9	12.5
>50years	6	8.3
<b>Marital status</b>		
Married	26	36.1
Divorced	5	6.9
Widowed	3	4.2
Never married	36	50.0
Separated	2	2.8
<b>Highest level of Education</b>		
SSS	1	1.4
Certificate	10	13.9
Diploma	37	51.4
Degree	24	33.3
<b>Number of years worked</b>		
<1year	15	20.8
1-10years	53	73.6
>11years	4	5.6

Greater percentages 19.4% of the respondents were staff nurses, followed by 18.1% enrolled nurses (figure 1). Majority of respondents interviewed 19.4% were from outpatient department followed by 16.7% of them from the emergency unit and 12.5% of them in the children's ward (figure 2).



### **Availability of Resources**

Most of the respondents 55.6% mentioned that all welfare facilities were reasonably accessible to them on site. Majority of them 72.2% had fire extinguishers available to them at their workplace, whilst 79.2% had first Aid facilities available to them as well. More than half 65.3% of the respondents also had adequate number of toilets, veronica buckets, cleaners and towels they can use at their workplace and that they were being well maintained. Majority 86.1% mentioned that management organised periodic health and safety talk sessions for them, whilst 76.4% of them have attended seminars on health and safety issues. More than half of respondents 65.3% had positive views on management relation in situations of fatal accident of an employee, whilst less than half 37.5% of them had a positive view on management relation in fatal accident compensation situation. Similarly, less than half 29.2% of the respondents had a positive view on how accident victims were compensated (Table 3).

**Table 2: Frequency Distribution of Responses of Availability of Resources**

<b>Whether welfare facilities are reasonably accessible to you on site (N=72)</b>	<b>Number</b>	<b>Percentage</b>
Yes	40	55.6
No	32	44.4
<b>Whether fire extinguisher is available to you on site</b>		
Yes	52	72.2
No	20	27.8
<b>Whether first aid facilities are available</b>		
Yes	57	79.2
No	15	20.8
<b>Whether there are adequate number of toilets etc</b>		
Yes	47	65.3
No	25	34.7
<b>Management organising periodic health and safety discussion</b>		
Yes	62	86.1
No	10	13.9
<b>Attended &amp; seminar on health and safety issue</b>		
Yes	55	76.4
No	17	23.6
<b>View on management relation in situation of fatal accident of an employee</b>		
Positive	47	65.3
Negative	7	9.7
Neutral	18	25.0
<b>View on management relation in fatal</b>		

accident compensation situation		
Positive	27	37.5
Negative	15	20.8
Neutral	30	41.7
How accident victims are compensated		
Positive	21	29.2
Negative	16	22.2
Neutral	35	48.6

How accident victims are compensated

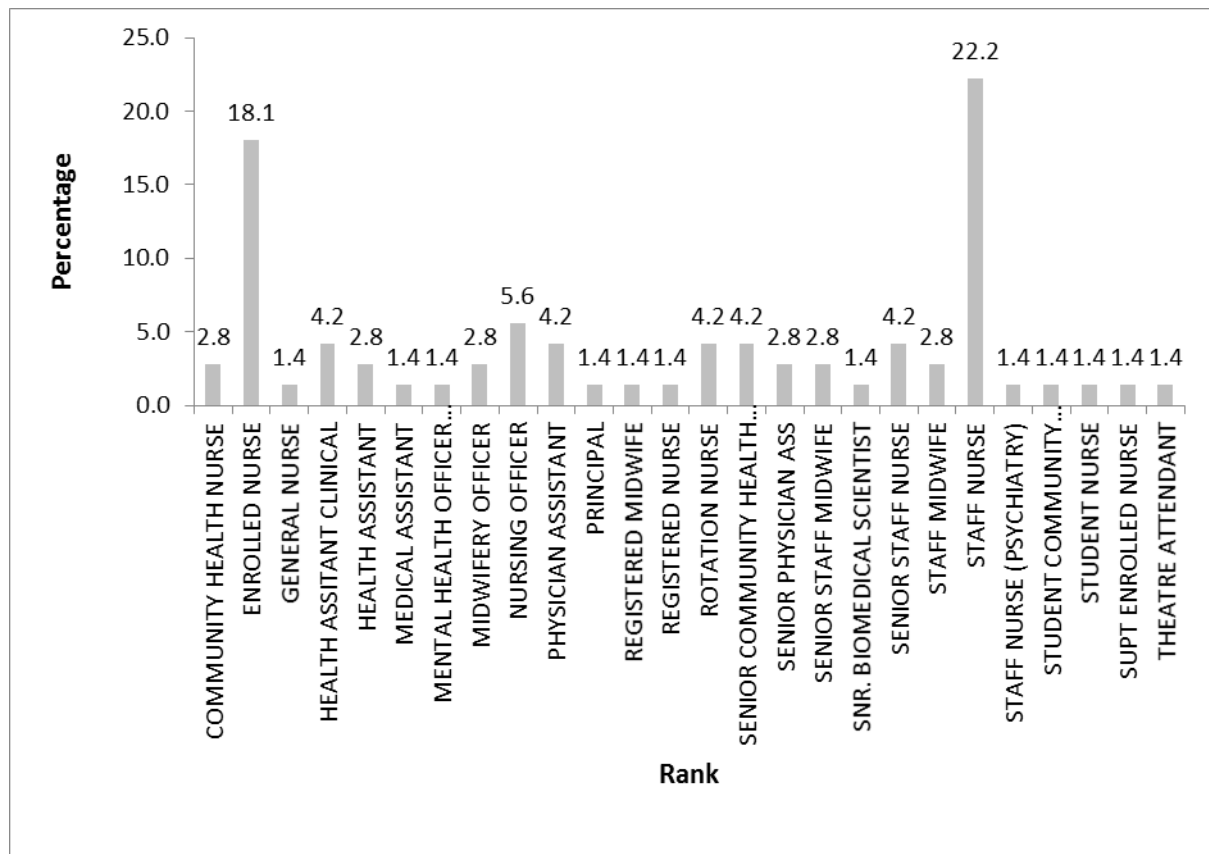


Figure 1: Rank of staff interviewed at the Kintampo Municipal hospital

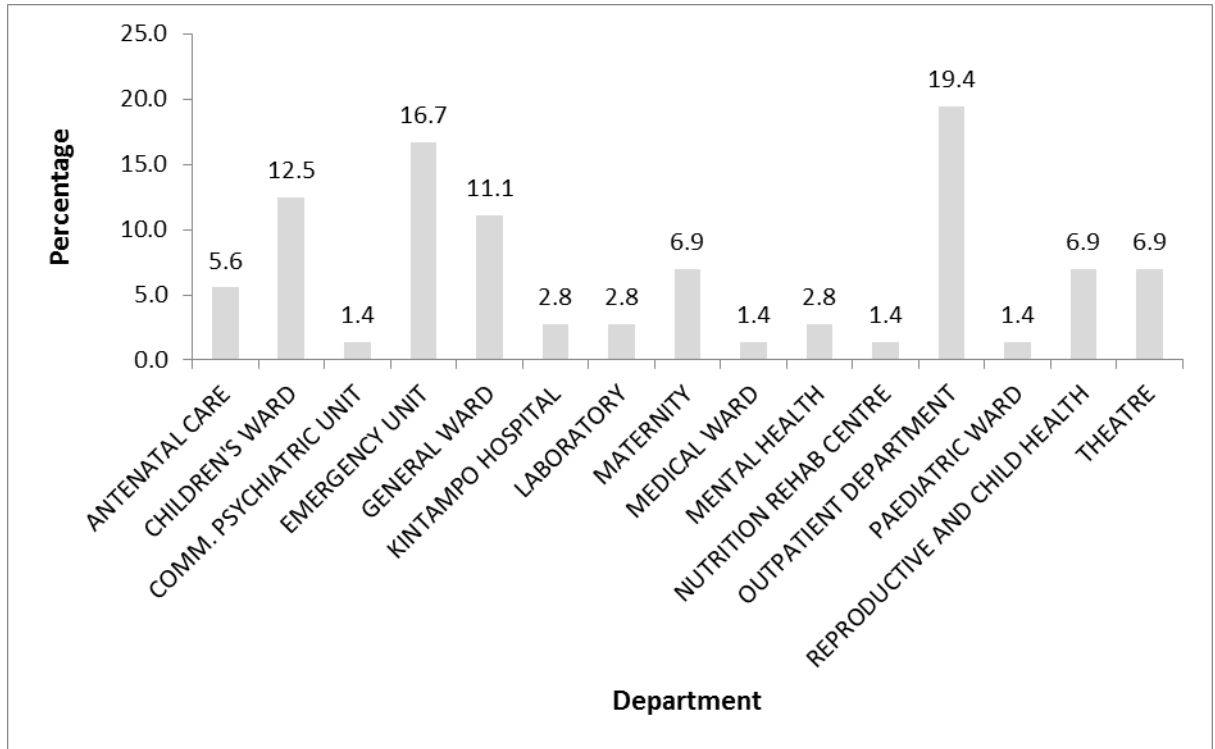


Figure 2: Departments staff belong to

### Employee Performance Skills

All 100% of the respondents (100%) agreed that safety and good health enhance their performance. Less than half of them (22.2%) have ever been involved in an accident before even though it was not job related whilst ,77.8% have never been involved in an accident. More than a quarter (29.2%) of the respondents mentioned that they have ever been involved in a non-job related accident that has influenced their work output. Some of the respondents (48.6%) mentioned that they have ever seen a health problem that has lowered the contribution of a co-worker, whilst 51.4% said no. Majority of the respondents (71.8% ) have never encountered any situation that made them pull back at work because of the risk involved in a task, whilst 28.2% of them have ever done so.

About 70.8% said that safety policy is a strong factor capable of motivating them while 29.2% think otherwise. Majority of the respondents ( 95.8%) rate themselves and co- workers as productive workers. About 98.6% of the respondents think that there are other things that could be done to boost their performance even though they did not name them. More than half 68.1% respondents said that they usually are able to meet daily target. About 31.9% think they are not able to meet daily targets. More than half (60.6%) of the respondents indicated that their group very often perform above the set target by the management. Less than half (35.2%) of the respondents said their group seldom perform above the set target by management while 4.2% confirmed that their group have never performed above the set target by the management.

**Table 3: Frequency Distribution of Responses of Respondents on Employee Performance Skills**

<b>Does safety and good health enhance your performance</b>	<b>Number</b>	<b>Percentage</b>
Yes	72	100.0
Total	72	100.0
<b>Whether you have been involved in any accident before</b>		
Yes	16	22.2
No	56	77.8
Total	72	100.0
<b>Type of Accident</b>		
Car Accident	5	29.4
Motor Accident	8	47.1

**Table 3 continued**

NA	2	11.8
Road Traffic Accident	1	5.9
Tramatic fracture from football	1	5.9
Total	17	100.0
<b>Has the accident influence your workout-put</b>		
Yes	21	29.2
No	46	63.9
Neutral	5	6.9
Total	72	100.0
<b>Scene where health problem lowered contribution of co-worker at work</b>		
Yes	35	48.6
No	37	51.4
Total	72	100.0
<b>Have there been time you have pulled back at work</b>		
Yes	20	28.2
No	51	71.8
Total	71	100.0
<b>Whether safety policy is a strong factor capable of motivating you</b>		
Yes	51	70.8
No	21	29.2
Total	72	100.0
<b>Will you rate yourself and co-workers as being productive</b>		
Yes	68	95.8
No	3	4.2

**Table 3 continued**

Total	71	100.0
<b>Is there any other thing that could be done to boost your performance</b>		
Yes	71	98.6
No	1	1.4
Total	72	100.0
<b>Whether daily targets are usually achievable</b>		
Yes	49	68.1
No	23	31.9
Total	72	100.0
<b>How often does your group perform above the set target by the management</b>		
Very often	43	60.6
Seldom	25	35.2
Never	3	4.2
Total	71	100.0

### **Challenges of Occupational Health and Safety**

Majority of the respondents (78.9%) said there are noticeable problems facing employees' health and safety as against 22.2% who think there is none. Majority of the respondents (81.9% ) think that government is not performing up to their health and safety services while 18.1% respondents think that government is doing well with regards to their health and safety services needs. About 41.7% of the respondents have little stress challenges relating to their health and safety services at work while 23.6% of the respondents feel slight challenges of their health and safety services at work. About 22.2% of the respondents have serious

health problems while 12.5% of the respondents do not have challenges relating to their health and safety services at work. Majority 80.5% find it easy to abide by health and safety policies. About 15.3% of the respondents find it very easy to abide by health and safety policies while 4.17% of the respondents find it hard to abide by the health and safety policies of the organisation.

**Table 4: Frequency Distribution of Responses of Respondents on Challenges of Occupational Health and Safety**

<b>Are there any noticeable problems facing employees Health and safety. (N=72)</b>	<b>Number</b>	<b>Percentage</b>
Yes	56	78.9
No	16	22.2
<b>Whether government is performing up to your health and safety services</b>		
Yes	13	18.1
No	59	81.9
<b>Challenges relocating to your Health and safety services at work</b>		
None	9	12.5
Little(stress related)	30	41.7
Slightly	17	23.6
Serious Health Problems	16	22.2
<b>Whether health and safety policies are difficult to abide by</b>		
Easy	58	80.5
Very easy	11	15.3
Hard	3	4.17



## **Relationship between Employees' Health and Safety and their Level of Performance**

Results from univariate logistic regression identified employees' health and safety as associated with the availability of resources such as access to welfare facilities  $uOR=0.16$  [95% CI:0.03, 0.81  $P=0.027$ ]. Similarly, the presence of employees' health and safety policy was found to be associated with availability of first aid facilities at the workplace  $uOR =0.19$  [95% CI:0.05, 0.79  $P=0.022$ ]. The presence of employees' health and safety policy was associated with attendance of seminars on health and safety issues  $uOR=0.14$  [95% CI:0.03, 0.60,  $P=0.008$ ]. However, employees' health and safety was not associated with employee performance skills (Table 4.3.3). After adjusting for statistical significant explanatory variables from the univariate regression analysis, presence of employees' health and safety policy was found to be associated with attendance of seminars on health and safety issues and organisations not attending seminars on health and safety issues were about 5 times less likely to have health and safety policy for staff  $aOR=0.21$  [95% CI: 0.05, 0.93  $P=0.040$ ].

**Table 5: Relationship between Employees' Health and Safety and their Level of Performance**

characteristics	Univariate logistic regression				Multivariate regression		logistic
	n (%)	uOR	95% CI	P-value	aOR	95% CI	P-value
Access to welfare facilities							
Yes	38 (95.0)	1			1		
No	24 (75.0)	0.16	(0.03, 0.81)	0.027	0.23	(0.04, 1.28)	0.093
Availability of fire extinguisher							
Yes	47 (90.4)	1			-	-	-
No	15 (75.0)	0.32	(0.08, 1.25)	0.102	-	-	-
Availability of first aid facilities							
Yes	52 (91.2)	1			1		
No	10 (66.7)	0.19	(0.05, 0.79)	0.022	0.34	(0.07, 1.58)	0.171
Adequate number of toilets							
Yes	42 (89.4)	1			-	-	-
No	20 (80.0)	0.48	(0.12, 1.84)	0.281	-	-	-
Attended seminar on health safety							
Yes	51 (92.7)	1			1		
No	11 (64.7)	0.14	(0.03, 0.60)	0.008	0.21	(0.05, 0.93)	0.040
View on management relation in situations of fatal accidents							
Positive	41 (87.2)	1			-	-	-
Negative	6 (85.7)	0.88	(0.09, 8.62)	0.911	-	-	-
Neutral	15 (83.3)	0.73	(0.16, 3.30)	0.685	-	-	-
View on management in fatal accident compensation situation							
Positive	24 (88.9)	1			-	-	-
Negative	13 (86.7)	0.81	(0.12, 5.50)	0.831	-	-	-

**Table 5 continued**

Neutral	25 (83.3)	0.63	(0.13, 2.91)	0.549	-	-	-
How accident victims are compensated							
Positive	19 (90.5)	1			-	-	-
Negative	15 (93.8)	1.58	(0.13, 19.12)	0.720	-	-	-
Neutral	28 (80.0)	0.42	(0.08, 2.25)	0.312	-	-	-

**Table 6: Relationship between Employees' Health and Safety and their Level of Performance**

Characteristics	Univariate logistic regression				Multivariate logistic regression		
	n (%)	OR	95% CI	P-value	OR	95% CI	P-value
Involvement in any accident before							
Yes	14 (87.5)	1			-	-	-
No	48 (85.7)	0.86	(0.16, 4.51)	0.856	-	-	-
Whether accident has affected work output							
Yes	18 (85.7)	1			-	-	-
No	39 (84.8)	0.93	(0.21, 4.01)	0.921	-	-	-
Health problem lowered contribution co-worker at work							
Yes	28 (80.0)	1			-	-	-
No	34 (91.9)	2.83	(0.67, 11.98)	0.157	-	-	-
Pulled back because of risk involved in a task							
Yes	16 (80.0)	1			-	-	-
No	45 (88.2)	1.88	(0.47, 7.51)	0.375	-	-	-
Safety policy strong factor capable of							

**Table 6 continued**

motivating staff							
Yes	44 (86.3)	1			-	-	-
No	18 (85.7)	0.95	(0.22, 4.11)	0.950	-	-	-
Rating co-workers and yourself as being productive							
Yes	59 (86.8)	1			-	-	-
No	2 (66.7)	0.31	(0.03, 3.72)	0.352	-	-	-
Whether daily targets are usually achievable							
Yes	43 (87.7)	1			-	-	-
No	19 (82.6)	0.66	(0.17, 2.62)	0.558	-	-	-

uOR unadjusted odds ratio; aOR adjusted odds ratio; CI: confidence interval

## CHAPTER FIVE

### SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

#### Introduction

The purpose of this chapter is to look at the research outcome, the findings, observations and conclusions that can be drawn as to whether the research questions and objectives have been achieved. Suggestions and recommendation can then be made by the researcher.

The questionnaires were analysed using descriptive statistics. Proportion was used to summarise variables that were categorical in nature. The dependent variable (presence of employees' health and safety policy in organisations) in this study was binary in nature, therefore, the logistics regressions was used to determine the relationship between the dependent variable and other explanatory variables in this study. All variables that were identified to be statistically significant were adjusted for in the multivariate regression to determine the effect of several variables on the dependent variable. All variables with P- value less than 0.05 were considered as statistically significant.

The study was conducted with the broad objective of finding out the relationship between employee health and safety and performance using Kintampo-North Municipal Hospital as study area. Results from univariate logistics regression identified employees health and safety associated with the availability of resources such as access to welfare facilities. When the respondents

were asked whether welfare facilities were reasonably accessible to them on site, majority said yes. This indicates that the service has employee's health and safety in mind when setting out the work environment and policies.

Availability of fire extinguishers at the work place was found to be associated with employees' health and safety. Management of the hospital consider the health and safety of their employees very paramount by providing basic safety equipment despite various challenges district hospitals encounter.

First aid facilities are available at the Hospital. Hospitals generally make first aid available since occupational hazard is not rare in their work environment. Staff at work can suffer injuries or taken ill. It doesn't matter whether the injury or illness is caused by the work they do or not, it is important to give them immediate attention. This saves lives and prevents minor injuries becoming major ones. The Health and Safety (First Aid) Regulations 1981 require workplaces to provide adequate and appropriate first aid equipment and facilities so that employees can be given immediate help if they are injured or taken ill at work.

Adequate number of toilets at the hospital was also found to be closely associated with employees' health and safety. A toilet is a sanitation fixture used primarily for the disposal of human waste. Diseases, including cholera, which still affects some 3 million people each year can be largely prevented when effective sanitation and water treatment prevents fecal matter from contaminating drinking water supplies.

Majority of the respondents said management has been organising periodic health and safety discussion with them. These discussions in a way provide information to employees. Employees also have their say about hazardous/controls, incidents/accidents, work processes and the service's procedures. The Health and Safety Employment Act,1992, places duties on employers to provide their employees with opportunities to participate in safety activities.

More than half of the respondents have attended seminar on health and safety issue. Seminars have become very effective ways of maintaining safety awareness and bringing attention to any current or emerging hazards and risks. They are meant to be brief interactive discussions about a specific topic but can also touch on a number of issues relevant to the workplace.

The study revealed that management has been supportive to employees in fatal accident situations. An accident is an incidental and unplanned event that could have been prevented had circumstances leading up to the accident been recognised, and acted upon, prior to its occurrence. Work accidents are accidents arising out of work or during the execution of work. According to the International Labour Organisation (ILO), more than 337 million accidents happen on the job each year, resulting, together with occupational diseases, in more than 2.3 million deaths annually. Kintampo-North Municipal Hospital has found a way of rewarding or making up for employees loss, damage or injury by giving the injured party an appropriate benefit.

## **Conclusion**

In conclusion, performance goal is often upheld by kintampo municipal hospital. To accomplish this goal remains the sole responsibility of workers and as being directed by management. The management need to direct more attention and resources toward maintenance of machines, equipment and materials to the benefit of human resources, who are responsible for the manipulation of other resources, for the organization to achieve its set goals.

One of the areas often neglected by management of the hospital is the provision of safe work environment for workers. In Ghana, as is the case in almost all hospitals, there is no organized regulatory agency charged with the responsibility of conducting regular monitoring and checks in hospitals to ascertain compliance with the occupational and safety rules and procedures. Over the years, this has been the reason behind wanton degree of hospital workplace accidents and occupational diseases in hospitals.

Effective health and safety management have been discovered to have positive correlation with the increased organizational performance and profitability, as the cost associated with the absence of it could be highly minimized.

## **Recommendations**

There are many organizations with many workers in their employment, yet maintaining little or haphazard attention to health and safety program. They may see such program as a wasteful venture without considering the negative



cost implications of such perception. Researchers reveal greater percentage of organizational success based on the maintenance of effective health and safety management system. Therefore, to enable management reduce hazards accidents and effects of disasters in the work place, in order to reduce costs associated with the unsafe work environment in Kintampo Hospital, the following recommendations are made;

1. Management of kintampo hospital should develop effective health and safety policy and ensure its effective implementation within the hospital
2. Occupational health and safety organization or unit should be established by management of the hospital with specific responsibilities built into the service structure with competent leadership.
3. Management of kintampo hospital should incorporate selected workers in the development of health and safety program for the service to enhance their commitment in the implementation of health and safety policy as well as compliance with the relevant safety and health standards and procedures.
4. Staff training and induction programs should contain reasonable volumes of the hospital health and safety standards, rules, procedures, responsibilities, liabilities and sanctions.
5. Management of kintampo hospital should carry out adequate job analysis to help identify job related hazards, which should be communicated to workers during training induction, orientation, seminar or workshop.
6. Both managers and employees of kintampo hospital should be made to know specific health and safety responsibilities and goals to be built into

job description and contracts and made accessible to all the stakeholders of the hospital.

7. The hospital should promptly inform workers about health hazards associated with the jobs they are assigned to perform. This will help them to take appropriate actions in maintaining their health through- medical consultations and cure. Such information will also enable workers to take adequate precautionary measures by using appropriate equipment and protective facilities at work.

### **Direction for future research**

There is the need for further research work on this subject because of the limitations stated above.

The study only surveyed nurses. The transferability of the study findings could be further strengthened by surveying and interviewing the other category of workers to gain more comprehensive understanding of the issues suggested by the nurses. Further research work should find more innovative ways to access enough literature from which to draw the desired conclusion.

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APPENDIX A

UNIVERSITY OF CAPE COST

SCHOOL OF BUSINESS

DEPARTMENT OF MANAGEMENT STUDIES

EFFECTS OF ORGANIZATIONAL HEALTH AND SAFETY POLICIES  
ON EMPLOYEE PERFORMANCE: A STUDY OF KINTAMPO - NORTH  
MUNICIPAL HOSPITAL.

This questionnaire has been designed to solicit information for a survey being undertaken to determine Employees Opinion about the Effects of Organizational Health and Safety Policies on Employees Performance at Kintampo - North Municipal Hospital. The Results will provide the Hospital and others with insight on how to better serve the Health and Safety needs of Employees. Your Opinions are important to the study; they will strictly remain confidential.

**SECTION A: SOCIO DEMOGRAPHIC CHARACTERISTICS:**

1. Sex  Male  Female
2. Age  Below 20  20 - 29  30 - 39  40 - 49   
 Above 50
3. Marital status  Married  Divorced  Widowed   
 Never Married  Separated

4. Highest level of Education  SSS  Certificate  Diploma   
Degree and over (specify) -----
5. How long have you been working with this Hospital .....
6. What is your Rank .....
7. Which Department / Unit do you belong to? .....

**SECTION B: AVAILABILITY OF RESOURCES**

8. Are all Welfare facilities reasonably accessible to you on site?  Yes   
No
9. Are fire extinguishers available to you at your workplace?  Yes   
No
10. Are first Aid facilities available to you at your workplace?  Yes   
No
11. Are there adequate number of toilets, veronica buckets, cleaners and towels  
and are they being well maintained? Yes  No
12. Does the management organize periodic health and safety talk/ discussion  
session for you?  
Yes  No
13. Have you ever attended a seminar on Health and Safety Issue?  Yes   
No
14. What is your view on management relation in situations of fatal accident of an  
employee? Positive  Negative  Neutral



15. What is your view on management relation in fatal accident compensation situation? Positive  Negative  Neutral

16. How are these victims compensated? Positive  Negative  Neutral

**SECTION C: EMPLOYEE PERFORMANCE SKILLS**

17. Does safety and good health enhance your performance? Yes  No

18. Have you ever been involved in any accident before? Yes  No

If yes, please list the type of accident.....

19. Has this influence your work output? Yes  No

20. Have you ever noticed a scene where a health problem has lowered the contribution of a co-worker at work? Yes  No

21. Has there been time you have pulled back at work because of the risk involved in a task? Yes  No

22. Is the safety policy a strong factor that is capable of motivating you?  Yes   
No

23. Will you rate yourself and your other co-workers as being productive?  
Yes  No

24. Is there any other thing that could be done to boost your performance?  
Yes  No

25. Are the daily targets usually achievable? Yes  No

26. How often does your group perform above the set target by the management?  
Very often  Seldom  Never

**SECTION D: CHALLENGES OF OCCUPATIONAL HEALTH AND  
SAFETY**

27. Are there any noticeable problems facing employees Health and safety? Yes   
No
28. Is the government performing up to your expectation on Health and safety  
Services related? Yes  No
29. What are the challenges that you have relating to your Health and safety  
Services at work? None  little (stress related)  Slightly  Serious  
Health Problems
30. Are the health and safety policies difficult to abide by? Easy  Very easy   
Hard

**Thank you for your help.**